Amvale Limited

Amvale Medical Transport - Ambulance Station

Quality Report

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Date of inspection visit: 17 to 18 October 2017
Date of publication: 20/02/2018

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

Amvale Medical Transport – Ambulance Station is operated by Amvale Limited. The service provides emergency and urgent care and a patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17 October 2017.

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

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

The main provision provided by this service was a patient transport service. Where our findings on the patient transport service for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport core service.

Services we do not rate

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

We found the following areas of good practice:

- The service had improved on the majority of the issues for action highlighted in the previous inspection in January 2017. During the last inspection, we found that clinical waste was not stored in line with infection prevention and control practices. During this inspection, we found improvements and the storage of waste was in line with infection prevention guidelines.
- Staff followed infection control policies that managers monitored to improve practice. Managers were able to respond to requests to provide the service in a timely manner and had the flexibility in the resources to meet the needs of commissioners.
- We found the environment clean and tidy and the vehicles and equipment were well maintained.
- Staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learnt and changes in practice with staff. When things went wrong patients received an apology.
- Patients records were stored securely the patient record forms we checked were all completed fully.
- Staff had received training to enable them to care for patients effectively and staff were able to identify and respond appropriately to patients if they deteriorated.
- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults and children.
- Staff provided care and treatment based on national guidance and evidence, and used this to develop new policies and procedures.
- New staff received an induction programme and staff received annual appraisals.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Patients were taken to the appropriate hospital, based on their needs.
- We saw good evidence of multi-disciplinary working between staff from the hospital and the ambulance crews.
- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.

Summary of findings

- Staff provided emotional support to patients to minimise their distress.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results.
- Staff took into consideration the individual needs of patients when each booking was made to support the safe transport of patients.
- The service had a strategic plan and service values that were resonant across all groups of staff.
- Staff described the culture within the service as open to change and supportive. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- The service had a clear leadership structure and each member of the leadership team had clear roles and responsibilities.
- The service had effective systems and processes in place regarding recruitment of staff.
- The service has gone through periods of uncertainty over the last year with the reduction and termination of the urgent and emergency care service contract, the service and its staff showed resilience in the process and continued to support the contract and show flexibility to the demand on their services.

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

- During the previous inspection in January 2017, we found that controlled drugs were not checked in and out of the safe at the beginning and end of each paramedic's shift. During this inspection we found that this was still happening.
- We found a batch of a medicine that had passed the expiry date.
- We found that some hazardous substances were not stored in a locked cupboard. This did not comply with control of substances hazardous to health (COSHH) legislation.
- Not all staff we spoke with were aware of female genital mutilation (FGM) and had not received training regarding this. This is important, as reporting any recognised incidents of FGM is a legal requirement for all healthcare staff.
- A safeguarding lead had been appointed who had been trained to safeguarding level three. The intercollegiate document states that the identified safeguarding lead should be trained at level four for children.
- We found crews checked their vehicle daily, if a fault was found there was no audit trail as to whether this had been reported and resolved.
- Although a medicine policy was in place, there was no clear guidance for staff to follow or have consideration to when handling patients own medication, when administering patients own medication or when transferring a patient with a syringe driver (which is used to give patients medication continually over a period of time).
- An audit was in place of the patient report forms, which captured what care, and treatment had been provided in line with evidence-based practice, this audit had not taken place since August 2016.
- The service had a number of processes in place to monitor the quality and safety of the services that were provided. However, the service did not have oversight of other key areas, for example, the audit of the management and storage of controlled drugs was not robust.
- There was some duplication in the two management meetings that took place and some areas of clinical governance were not discussed within the meetings.
- The service did not have a fit and proper persons policy that all directors are required to comply with.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals Ellen Armistead, 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?
Emergency and urgent care services		We have not rated this service because we do not currently have the legal duty to rate this type of service or the regulated activities it provides. Urgent and emergency services were a small proportion of activity. The main service was patient transport services. Where arrangements were the same, we have reported findings in the patient transport services section.
Patient transport services (PTS)		We have not rated this service because we do not currently have the legal duty to rate this type of service or the regulated activities it provides. The main service provided by this ambulance service was the patient transport service. Where our findings on the patient transport service, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the patient transport service section.

Amvale Medical Transport - Ambulance Station

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS)

Detailed findings

Contents

Background to Amvale Medical Transport - Ambulance Station

Amvale Medical Transport – Ambulance Station is operated by Amvale Limited. Amvale Medical Transport Limited (AMTL) was established in 1991 as part of Amvale Limited which was established in 1985. The company expanded and introduced in 1998 non-clinical transport services with blood and organs for United Kingdom Transport for Transplants and the British Transplant Service. This provision is not regulated by the Care Quality Commission; therefore we did not inspect that part of the service.

The service provides a patient transport service and an urgent and emergency care service. In addition it provides specialist transport for patients with mental health needs across the United Kingdom. This service for patients with mental health needs is provided on an ad-hoc basis, using some staff who work as part of the non-clinical transport services with blood and organs, and some staff from the patient transport service. AMTL also sub-contracts some of the mental health work to other independent ambulance providers across the country.

The patient transport services serve the communities of Lincolnshire and Hull and East Yorkshire. The emergency and urgent care aspect of the service serves the communities within the East Midlands, although both services are able to undertake long distance journeys if required. AMTL have contracts from two NHS Hospitals and two NHS ambulance providers.

We previously undertook a focussed inspection of the emergency and urgent care service in January 2017. We inspected a hub location in Leicester which has since been closed due to the reduction in the contract. Following that inspection we served the company with a requirement notice against regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. This was in relation to the proper and safe management of medicines.

The service is run from the headquarters based in Scunthorpe. The NHS contract for the urgent and emergency care service is due to finish at the end of October 2017.

The service has a registered manager in post since 1991. The current registered manager had taken over that role in December 2016.

Our inspection team

The team that inspected the service comprised of Annette Wilkes (CQC lead inspector),two other CQC

Detailed findings

inspectors, and a specialist advisor with expertise in governance and leadership. The inspection team was overseen by Lorraine Bolam, Interim Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the headquarters at Scunthorpe, where the ambulance station is based. We spoke with 20 staff including; emergency care assistants, ambulance care assistants and management. We spoke with one patient and one relative. During our inspection, we reviewed 10 patient records.

Facts and data about Amvale Medical Transport - Ambulance Station

The service is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in January 2017. This was follow up inspection as a result of a responsive inspection in July 2015.Following this inspection we issued a requirement notice telling the service that they must improve.

Activity

- In the reporting period January 2017 to June 2017 there were 4393 patient transport journeys undertaken.
- The data for the urgent and emergency care services was not collected. However, the management team informed us that during the last 6 months there had been an average of 1200 patient report forms generated by the crews. These are forms completed for each patient with details of the patient and the treatment received.

Two registered paramedics, 2 technicians and 13 emergency care assistants worked on the urgent and emergency care side of the service.

10 ambulance care assistants and 10 technician's level 1 worked on the patient transport side of the service.

The service had five patient transport ambulances and four emergency ambulances in use at the time of the inspection.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No Never events
- No serious incidents
- One formal complaint regarding the patient transport service.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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

Summary of findings

We have not rated this service because we do not currently have the legal duty to rate this type of service or the regulated activities it provides.

Emergency and urgent care services

Are emergency and urgent care services safe?

We do not currently have a legal duty to rate independent ambulance providers. We found the following areas of good practice: -

- During the last inspection in January 2017, we found at a hub location that clinical waste was not stored in line with infection prevention and control practices. During this inspection, we found the storage of waste to be in line with infection prevention guidelines. Staff followed infection control policies that managers monitored to improve practice.
- During the previous inspection, we found that the transportation of controlled drugs documentation was not always completed. We found during this inspection, due to the fact that hub location was now closed; the transportation of controlled drugs (CD) s documentation was no longer in use.
- During the previous inspection, we found a patient group directive (PGD) was not in place for the administration a drug that was not covered in Schedule 17 and 19 of the Human Medicine Regulations. This had been since put in place and signed by the appropriate personnel.
- Medicines were stored securely.
- We found the environment clean and tidy and the vehicles and equipment were well maintained.
- Staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learnt and changes in practice with staff. When things went wrong patients received an apology.
- Patients records were stored securely the patient record forms we checked were all completed fully.
- Staff had received training to enable them to care for patients effectively and staff were able to identify and respond appropriately to patients if they deteriorated.
- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults and children.

However,

- We found a batch of a medicine had passed the expiry date.
- During the previous inspection in January 2017, we found that controlled drugs were not checked in and out of the safe at the beginning and end of each paramedics shift. We still found gaps in the process and there was no guidance in place for staff to follow.
- A process the service had in place of auditing the use of controlled drugs against the patient report forms had not taken place for the past 12 months.

Incidents

- The service had an untoward incident policy and a serious incident and never event policy available to all staff. Incident reporting was provided as part of the mandatory training.
- There were no never events or serious incidents reported between March 2016 and September 2017.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- There had been four non clinical incidents between March 2016 and September 2017. Actions were taken as result of the incidents to improve patient care.
- Incidents were discussed within the management monthly team meeting and the clinical governance co-ordinating group meeting (held every three months). We saw evidence of joint investigations with the NHS ambulance service, for which the service was a sub-contractor.
- Staff were able to explain the process of reporting incident and most staff said they received feedback as a result of an incident either in person or by email.
- Some junior members of staff were not aware of the duty of candour, which 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.

- The service had not had any incidents that led to moderate or above harm that would trigger the duty of candour principles. The senior management told us they would apply duty of candour if necessary.

Cleanliness, infection control and hygiene

See patient transport section for main findings.

Environment and equipment

See patient transport section for main findings.

Medicines

- During the previous inspection in January 2017, the 'transportation of medicines' form was not completed at all stages in the transportation of controlled drugs. We found during this inspection, due to the fact that hub location was now closed; the transportation of controlled drugs (CD's) documentation was no longer in use.
- During the previous inspection we found that controlled drugs were not checked in and out of the safe at the beginning and end of each paramedics shift. We still found that this practice was still taking place during this inspection.
- During the previous inspection in January 2017, we found a patient group directive (PGD) was not in place for the administration a drug that was not covered in Schedule 17 and 19 of the Human Medicine Regulations. This had been since put in place and signed by the appropriate personnel. PGD's provide a legal framework, which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a defined group of patients without them having to see a doctor.
- There was a medicine policy in place that described that storage should be in a locked cabinet or approved safe.
- The medicine policy describes the accountable officer for controlled drugs as the clinical lead. The chief executive officer has the overall statutory responsibility for the safe and secure handling of medicines and is responsible for ensuring that adequate resources are made available to facilitate medicines management, including the provision of an organisation pharmacist advisor. The medical advisor is responsible for ensuring the necessary policies and procedures are in place for the safe management of medicines and managing and supporting the developing of PGD's and providing expert advice on the management of medicines.
- Prescription only medicines including controlled drugs were ordered from a local pharmacy
- Monthly stock checks audits were completed and we saw evidence of these.
- The ambulance headquarters had a Home Office United Kingdom Controlled Drug Licence to allow them to possess and supply controlled drugs.
- We found prescription only medicines were stored appropriately in a locked room and in a metal cabinet.
- Medical gases were stored in a locked metal cabinet in a locked garage. Empty cylinders were stored in a separate cage. Gases were obtained directly from an external supplier.
- Oxygen and analgesic gases were securely stored on the ambulances. These were full and in date.
- We found the CDs were stored in a locked medicine room; the key was accessed from a key safe with coded access. The CD cabinet was metal and limited people had access to the key for the room and the codes.
- We checked the cupboard which contained a CD register which the pharmacist and a witness used to sign in the CD's. These CD's were then used to stock individual lockable metal tins which were numbered and tagged. The majority of the tins were tagged red which meant they were not in use. There were five tins in use, these were tagged green. The number of tins in use had reduced due to the workload reducing. Each tin contained the drugs and a book that the paramedics completed which included the patient name, the name of the drug given, the date, time, amount, batch number, expiry date and a witness signature. The books we looked at were all fully completed.
- We found two tins that contained a batch of the same drug that had passed their expiry date, the manager was alerted and took these out of use.
- There was a book used where paramedics documented that they checked out the tin at the beginning of the shift and checked the tin in at the end of the shift. We found gaps in this, one tin had been kept out for two days and we found one tin missing. We alerted the management team, and found the paramedic on duty had the missing tin. This had been booked out 17 days previously and not booked back in. The management team had failed to noticed this. When they spoke with the paramedic, they found that as there were only two paramedics working currently for the organisation, they had been leaving the tin in the ambulance safe. This was safe, as the ambulance safe was locked in a locked

ambulance in a locked manned garage, with closed circuit television (they have a 24 hour control room running from the premises). However, there was no audit trail if a drug was missing or record of which shift it went missing, therefore they would not be able to ascertain who was responsible for the missing drug.

- Two ambulance technicians worked as part of an NHS ambulance contract. They gave limited medications that were covered by the NHS ambulance contract policies and ways of working.
- An audit of the use of controlled drugs was cross-referenced against the entries on the patient report forms took place every month. However, we found this audit had not taken place since January 2017 therefore, the service cannot be assured that the controlled drugs given were given appropriately and the amount given were accounted for.
- There were paramedic bags within the medicine storage room, these were tagged and sealed to allow crews to notice if they had been tampered with. Each paramedic bag contained a selection of cannula's, a sharps bin that was dated and signed, and a form that crews completed when they gave medicines. This included the patients' details, date, batch number, patient report form number and amount given. This form was audited and matched against the patient report forms when they were audited.
- There were two separate pouches, one containing drugs used in a cardiac arrest including intravenous fluids, and one pouch containing drugs used for patients who were diabetic and had low blood glucose levels.

Records

- The service had confidentiality and data protection policy and an information technology policy. The policies highlighted the importance of keeping all records secure and how to maintain confidentiality and not disclosing personal identifiable information.
- The clinical coordinator explained that they had completed an audit of patient record form completion. This was last undertaken in August 2016. We saw that some areas scored 100% for record completion, such as for recording the incident date, patient history, and chief complaint. However, other areas were identified as needing to improve such as recording crew signatures, location, and timings. The clinical coordinator told us that staff had been sent emails reminding them of recording requirements.
- We reviewed ten recent patient record forms. These were fully completed and legible.
- Records were stored securely in a yellow plastic wallet on the vehicles and returned to the station at the end of the shift.
- Information and special notes such as do not attempt resuscitation orders (DNACPR) were included, as part of patient records and staff were made aware prior to transporting a patient if a DNACPR order was in place. When we spoke to staff, they were aware they needed to have original copies.

Safeguarding

- The service had a safeguarding adults and children's policy. An information leaflet was also given to crews that guided staff in recognising a potential safeguarding concern and who to report it to. This included useful contact numbers including the 24-hour helpline and numbers such as the Samaritans and national domestic violence helpline that they could give to patients.
- We were told if a service user had a protection plan in place, the control centre would flag this and the crews would be informed by the NHS trust for which the service subcontracted.
- A safeguarding lead had been appointed who had been trained to safeguarding level three. The intercollegiate document states that the identified safeguarding lead should be trained at level four for children. We were told they were looking into doing the training in the near future. Managers told us that all staff undertook safeguarding children and adults training at induction and we saw evidence of this in the training files. This was provided in partnership with the local council safeguarding forum. They said that all staff was expected to undertake safeguarding level three training within one year of induction. Staff told us that they had received safeguarding children, adults training, and updates.
- Staff were aware of what to do if they identified safeguarding concerns. This included taking immediate steps to keep the patient safe, seeking advice from senior staff in the organisation, and liaising with other health and social care professionals to safeguard the wellbeing of a patient. Three members of staff gave specific examples of when they had raised a

safeguarding concern and taken appropriate actions to safeguard patient wellbeing. Staff told us that they could seek 24-hour clinical advice from the organisation if they needed it.
- The crews working as part of the NHS contract would report a safeguarding concern using the 24 hour safeguarding reporting line which the NHS trust has in place. This reporting line telephone number was stored in the ambulance mobile phones to enable easy and quick reporting.
- Crews we spoke with were not aware of female genital mutilation (FGM) and had not received training regarding this. This is important, as reporting any recognised incidents of FGM is a legal requirement for all healthcare staff.
- Information supplied by the provider showed that four staff had completed preventing radicalisation training during 2017.

Mandatory training

- All staff had received mandatory training in 2016, which included basic life support and the use of an external automated defibrillator, ambulance equipment, oxygen therapy, ECG monitoring, confidentiality, health and safety and incident reporting and complaints management.
- The training lead and clinical coordinator said that some staff had very recently undertaken face-to-face basic life support and AED training and assessment. Six staff members within the organisation were still due to complete the updates for 2017. The clinical coordinator explained that additional training days had been provided for staff that had been unable to attend original dates. They said that reminders were sent to staff that had not completed training updates and if they did not undertake training within a specified time frame then they could be suspended from duty until they had.
- There was a designated member of staff responsible for managing training in the organisation. The clinical lead / training manager told us that there was not a policy to specify which training was required for different staff members and how frequently training should be undertaken. However, they said that annual online updates were required for all staff.
- We saw examples of the course programme for the emergency care assistants, which consisted of a role-specific training programme and assessments.
- Staff training was recorded in staff files. The clinical coordinator also showed us a spreadsheet of training completed by staff compiled in 2016, but this spreadsheet was not routinely updated. There was an additional system to check that online training had been completed for staff. The clinical coordinator told us that there were plans to develop and maintain a training matrix to help monitor that all induction, online, and face to face training was completed within agreed timeframes for all staff.
- The training lead told us that staff undertook in house driver training. For those staff that were trained in blue light driving this course was nationally recognised driving qualification required by all NHS ambulance services and was delivered in conjunction with the NHS ambulance service. We saw the agenda of the four-week course, which included written and practical assessments. Driving was monitored using a global positioning system (GPS) that was present on all vehicles. If a staff member exceeded the speed limit then this could be flagged.
- Paramedics were given a clinical skills record book to monitor and evidence the clinical skills they performed to add to their personal professional portfolios.
- Staff were supported to obtain further qualifications to enable them to advance their career roles.

Assessing and responding to patient risk

- Staff were trained to assess for the early detection and treatment of deteriorating patients.
- Pathways were used in conjunction with the NHS ambulance trust, which the service sub-contracts.
- Staff were able to access the clinical hub of the ambulance service if they required further clinical advice.
- National Early Warning Scores (NEWS) was used, which supported the process for early recognition of those patients becoming unwell. The audit of the patient report forms demonstrated that NEWS was recorded.

Staffing

- There was a resource and staffing manager in post who dealt with staffing for the whole organisation.
- Emergency care assistants and technicians were on full time contracts and employed by the provider. One paramedic was also directly employed on a full time contract. All other paramedics were employed as self-employed contractors as required.

Emergency and urgent care services

- There were two paramedics, 13 emergency care assistants and two ambulance technicians employed to cover a contract with a local NHS ambulance service. This contract had recently been reduced and was due to end in October 2017. Staff were to TUPE across to the NHS ambulance organisation. TUPE stands for the Transfer of Undertakings (Protection of Employment) Regulations.
- Staff told us they were well supported by the service during this process.
- Staff worked day shifts either 8am to 8pm or 9am to 9pm. There was at least 11 hours between shifts in line with the working time directive. If crews were late off then they would start later the next day.
- There was a sickness and absence policy and sickness was managed using a tool, which identified trends in sickness, which is a point system that is linked with the disciplinary policy. The service did not provide us with an overall sickness percentage rate, but were able to provide us with a spreadsheet with each staff member's sickness and a score based on the tool used to measured unplanned absence from work.

Response to major incidents

- Staff received training as part of their induction regarding their role in a major incident.
- There were no action cards or triage packs on the emergency ambulances if the crews were first on scene. We were told they would escalate to the NHS ambulance service and support them with the resources they had available. This would include liaising with the NHS ambulance providers and hospitals management teams.
- The service had a control disaster and reactivation policy, which discussed what to do in the event of an incident which would affect the service delivery such as a power failure, communication failure or flooding. It discussed what equipment was available and what would be needed to relocate premises.

Are emergency and urgent care services effective?

At present, we do not rate independent ambulance services. However, during our inspection we noted the following for effective;

- Staff provided care based and treatment based on national guidance and evidence, and used this to develop new policies and procedures.
- New staff received an induction programme and staff received annual appraisals.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Response times were in line with the NHS Trusts from which the service sub-contracted.
- Patients were taken to the appropriate hospital, based on their needs.

However;

- An audit was in place of the patient report forms audit, which captured care, and treatment had been provided in line with evidence-based practice, this audit had not taken place since August 2016.

Evidence-based care and treatment

- A range of pathways were in use that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. These pathways were from the NHS Ambulance Trust from which the service sub-contracted.
- Guidelines and pathways were easily accessible for the staff. These were sent to staff via email and bulletins from the NHS ambulance trust were displayed in the ambulance station.
- The patient report form audit captured if the pathways were followed correctly. Data had been used to evaluate performance against national and local performance indicators relating to conditions such as asthma, falls, febrile convulsions, stroke, and chronic obstructive pulmonary disease. Staff told us that any required actions identified from the audit were communicated verbally to individual staff members or through clinical bulletins, which were emailed to staff. However, the audit of patient report forms had not been undertaken since August 2016.
- Data was analysed for each staff member and staff were then provided with individual action plans. This data was also shared with the NHS ambulance trust. However, the audit had not been completed since August 2016, so we had no assurance that staff were

following the correct pathways and giving the best care and treatment. No complaints were upheld that had been received from the hospitals or the NHS ambulance trust relating to care and treatment in the last 12months.

Assessment and planning of care

- Patients had their needs assessed and their care provided in line with best evidence based practice. If patients did not require transport to hospital then crews would provide treatment and advice as appropriate and leave the patient at home. Additional support or advice would be given if necessary for example a referral to the GP.
- Staff were aware of local protocols for the transportation of patients who required specific hospitals. For example, if a patient had a suspected heart attack or stroke, they would take the patient to the appropriate centre for the treatment of that condition. This may require bypassing the local hospital to go to a tertiary centre.
- Protocols for the treatment of children were followed as directed by the NHS trusts.

Response times and patient outcomes

- Response times were in line with the NHS Trusts from which the service sub-contracted. If the service did not meet the response times then the NHS provider would contact the management team who would investigate.
- The service could electronically track all vehicles and could monitor the speed, route, time spent on scene, and time spent at the hospitals. This was a useful tool if there was any complaints regarding response times, the management team could look back on the data.
- The service provided a 999 service for one NHS ambulance trust and was dispatched by the trust to Red 1 calls, which are immediate life threatening calls.
- The service did not take part in any national audit or wider benchmarking.

Competent staff

- Staff told us that individual managers were responsible for carrying out appraisals of their teams and that details of appraisals were logged in individual staff members' files.
- All staff had received an appraisal in the last 12 months.
- All staff had completed induction training that included organisational familiarity and code of conduct. Staff received an induction document to complete which had personal details plus an overview of the site, departments and procedures. Staff that we spoke with told us that they had attended induction training. Records provided by the training lead showed that induction training included topics such as safeguarding, basic life support, use of automated external defibrillator (AED), moving and handling, information governance, capacity and consent, infection prevention and control, equality and diversity, and mental health. Staff had access to online training courses on these and other topics to enable them to develop and update their knowledge.
- Training was given by appropriately qualified staff and staff had could access additional training if needed following a discussion with a manager. Staff we spoke with felt they had the adequate skills to carry out their jobs.
- Staff training was recorded in staff files. The clinical coordinator also showed us a spreadsheet of training completed by staff compiled in 2016, but this spreadsheet not routinely updated. There was an additional system to check that online training had been completed for staff. The clinical coordinator told us that there were plans to develop and maintain a training matrix to help monitor that all induction, online, and face to face training was completed within agreed timeframes for all staff.
- Managers told us that two references were required for each staff member, one to include a previous employer. The clinical lead told us that all staff underwent pre-employment and random drug and alcohol checks to ensure fitness to undertake their role.
- The clinical coordinator showed us the system for ensuring that paramedic staff were up to date with professional registrations. A spreadsheet indicated registration renewal dates and status. The clinical coordinator said they regularly checked this spreadsheet and the Health and Care Professional Council (HCPC) website to ensure professional registration was current. The clinical coordinator noted that for one staff member a check had not been undertaken until after their professional registration documentation had expired. Therefore, for a 12 day period there would not have been assurance that the person was appropriately registered. However, the

Emergency and urgent care services

clinical coordinator explained that when the check had later been completed, the person was shown to have current and continuous registration for this 12-day period.
- Paramedics completed a three monthly declaration in which staff were asked to indicate whether continuous professional development was up to date.
- We saw evidence of Disclosure and Barring Service (DBS) checks, which help employers, make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.
- Driving license checks occurred six monthly and there was a SOP in place that described a protocol if points had occurred.

Coordination with other providers

- There was agreed care pathways in place with the NHS ambulance trust from which the service sub-contracted. These ensured patients were treated in a way to achieve the best possible outcome.
- Patients were taken to the appropriate hospital, based on their needs. For example, patients with major trauma were taken to a tertiary centre for major trauma.
- There appeared to be a good relationship between the provider and the NHS ambulance trust and they could escalate of any issues. For example, we saw evidence of joint working when investigating complaints and incidents.

Multi-disciplinary working

- See patient transport section for main findings.

Access to information

- See patient transport section for main findings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- See patient transport section for main findings.

Are emergency and urgent care services caring?

We did not inspect the caring domain for urgent and emergency care services.

See patient transport section for main findings.

Are emergency and urgent care services responsive to people's needs?

At present, we do not rate independent ambulance services. However, during our inspection we noted the following for responsive;

- Managers were able to respond to requests to provide the service in a timely manner and had the flexibility in the resources to meet the needs of commissioners.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results.

Service planning and delivery to meet the needs of local people

See patient transport section for main findings.

Meeting people's individual needs

See patient transport section for main findings.

Access and flow

- The service worked with the NHS ambulance service to support them to meet patient demand for their service.
- The services response times and turnaround times were monitored by the NHS ambulance trust from which the service sub-contracted; the service did not hold these figures.
- Between January 2017 and June 2017, the approximate number of patient journeys was 1200. These figures were not routinely collected.

Learning from complaints and concerns

See patient transport section for main findings.

Are emergency and urgent care services well-led?

See patient transport section for main findings.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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

Summary of findings

We have not rated this service because we do not currently have the legal duty to rate this type of service or the regulated activities it provides.

Patient transport services (PTS)

Are patient transport services safe?

At present we do not rate independent ambulance. However, during our inspection we noted the following for safe;

- We found the storage of waste to be in line with infection prevention guidelines. Staff followed infection control policies that managers monitored to improve practice.
- We found the environment clean and tidy and the vehicles and equipment were well maintained.
- Staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learnt and changes in practice with staff. When things went wrong patients received an apology.
- Patient's records were stored securely and staff felt they had the correct amount of information recorded when they received a booking.
- Staff had received training to enable them to care for patients effectively and staff were able to identify and respond appropriately to patients if they deteriorated.
- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults and children.

However,

- Not all staff we spoke with were not aware of female genital mutilation (FGM) and had not received training regarding this. This is important, as reporting any recognised incidents of FGM is a legal requirement for all healthcare staff.
- A safeguarding lead had been appointed who had been trained to safeguarding level three. The intercollegiate document states that the identified safeguarding lead should be trained at level four for children.
- We found crews checked their vehicle daily, if a fault was found there was no audit trail as to whether this had been reported and resolved.
- Although a medicine policy was in place, there was no clear guidance for staff to follow or have consideration to when handling patients own medication, when administering patients own medication or when transferring a patient with a syringe driver which is used to give patients medication continually over a period of time.
- We found that some hazardous substances were not stored in a locked cupboard. This did not comply with control of substances hazardous to health (COSHH) legislation.

Incidents

- There had been two incidents between March 2016 and September 2017. Actions were taken as result of the incidents.
- The service had an untoward incident policy and a serious incident and never event policy available to all staff. There were no never events or serious incidents reported between March 2016 and September 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Incidents were discussed within the management monthly team meeting and the clinical governance co-ordinating group meeting (held every three months). We saw evidence of joint investigations with the NHS ambulance service, for which the service was a sub-contractor.
- Incident reporting was provided as part of the mandatory training.
- Staff were able to explain the process of reporting incident and most staff said they received feedback as a result of an incident either in person or by email. Some junior members of staff were not aware of the duty of candour, which 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. The senior management told us they would apply duty of candour if necessary.

Cleanliness, infection control and hygiene

- We found the storage of waste to be in line with infection prevention guidelines. Clinical waste was

bagged stored in clinical waste bins, which were emptied by an outside company every four weeks. Any infectious waste was double bagged and placed in a red bag before going into the waste bin.
- The service had an infection prevention policy that was available to all staff.
- Infection prevention and control training was delivered to all staff as part of their induction training and mandatory training updates.
- Staff reported that there were adequate supplies of personal protective equipment (PPE) which included clinical gloves and aprons. Staff were aware when these should be used.
- We observed good hand hygiene, no wristwatches were worn and staff washed their hands appropriately and used hand gel. Hand gel was available on the vehicles and each staff member carried a hand gel. The service did not carry out hand hygiene audits.
- In order to support staff in managing infectious patients appropriately, a screening question was asked as part of the booking procedure. This was added to the information that was sent to the ambulance crew prior to transporting the patients if needed.
- Staff told us that when they transported a patient with an infection they would follow hospital guidance regarding the patient and the infection prevention and control policy, wear appropriate personal protective equipment, clean the vehicle after the patient left, and deep clean the vehicle if required.
- Staff told us that the schedule for deep cleaning vehicles was every six weeks. The provider used checklists to ensure that all external and internal areas of the vehicle were appropriately cleaned.
- Staff told us that cleaning also took place after each patient as an infection prevention and control measure. In September 2017, the service had introduced a cleaning checklist to be completed by staff after each patient. We saw that a small number of these forms had been completed. Staff told us that cleaning had been undertaken, but that this was not always documented.
- Management staff told us that infection prevention and control vehicle spot checks took place.
- We saw evidence of weekly audits, which took place ensuring the environment was cleaned and mop heads were changed according to policy.
- All ambulances, the garage, staff areas and offices were visibly clean and tidy.
- Cleaning equipment was available and a colour coding system was used which separated equipment used for different areas. For example, mop buckets were different colours for the cleaning of the toilets on station, the cab and the inside of the ambulances.
- Disinfectant wipes were available on ambulances to clean equipment such as wheelchairs and stretches.
- The service had a uniform policy, which outlined the roles and responsibilities of all staff members. Staff had an awareness to wash their uniforms separately to all other clothes so that the risk of contamination was reduced. We observed staff uniforms to be clean and smart.

Environment and equipment

- We visited the main headquarters were the patient transport service and urgent and emergency care service were based. The headquarters was manned 24 hours a day seven days a week. The garage was part of the headquarters.
- The headquarters had closed circuit television in place and the garage was locked out of hours.
- The garage was visibly tidy and clutter free. Vehicles were kept inside the garage unless in use that shift. An ambulance station manager and assistant manager manned the station during daytime hours.
- Vehicle keys were kept in a secure locked cabinet.
- We found that some hazardous substances were not stored in a locked cupboard. This did not comply with control of substances hazardous to health (COSHH) legislation. When we highlighted this, they were removed immediately and locked in a metal cupboard clearly labelled COSHH.
- The service had a COSHH file, which included information on substances used.
- Staff told us that they had access to sufficient equipment to carry out their roles. They said if they needed additional equipment, they could request this and it was supplied promptly. One staff member was responsible for checking that ensuring that consumables were in date and replaced as needed.
- There was equipment available for both adults and children, which included harnesses for children and a baby seat.
- The storeroom was well organised, consumables were stored in plastic boxes and were clearly labelled and stored appropriately. There was evidence of good stock rotation. The stock we checked was all in date.

- The service had a total of five patient transport type vehicles and 17 frontline ambulances of which four were currently in use to deliver the urgent and emergency care service. Other vehicles were owned by the service, these were used for activities not regulated by the care quality commission, although these vehicles could be used if needed for the delivery of the services we inspected.
- There was a system to monitor that vehicles on-site and at other bases were maintained. There was a whiteboard, which showed details of the dates of six weekly vehicle safety checks and deep cleans, vehicle servicing, MOT, tax, and vehicle mileage. Folders were maintained for each vehicle that contained documents to show that checks were undertaken. Two frontline ambulances MOT's were overdue however, these vehicles were no longer in use.
- Staff told us that vehicles underwent six weekly safety checks. We saw evidence of six weekly checks recorded on the whiteboard. Staff told us if any vehicle maintenance issues were identified the mechanic was immediately informed and an entry was made into the mechanic's 'fault log'. When the vehicle repair had been completed this was signed off in the fault log by the fleet manager and mechanic.
- Staff were also responsible for carrying out daily vehicle checks to ensure that the vehicle was in a good state of repair. There was a standard list of checks to be undertaken. We reviewed a sample of records that showed that these checks had been completed. However, the person completing the form did not always sign these records. Furthermore, where a fault had been identified, daily vehicle check records did not always indicate the action that had been taken as a consequence, such as reporting the issue, or filling out the relevant forms. Therefore, there was not a system for auditing that all vehicle faults highlighted by crews were reported and resolved appropriately.

Medicines

- The service had a medicines management policy, which described the chief executive officer, has the overall statutory responsibility for the safe and secure handling of medicines and is responsible for ensuring that adequate resources are made available to facilitate medicines management, including the provision of an organisation pharmacist advisor. The medical advisor is responsible for ensuring the necessary policies and procedures are in place for the safe management of medicines and providing expert advice.
- The policy did not give guidance to the handling of patients own medication, when administering patients own medication or when transferring a patient with a medical device in situ, such as a syringe driver (a syringe driver is used to give a patient medicines continuously over a period). The staff told us they would keep the patient's own medication with the patient, and if a patient required medication during the transfer than a nurse from the hospital would escort the patient with them.
- We were told the syringe drivers would be switched off for the journey, unless the medication was needed then a nurse would escort the patient. We asked a manager if staff had been trained as to what to do if the cannula dislodged and we were told they would not know what to do.
- There was no written guidance for the administration of oxygen. The amount of oxygen that patients required was requested as part of the booking procedure and the relevant information was passed to staff prior to transport.
- Staff had received training regarding the administration of oxygen therapy.
- Medical gases were stored in a locked metal cabinet in a locked garage. Empty cylinders were stored in a separate cage. Gases were obtained directly from an external supplier.
- Oxygen and analgesic gases were securely stored on the ambulances. These were full and in date.

Records

- The service had confidentiality and data protection policy and an information technology policy. The policies highlighted the importance of keeping all records secure and how to maintain confidentiality by not disclosing personal identifiable information.
- Records were stored securely in a yellow plastic wallet on the vehicles and returned to the station at the end of the shift.
- Information and special notes such as do not attempt resuscitation orders (DNACPR) were included, as part of

patient records and staff were made aware prior to transporting a patient if a DNACPR order was in place. When we spoke to staff, they were aware they needed to have original copies.
- We reviewed three patient transport record sheets. These contained relevant information and were legible. However, two of these were not signed.
- Paper records were used for recording information, this included basic information such as patient details, arrival and drop off times and if the patient required oxygen, had an infection, had a DNACPR in place.

Safeguarding

- The service had a safeguarding adults and children's policy. An information leaflet was also given to crews, which guided staff in recognising a potential safeguarding concern and who to report it to. This included useful contact numbers including the 24 hour helpline and numbers such as the Samaritans and national domestic violence helpline which they could give to patients.
- A safeguarding lead had been appointed who had been trained to safeguarding children and adult level three. The intercollegiate document states that the identified safeguarding lead should be trained at level four for children. We were told they were looking into doing the training in the near future.
- Managers told us that all staff undertook safeguarding children and adults level three training at induction and we saw evidence of this in the training files. This was provided in partnership with the local council safeguarding forum. They said that all staff was expected to undertake safeguarding level three training within one year of induction. Staff told us that they had all received safeguarding children and adults training and updates annually.
- Staff were aware of what to do if they identified safeguarding concerns. This included taking immediate steps to keep the patient safe, seeking advice from senior staff in the organisation, and liaising with other health and social care professionals to safeguard the wellbeing of a patient. Three members of staff gave specific examples of when they had raised a safeguarding concern and taken appropriate actions to safeguard patient wellbeing. Staff told us that they could seek 24-hour clinical advice from the organisation if they needed it.
- Crews we spoke with were not aware of female genital mutilation (FGM) and had not received training regarding this. This is important, as reporting any recognised incidents of FGM is a legal requirement for all healthcare staff.
- Information supplied by the provider showed that four staff had completed preventing radicalisation training during 2017.

Mandatory training

- All staff had completed induction training that included organisational familiarity and code of conduct. Staff received an induction document to complete which had personal details plus an overview of the site, departments and procedures. Staff that we spoke with told us that they had attended induction training. Records provided by the training lead showed that induction training included topics such as safeguarding, basic life support, use of automated external defibrillator (AED), moving and handling, information governance, capacity and consent, infection prevention and control, equality and diversity, and mental health. Staff had access to online training courses on these and other topics to enable them to develop and update their knowledge.
- All staff had received mandatory training in 2016, which included basic life support and the use of an external automated defibrillator, ambulance equipment, oxygen therapy, ECG monitoring, confidentiality, health and safety and incident reporting and complaints management. The training lead and clinical coordinator said that some staff had very recently undertaken face-to-face basic life support and AED training and assessment. Six staff members were still due to complete the updates for 2017. The clinical coordinator explained that additional training days had been provided for staff that had been unable to attend original dates. They said that reminders were sent to staff that had not completed training updates and if they did not undertake training within a specified time frame then they could be suspended from duty until they had.
- There was a designated member of staff responsible for managing training in the organisation. The clinical lead / training manager told us that there was not a policy to

specify which training was required for different staff members and how frequently training should be undertaken. However, they said that annual online updates were required for all staff.
- We saw examples of the course programme for the emergency care assistants, which consisted of a role-specific training programme and assessments.
- Staff training was recorded in staff files. The clinical coordinator also showed us a spreadsheet of training completed by staff compiled in 2016, but this spreadsheet was not routinely updated. There was an additional system to check that online training had been completed for staff. The clinical coordinator told us that there were plans to develop and maintain a training matrix to help monitor that all induction, online, and face to face training was completed within agreed timeframes for all staff.
- The training lead told us that staff undertook in house driver training.
- Driving was monitored through the use of a global positioning system (GPS) that was present on all vehicles. If a staff member exceeded the speed limit then this could be flagged.
- Staff were supported to obtain further qualifications to enable them to advance their career roles.

Assessing and responding to patient risk

- Basic risk assessments were undertaken as the crews looked at the information on the booking forms. This included a number of screening questions such as if the patient required oxygen, if the patient had an infection, if the patient had a DNACPR order in place and the level of mobility. Staff told us that if they had any concerns about a patient when they went to collect them they would seek advice from the hospital staff regarding whether the patient was fit enough to be moved. Patients who were unstable were transferred with a nurse or doctor escort.
- Staff were able to tell us how they would recognise a deteriorating patient and were confident in knowing what to do to support patients with specific risks. One member of staff gave an example of a patient returning home to an environment that posed a risk. The crewmembers called for assistance and waited with the patient until assistance arrived.
- Staff informed us that if a patient deteriorated on route they would call 999 for emergency assistance.
- Ambulances had automatic external defibrillators (AED) on every vehicle. An AED is a device with simple audio and visual commands, which through electrical therapy allows the heart to re-establish an organised rhythm so that it can function properly.

Staffing

- There was a resource and staffing manager in post who dealt with staffing for the whole organisation.
- The patient transport service staff were directly employed by AMTL. They had 10 ambulance care assistants and 10 level one technicians. Eleven staff was classed as 'on relief,' these staff covered for holidays, sickness and additional work. They mirrored the same shift patterns as the other crews, allowing them to know in advance, what they were working. This allowed sufficient numbers of staff to cover the service.
- Crews worked a mixture of days and night shifts.
- There was a sickness and absence policy and sickness was managed using a tool, which identified trends in sickness, which is a point system that is linked with the disciplinary policy.
- Staff had access to an external occupational health provider and counselling.
- Staff told us that they had enough breaks and usually finished their shift on time.

Response to major incidents

- Staff received training as part of their induction regarding their role in a major incident.
- If crews came across a major incident they would escalate to the NHS ambulance service and support them with the resources they had available. This would include liaising with the NHS ambulance providers and hospitals management teams.
- The service had a control disaster and reactivation policy, which discussed what to do in the event of an incident which would affect the service delivery such as a power failure, communication failure or flooding. It discussed what equipment was available and what would be needed to relocate premises.

Are patient transport services effective?

At present, we do not rate independent ambulance services. However, during our inspection we noted the following for effective;

Patient transport services (PTS)

- Staff provided care based and treatment based on national guidance and evidence, and used this to develop new policies and procedures.
- New staff received an induction programme and staff received annual appraisals.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Managers collated and monitored the patient journeys. This included information such as mileage, shift times, number of patients, and the percentage of time staff were with patients.
- We saw good evidence of multi-disciplinary working between staff from the hospital and the ambulance crew.

Evidence-based care and treatment

- Staff were able to access policies and procedures and these had all been recently updated.
- There was a standard operating procedure (SOP) in place for the transport of patients with mental health needs. This included the importance of ascertaining if the patient is sectioned under the Mental Health Act and provided guidance around restraint. The SOP had links to other legislation such as the Mental Capacity Act 2005 and the Human Rights Act 1998.
- A separate team provided the transport for patients with mental health problems; this team had received additional training.

Assessment and planning of care

- Staff members told us the booking system provided them with sufficient information to plan for their patients, which included details of support needs, infections, and DNACPR.
- Staff gave us an example when a DNACPR form was missing and they declined to take the patient until a new form was completed. This demonstrated that the crews were aware of the correct procedures.
- The bookings included if the patient required oxygen therapy during the journey, this was documented on the booking form and crews had been trained in the delivery of oxygen therapy. Bookings were made from the hospital were the crews were based.
- Staff told us they would talk to the patient prior to transfer and assess whether they were well enough to move. They described a good working relationship with the hospital staff and would raise a concern if they felt the patient was too unwell. At times, a nurse escort would accompany them if a patient needed additional care and treatment.

Response times and patient outcomes

- The service could electronically track all vehicles and could monitor the speed, route, time spent on scene, and time spent at the hospitals. This was a useful tool if there was any complaints regarding response times, the management team could look back on the data.
- Administrative staff entered data from patient transport record sheets onto a spreadsheet. This included information such as mileage, shift times, number of patients, and the percentage of time staff were with patients. Staff told us that they did not pro-actively use the information collected to audit service provision, but reviewed data when there was a specific need.
- The service did not take part in any national audit or wider benchmarking.

Competent staff

- Appraisal rates for ambulance care assistants were 65.8%. Twenty five out of 38 staff had an up to date appraisal. There was a plan in place to be 100% complete by the end of the year.
- Staff told us that individual managers were responsible for carrying out appraisals of their teams and that details of appraisals were logged in individual staff members' files.
- All staff had completed induction training that included organisational familiarity and code of conduct. Staff received an induction document to complete which had personal details plus an overview of the site, departments and procedures. Staff that we spoke with told us that they had attended induction training. Records provided by the training lead showed that induction training included topics such as safeguarding, basic life support, use of automated external defibrillator (AED), moving and handling, information governance, capacity and consent, infection prevention and control, equality and diversity, and mental health. Staff had access to online training courses on these and other topics to enable them to develop and update their knowledge.

- Training was given by appropriately qualified staff and staff had could access additional training if needed following a discussion with a manager. Staff we spoke with felt they had the adequate skills to carry out their jobs.
- Staff training was recorded in staff files. A spreadsheet of completed training was compiled in 2016, but this spreadsheet was not routinely updated. There was an additional system to check that online training had been completed for staff. The clinical coordinator told us that there were plans to develop and maintain a training matrix to help monitor that all induction, online, and face to face training was completed within agreed timeframes for all staff.
- Managers told us that two references were required for each staff member, one to include a previous employer. The clinical lead told us that all staff underwent pre-employment and random drug and alcohol checks to ensure fitness to undertake their role.
- We saw evidence of Disclosure and Barring Service (DBS) checks, which help employers, make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.
- Driving license checks took place six monthly and there was a SOP in place, which described a protocol if points had occurred.

Coordination with other providers and multi-disciplinary working

- The majority of the services work was with two local hospital trusts. The service also provided a transport service for transporting. We saw good evidence of multi-disciplinary working between staff from the hospital and the ambulance crew.
- Staff we spoke with informed us that they had good working relationships with each other.

Access to information

- Staff accessed the information needed for specific patient journeys via the booking system and reported that this worked well.
- Staff reported if they needed additional information, they would ask the hospital staff.
- Each ambulance was fitted with up-to-date satellite navigation systems.
- Staff had access to policies and procedures by using a computer at the station. Some paper copies were also available.

·Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that they had undertaken training on informed consent and on the Mental Capacity Act, this was part of their mandatory training.
- Staff told us that they would always seek informed consent before providing treatment or transporting a patient and respect the patient's decision. We saw evidence on the patient record forms that consent had been sought appropriately.
- The teams used to transport patients with mental health needs had received additional training, which included law and legislation, calming techniques and communication, restraint methods (used only for patients who were sectioned under the mental health act).
- We were told RESPECT training was to be rolled out in the near future. RESPECT is an innovative programme that teaches staff the importance of empathy and compassion in understanding why service users may display disturbed behaviour.
- The service had a mental health policy and a standard operating procedure for the bookings for transfers of patients with mental health needs.

Are patient transport services caring?

At present, we do not rate independent ambulance services. However, during our inspection we noted the following for caring;

- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- Staff provided emotional support to patients to minimise their distress.

Compassionate care

- We spoke with one patient and one relative, who used the service. The patient had used the service previously and said that crews were excellent, very caring and respectful.

Patient transport services (PTS)

- We observed the patients' dignity was maintained throughout the journey. The patient was covered with a blanket and when the patient was transferred from a trolley to a wheel chair, the rear doors of the ambulance were closed.

Understanding and involvement of patients and those close to them

- A relative explained that the crews had an understanding of the difficulties in moving the patient down the side of her home and up a narrow ramp, so they arranged another crew to meet them to assist, to ensure the patient got inside quickly safely.
- If a patient did not meet the eligibility for the patient transport service, they would keep the patient and their relatives informed and alternative arrangements would be made by the hospital or service.

Emotional support

- We observed staff providing emotional support. They explained each stage of what they were doing and maintained a good rapport with the patient throughout the journey. Explanations were clear and in a way, the patients could understand.
- Staff were able to give us examples when they have provided emotional support to patients.

Are patient transport services responsive to people's needs?

At present, we do not rate independent ambulance services. However, during our inspection we noted the following for responsive;

- Staff took into consideration the individual needs of patients when each booking was made to support the safe transport of patients.
- Managers were able to respond to requests to provide the service in a timely manner and had the flexibility in the resources to meet the needs of commissioners.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results.

Service planning and delivery to meet the needs of local people

- The service delivery for the patient transport service was based on a set of predetermined contracts with a number of health service providers and commissioning groups who require patient transport services and urgent and emergency care services.
- The service also provided some 'ad-hoc' services to the local hospitals, and managed these within the workforce flexibility, for example, they had 'relief staff 'who were rostered for shifts and covered this extra demand.
- There were additional mental health teams, who provided transport for patients with mental health needs across the country. The service was able to use staff from the blood and organ transport team to provide this service. The members of this team had received additional training to support patients with mental health needs. The service also sub-contracted elements of this service out to other independent ambulance providers.
- The service had a 24 hour, seven day a week control room, which took bookings for the patient transport service and mental health transport service.
- The service had shown its ability to respond to the needs of an NHS ambulance trust that has recently extended the contract at short notice.
- A resource and planning manager was in post that ensured they had sufficient staff available and flexibility within the whole workforce to deliver the services required.

Meeting people's individual needs

- Staff told us that training assisted them in meeting the needs of individuals. Staff gave examples of attending training courses on how to support people diagnosed with dementia or mental health difficulties. Staff also attended training on equality and diversity and person centred care.
- Staff told that if an interpreter was needed the NHS provider would coordinate this. The clinical lead stated that they were looking into methods for communicating with patients who spoke other languages including 'language line' and permission for the use of a multilingual handbook.
- Staff did not have access to pictorial communication guides to help communicate with people who were unable to speak, had cognitive difficulties, or spoke English as a second language

- The mental health team had received additional training in caring for patients with complex mental health needs.
- Staff received training in dementia awareness and dealing with disturbed or violent patients.

Access and flow

- Between January 2017 and June 2017, the service had undertaken 4393 patient journeys.
- The resource and planning manager and station manager ensured that resources where they needed to be at the time required.
- The staff went to the hospital base at their required shift time. The bookings were made directly at the hospital and allocated to the crews.
- Any out of hour bookings were made through the 24-hour control room. Any cancellations would be made through the control room or directly through the hospital booking system.

Learning from complaints and concerns

- The service had a complaints policy to support the handling of concerns and complaints.
- In the event of a concern or complaint being made by a patient or relative, the clinical lead would speak to them directly. The timescales for dealing with complaints or concerns were that the complainant would be contacted within 24 hours and the investigation completed within 15 days.
- We saw evidence of complaints been responded to in a timely manner. No written acknowledgement of the complaint received was sent, however we were told the manager would telephone the complainant directly.
- Complaints were graded as formal or informal, clinical, non-clinical and operational. These were logged on a formal complaint and investigation form.
- There were two managers responsible for investigating complaints, the clinical lead dealt with the clinical complaints and the national operations and compliance manager dealt with non-clinical and service delivery complaints. We were unable to establish what training they had in complaints handling and investigation skills. We reviewed a sample of responses and found they did offer an apology.
- We were told there had been one formal complaint and 10 informal concerns in 2017. However, we were not assured these were graded correctly as we saw one complaint identified as informal, as this was received through the patient advisory liaison service at the NHS ambulance trust; however this was a formal complaint.
- All complaints were discussed at the clinical governance meetings; we saw evidence of this in the minutes. Any clinical complaint was discussed with the medical adviser.
- Staff told us that they knew about the complaints system. Staff said that learning from complaints was shared on an individual basis.
- Information about how to make a complaint by email or telephone was displayed on the provider's website and on stickers in the ambulances.

Are patient transport services well-led?

At present, we do not rate independent ambulance services. However, during our inspection we noted the following for well led;

- The service had improved on the majority of the issues for action highlighted in the previous inspection.
- The service had a strategic plan and service values that were resonant across all groups of staff.
- Staff described the culture within the service as open to change and supportive. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- The service had a clear leadership structure and each member of the leadership team had clear roles and responsibilities.
- The service had effective systems and processes in place regarding recruitment of staff.
- The service has gone through periods of uncertainty over the last year with the reduction and termination of the urgent and emergency care service contract, the service and its staff showed resilience in the process and continued to support the contract and show flexibility to the demand on their services.
- The service had some governance, risk management and quality measures to improve patient safety and outcomes.

However;

- The service had a number of processes in place to monitor the quality and safety of the services that were

provided. However, the service did not have oversight of other key areas, for example, the audits of the patient report forms and the audit of the management and storage of controlled drugs was not effective.
- The service did not have a fit and proper person's policy that all directors are required to comply with, although the CEO was the owner of the company and had been in post for the last 30 years. The other director was not a shareholder.
- There was some duplication in the two management meetings that took place and some areas of clinical governance were not discussed in the meetings such as risk management, clinical audit, clinical effectiveness and research and development.
- A system was in place, which asked for patient feedback. However, no feedback had been received.

Leadership / culture of service related to this core service

- The service had a clear leadership structure. This included a chief executive officer, a managing director, operations and compliance manager and a clinical lead/training manager. A medical advisor supported the clinical lead. Each member of the leadership team had clear roles and responsibilities, which included finance, procuring contracts and tendering, clinical governance and training and development.
- There were four divisions, which were operational control, fleet, administration and governance and training.
- Staff that we spoke with was able to identify the senior management team and knew what their roles and responsibilities were. The management team described an open door policy and the staff we spoke with spoke highly of the management team and described them as supportive and approachable.
- We heard evidence of how staff had been supported and received a debriefing after a difficult job and staff had been referred for counselling.
- The culture was described as open to change, disciplined and supportive of each other. We observed the culture as caring in regards to staff cared for patients and the management team had been supportive and caring of their staff particular the ones in the urgent and emergency care service as they were going through a period of uncertainty as the contract was due to end with the NHS ambulance trust.

Vision and strategy for this this core service

- The service had a strategic plan that was written in October 2016. This included the service vision, which was to provide excellence in all the care and services they provided. It had a mission statement, which was to meet the requirements of the CQC.
- Key objectives listed in the strategic plan included 'working in partnership with other health agencies' and 'to pro-actively help in the development of community safety and prevention programmes'.
- The strategic plan did not discuss the business strategy however; we were told part of the strategy was to grow the niche market of the business.
- The service had values, which were resonant across all groups of staff. These included professional standards of behaviour, to act responsibly and be accountable, promote and encourage team work, show care and respect and to contribute to continual professional

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

- We viewed minutes of the clinical governance co-ordinating group meeting (held every three months). The senior leadership team attended this meeting; there was no member of staff or external agent for challenge. Some areas of clinical governance were on the agenda, but other areas were not such as risk management, clinical audit, clinical effectiveness and research and development.
- Meeting discussions included safeguarding incidents and training, medicine management, incidents, complaints and compliments. Training and development and infection prevention and control were also discussed. We saw evidence of actions taken.
- The management team held a monthly meeting. There was some duplication with the clinical governance co-ordinating meeting. We viewed a copy of the minutes and found these included discussions about human resources issues such as disciplinary actions, training, sickness and rotas. Complaints and incidents were discussed and we saw evidence of joint investigation with the NHS ambulance service, which the service sub-contracted.
- The clinical coordinator told us that clinical information and patient safety alerts were received from external organisations, such as the Medicines and Healthcare

products Regulatory Agency (MHRA). The senior management team disseminated and actioned as required then reviewed these. We saw alerts had been circulated to staff on topics regarding clinical care and safety. Alerts were circulated by email, and in hard copy.

- The service had a number of processes in place to monitor the quality and safety of the services that were provided. These included checks and audits that covered infection control and equipment. However, the service did not have oversight of other key areas, for example, the audits of the patient report forms had stopped in August 2016, which meant the service could not assure themselves that pathways were followed correctly and patients care and treatment was delivered in line with best practice. There was no system in place to ensure all vehicle faults that had been recorded had been resolved.
- There was no risk management policy, although there was a risk register and individual documents that guide practice for individual risks. These risks were risk rated and had mitigation of the risk. There was a risk assessment documents index, which pulled together a contents list of the titles of the risks they had.
- The service did not have their own key performance indicators; however, they were measured against the hospitals for the patient transport service and the NHS ambulance service for the urgent and emergency care service they provided, the service did not hold this information.
- The service did not have a fit and proper persons policy that all directors are required to comply with. The chief executive officer had founded the company in 1988, there were no insolvency and bankruptcy checks, or checks being done against the disqualified directors register, however, he was the only director shareholder. An up to date DBS check was completed.

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

- A system was in place, which asked for patient feedback. This consisted of the service website and notices in ambulances. We were told no feedback had been received.
- There were no questionnaires sent to patients from the service as these would be sent from the NHS ambulance service directly to patients and form part of their patient feedback analysis.
- The service provided ambulance provision at local charity events.
- Staff meetings did not take place routinely. Information and updates were provided to staff using email and face-to-face conversations. As staff worked out of the main headquarters at the beginning and end of their shift, they saw the management team and information would be shared.

Innovation, improvement and sustainability

- The service had built up over the past 30 years. The senior management team wanted to continue with the services they provided and develop growth in the niche markets such as the transport of patients with mental health needs.
- Due to the size of the company and the staff they had in place supporting services that do not require regulation with the CQC, the service had staff around the country which could support business growth.
- The service had gone through periods of uncertainty over the last year with the reduction and termination of the urgent and emergency care service contract they had with a NHS ambulance provider.
- Due to the reduction of the contract, the service had to close a hub location. The hub location was opened as a response to increasing demand of this service. The service and its staff showed resilience in the process of reduction of work and continued to support the contract and show flexibility to the demand on their services.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must take prompt action to address concerns identified during the inspection in relation to the management and audit of controlled drugs.
- The provider must have a process in place to check the expiry date of drugs.
- The provider must ensure the safeguarding lead has the appropriate level of training required.

Action the hospital SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should consider ways in which to make sure all staff have an understanding of child exploitation and abuse, including female genital mutilation.
- The provider should consider they have mechanisms in place to ensure staff are aware if a fault reported on a vehicle has been rectified.
- The provider should consider staff patient transport staff have clear guidance to follow in regards to the transportation of patients with medication.
- The provider should ensure there is a system in place to ensure emergency and urgent care staff have provided care in line with evidence-based practice and that the medications given are accounted for.
- The provider should consider all areas of governance are reflected in their management meetings.
- The provider should consider having a policy in place to manage risk and an overarching risk register for the services provided.
- The provider should consider having in place fit and proper person's policy that all directors are required to comply with.
- The provider should consider having action cards or triage packs on the emergency ambulances if the crews were first on scene at a major incident.
- The provider should ensure hazardous substances are stored in a locked cupboard to comply with control of substances hazardous to health (COSHH) legislation. c
- The provider should consider training for staff around child exploitation.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment 12.— 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (c) - ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (g) - the proper and safe management of medicines; This is because: • The safeguarding lead did not have the correct level of children's safeguarding training in line with intercollegiate guidance. This is a breach of Regulation 12 (1)(2)(c) • The audit of controlled drugs was not effective. • We found one batch of medicines that had passed their expiry date. This is a breach of Regulation 12 (1)(2)(g)