Castlebrand Limited

Phoenix Private Ambulance Service

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The service could not provide assurance that infection risks were controlled well through consistent standards of cleanliness.
- Not all risk to patients or staff were controlled or assessed.
- Senior staff did not adhere to the provider's safe recruitment policy. The policy reflected national standards but was not consistently followed.
- Safety arrangements in the garage used to stored and dispatch vehicles did not reflect safe practice or the provider's policies.
- Staff did not collect safety information or monitor performance and response times in order to improve the service.

However, we also found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients. Staff were clear about their roles and accountabilities. The service engaged well with patients and other providers to plan and manage services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires Improvement 	The service provides patient transport for people are medically stable and do not require clinical intervention. Typical journeys are between hospitals, care homes, tertiary clinics, and people's private homes. We rated the service as requires improvement because there was room for improvement in aspects of safety and governance.

Summary of findings

Contents

Summary of this inspection

Background to Phoenix Private Ambulance Service

Phoenix Private Ambulance Service provides transport for adult medically stable patients between locations such as hospital discharge units, care homes, and specialist outpatient units. The service provides contracted patient transport for renal dialysis patients and for COVID-19 capacity support to an NHS ambulance trust.

The service does not provide emergency care or emergency transport.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an inspection on 22 October 2021 using our comprehensive methodology. We undertook this inspection as part of a random selection of services rated good and outstanding to test the reliability of our new monitoring approach.

The inspection team comprised of a lead CQC inspector, a second CQC inspector, a specialist advisor and an offsite CQC inspection manager. We gave the service short notice of the inspection to ensure the service was in operation at the time we planned to visit.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that new staff undergo a safe recruitment process that includes a criminal background check, confirmation of the reason for gaps in employment, and two appropriate references. (Regulation 17, 2 (d)).
- The service must ensure infection prevention and control standards are implemented consistently and with documented evidence. (Regulation 12, 2 (h)).
- The service must ensure new staff have safe driving checks. (Regulation 12, 2 (c)).
- The service must ensure safe recruitment practices are followed and that all staff have an appropriate Disclosure Barring Service (DBS) check, appropriate references, and appropriate employment checks. (Regulation 17, 2 (b)(d)).
- The service must ensure clinical and hazardous waste is stored and disposed of in line with national safe standards of practice. (Regulation 12, 2 (h)).
- The service must ensure mops used to clean vehicles use single-use mop heads in line with national guidance. (Regulation 12, 2 (h)).
- The service must ensure staff follow the provider's policy guidance when maneuvering vehicles in cluttered areas. (Regulation 17, 2 (b)).

Action the service SHOULD take to improve:

- The service should ensure all staff are confident in the use of deteriorating patient and death-during-transport policies.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires Improvement	Good	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Insufficient evidence to rate	Good	Requires Improvement	Requires Improvement

Requires Improvement

Patient transport services

Safe	Requires Improvement
Effective	Good
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Requires Improvement

Are Patient transport services safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The service provided statutory and mandatory training using a combination of face-to-face sessions and e-learning. We reviewed the staff training matrix which showed 100% of staff were up-to-date.

Staff attended an annual moving and handling simulated training day to ensure their skills remained up-to-date. Staff completed practical first aid training and maintained other training using an e-learning system. The registered manager monitored levels of training compliance and provided staff with protected time to complete updates.

The mandatory training met the needs of patients and staff. It included medical gases, information governance, equality and diversity, health and safety, basic life support, infection control, duty of candour, safeguarding children and adults level two and three, the Mental Capacity Act and Deprivation of Liberty Safeguards, health and safety, manual handling and medication safety. The registered manager provided new staff with specific training on each vehicle and equipment and carried out refresher training annually.

All staff were trained to the same standard and staff training records contained consistent documentation in relation to planning updates and refreshers.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Patient transport services

Staff received training specific on how to recognise and report abuse. Safeguarding children and adults level two training formed part of the annual mandatory training programme for staff. At the time of our inspection all staff were up-to-date.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of when they had taken action to prevent harm when they identified a safeguarding need. For example, when transporting an elderly person home and finding the house to be empty without the expected relative in attendance. In such cases crews contacted the commissioning service or referring individual. Staff said they would not leave a person alone or in an unexpected situation and described causes for concern, such as finding a cold house without adequate food available. Staff said they would refer back to the booking organisation and contact the local safeguarding team in such situations.

Safeguarding contacts were displayed in each ambulance and included local crisis teams' details. Staff carried contact details for local safeguarding teams with them during journeys, including for longer, out of area journeys.

The service had an up-to-date chaperone policy to reflect the changes made during the pandemic. For example, capacity in each ambulance was limited but staff balanced various risks to patients and ensured chaperones could accompany patients.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could access support from senior staff if needed. The registered manager was the safeguarding lead and was trained to level two. The service did not have any staff trained to levels three or four. The service had not made any safeguarding referrals in the past 12 months.

The provider had an up-to-date safeguarding risk assessment and reviewed this annually. This reflected the type of service provided and enabled staff to follow a process to obtain support in the event they had an immediate concern about a patient.

Cleanliness, infection control and hygiene

The service could not provide assurance it controlled infection risk consistently well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection.

The service could not provide evidence of performance for cleanliness. There was no audit trail for deep cleans of ambulances or equipment and staff only noted the next due date for deep cleans to be conducted. This meant the service could not provide assurance deep cleans took place regularly or were fit for purpose. After our inspection, the registered manager provided evidence they had established a new audit system based on NHS England guidance. The audit was suitable for the service and included the frequency of deep cleans along with the equipment it included, such as vehicle interiors and fixed equipment such as chairs.

All staff were up-to-date with mandatory infection prevention and control (IPC) training.

The service had an up-to-date infection and prevention control policy that outlined standard infection prevention and control precautions staff were expected to take, including hand washing and use of personal protective equipment (PPE). However, it was unclear how the provider checked staff practice and the policy did not detail specific

requirements for hand hygiene, PPE, or equipment cleaning. The provider told us staff were trained to wash and sanitise their hands after every patient interaction and they provided a visual aid to guide staff in effective practice. However, staff did not carry out audits or checks on knowledge or compliance with IPC practices. This meant we were not assured of consistent, safe IPC practice.

Mop heads used to clean vehicles were not single use, which is expected best practice, and we saw a dirty mop head stood in a bucket adjacent to vehicles. As there was no tracking or audit system for such equipment, the dirty mop may be used for cleaning vehicles, which would present an IPC risk to patients and staff. After our inspection, the registered manager provided evidence they had resolved this risk through the implementation of single-use mop heads and new guidance for staff on how to use them.

Hand-washing and sanitising facilities were available for staff and visitors in the garage.

Hand-washing and sanitising facilities were available for staff and visitors in the garage although this was also used as a sluice for disposing of dirty water, which did not reflect best practice.

We carried out IPC checks on two ambulances and a patient transport car. All vehicles were visibly clean, including equipment such as slide sheets and trollies. Clean linen, hand sanitiser and decontamination wipes were on board each vehicle.

The provider had a COVID-19 policy and risk assessment that supplemented the service's overarching IPC guidance. This directed staff in the enhanced use of PPE and steps to take if they felt ill. The nature of the service meant there was a high probability that patients infected with COVID-19 may be transported. The risk assessment included mitigating actions and the provider had begun early, productive conversations with staff about vaccinations.

On 11 November 2021, the UK government implemented an amendment to Regulation 12 of the Health and Social Care Act (2008) that mandates staff in care homes, or healthcare professionals entering care homes, to be fully vaccinated against COVID-19. As staff in this service regularly entered care homes, the vaccination mandate applied to them. The registered manager understood this, and staff were fully compliant with this.

Staff adopted the COVID-19 policy of a local NHS ambulance trust with regards to regularly testing staff for infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, staff did not manage clinical waste in line with national guidance.

The service had suitable facilities to meet the needs of patients. The service had three vehicles used for patient transport services. The manager planned equipment servicing up to one year in advance to meet manufacturer requirements. The registered manager maintained accurate records of maintenance and service history including for equipment such as chairs and stretchers used on ambulances, in line with manufacturer guidance. All such equipment had been recently serviced. Ambulance crews checked tyre pressure and fluid levels weekly. The vehicles were in a good state of repair and well presented.

The service had a stock of wheelchairs used to support patients access to ambulances. Wheelchairs were in a good state of repair with up-to-date service checks recorded in service records.

Requires Improvement

Patient transport services

The service had enough suitable equipment to help them to safely care for patients. There was an effective system to ensure that repairs to broken equipment were carried out quickly so that patients did not experience delays to transport. Servicing and maintenance of vehicles and equipment was carried out using a planned preventative maintenance programme. Service dates for all vehicles and equipment were within their service date.

We carried out maintenance checks on two ambulances and a patient transport car. Vehicles and equipment were kept in a good state of repair and the registered manager planned maintenance in advance. Maintenance checks were up-to-date, and staff knew how to check vehicle safety before they began their shift. The registered manager tracked MOT dates in line with Department for Transport guidance and

During our inspection we found oxygen cylinders in the garage were not stored safely and securely. This was because the cylinders were loosely standing next to combustible material and not in a rigid, secured structure in line with Health and Safety Executive (HSE) guidance. After our inspection the registered manager resolved this risk by storing the cylinders in a trolley designed for the purpose. They provided photographic evidence of the new storage.

Vehicles were maintained in line with manufacturer and Department for Transport guidance. Staff checked tyres and fluids weekly. The manager monitored the life cycle of each tyre and planned for their replacement in advance. The service held contracts with a local vehicle maintenance service and with roadside recovery services. This enabled a rapid response in the event of urgent unplanned maintenance or a breakdown. All staff we spoke with knew how to summon roadside assistance services and the service had a protocol to ensure patients were kept safe and comfortable in the event of a vehicle breakdown.

Chemicals subject to the control of substances hazardous to health (COSHH) (2002) regulation were stored in the garage and only staff had access to this area. An independent health and safety assessment had found the storage and documentation around COSHH items to be compliant with requirements.

We looked at servicing records and saw they were maintained and up-to-date. This included wheelchairs, which staff could provide to support patients accessing and leaving vehicles.

Laundry was managed through a service level agreement with a hospital that included a like-for-like swap of soiled and clean laundry.

However, the service's management of clinical waste and used linen did not reflect best practice. A full clinical waste bag was tied to a bulkhead chair in one ambulance. This was not in line with national Environment Agency guidance which states clinical waste should be stored in a fully enclosed, lockable, and rigid container or structure. After our inspection the provider improved practices and provided evidence of a new storage process that ensured hazardous waste bags were securely tied and stored during transit.

Assessing and responding to patient risk

Understanding of emergency response protocols was inconsistent.

The service had a policy for staff to follow in the event of an unexpected patient death during transport and staff we spoke with knew who they would need to inform in such an event. However, staff knowledge of the procedure was inconsistent.

Requires Improvement

Patient transport services

Patients transported as part of the service were medically stable and not considered to be at risk of deterioration by the referring hospital or department. Staff used a deteriorating patient policy in the event someone became unwell during a journey. Staff were trained to carry out first aid, including cardiopulmonary resuscitation, and said they would follow instructions on the patient's recommended summary plan for emergency care and treatment (ReSPECT), such as if the patient had previously signed a 'do not attempt resuscitation' (DNAR) form. Staff carried a first aid kit and said they would always call 999 in an emergency. This was in line with the provider's deteriorating patient policy. Although policy and training reflected good practice, staff we spoke with had varying levels of understanding of what to do in a medical emergency.

Staff were trained in the use, management, and transport of oxygen cylinders and the provider had up-to-date risk assessments in place. Where patients carried their own oxygen, staff secured containers and followed a specific risk management process.

Staff carried a cascade process for use in the event of an emergency or incident when away from the base area. This ensured they contacted services such as police or breakdown services in the safest sequence.

Each vehicle carried a breakdown assistance card that enabled them to obtain vehicle recovery and maintenance support urgently.

The provider maintained a series of risk assessments, policies, and procedures to support staff in working safely. We looked at the risk assessments and policies for manual handling, slips, trips and falls, and lone working. Each was up-to-date and provided staff with clear guidance on reducing risk.

The service had a lone working policy and staff said they would contact the manager on duty in the event of a problem. Staff were unaware of a formal risk assessment although the provider told us a long-standing version was in place.

Staffing

The service had enough staff to care for patients but we were not assured they always had the right qualifications, skills, training and experience to keep patients safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and skill mix and provided an induction for new staff.

The service had enough staff to keep patients safe in line with transport agreements. The service had six whole time equivalent (WTE) ambulance crew, including one new recruit who was in their induction period. The service had low turnover and sickness rates.

The registered manager provided new staff with an induction programme that included logistics of daily operations, policies and procedures and an orientation of each vehicle in the fleet.

Staff were required to be at least 25 years of age on joining the organisation.

Staff were required to maintain a valid UK driving licence with no more than three penalty points. The registered manager documented this check during the recruitment process and checked the status annually.

The registered managed checked this during the recruitment process and carried out an annual check of license status with the Driver and Vehicle Licensing Agency (DVLA).

The service had a safe recruitment policy that included requirements for references, background checks and employment history checks. However, the provider did not consistently follow this practice. We looked at the recruitment records for four members of staff and found gaps in documentation for each. For example, one person did not have a documented employment history, and another had an unexplained gap in employment history. One member of staff had been recently recruited without a valid Disclosure Barring Service (DBS) check, which meant the provider could not be assured the member of staff had a history free from criminal convictions. The provider was undertaking a new DBS check but the new member of staff had already started work.

The provider did not always obtain two professional references for new staff. Although the provider always requested references, these were not always supplied. The newest member of staff had one reference on file, and this was not from their most recent employer. Two of the other three records we checked had no record of references. One of these individuals had worked in the service for a very long time and had been recruited when it was operated by a different organisation and before CQC regulated this type of care. The provider was not obligated to obtain retrospective recruitment checks although there were no risk assessments to ensure they could be assured staff were fit and proper to work in the service. We spoke with the registered manager about this who said the staff in question had been in post for over 10 years and they were satisfied with their good standing.

The senior team did not routinely carry out safe driving checks on new staff and checks with existing staff were sporadic. This meant the provider could not be assured of the driving skills and standards of individual members of staff. This risk was mitigated to some extent by a driving risk assessment, which all staff were trained to follow.

Records

Staff kept detailed records of patients' care and transfers. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Staff recorded key patient information from the initial booking process and used a daily job sheet to track planned transfers. These records included information on any specific patient needs such as communication or mental health needs or the existence of a do not attempt resuscitation (DNAR) order.

Records handled by staff related only to the safe transport of patients such as the time of collection and drop-off and notes relating to any events during the journey. Notes were stored in a locked unit in the garage and when staff collected patients, they kept records with them in the cab of the ambulance. This meant risks relating to confidentiality were minimised.

The service received patient referrals through a secure email or telephone call from the referring hospital in the office location. Records relating to these were stored securely, such as in encrypted digital files or in locked storage for hard copies.

Medicines

The service did not store, prescribe, or administer medicines. Where patients were transported with their own medicines, these remained the responsibility of the individual and stayed on their person or in their bag.

Staff were trained in the administration of oxygen during journeys including connecting oxygen cylinders to face masks and nasal cannulas and monitoring flow rates. Nasal cannulas are devices used to deliver supplemental oxygen.

Requires Improvement

Patient transport services

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff knew what to do if things went wrong and said they would apologise and give patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The service used an incident reporting system and all staff we spoke with were familiar with the system. Staff were trained to make contemporaneous notes during an incident and to date and sign each statement.

Staff said there was a good reporting culture and that they were encouraged to report near miss situations, which reflected a positive approach to learning. Although staff described a good safety culture in this respect, we did not see any instances of documented near misses. Where incidents involved other services, staff and the registered manager worked with colleagues to investigate incidents. For example, the service worked with an NHS hospital team after a patient suffered a fall whilst being supported jointly by ward staff and an ambulance crew.

The service reported that there were no never events in the previous 12 month reporting period. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The service had a duty of candour policy and this was included in the staff handbook. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood the provider's policy and their responsibilities under the duty of candour. The service reported no incidents that triggered the duty of candour.

Are Patient transport services effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance issued by organisations such as the National Institute for Health and Care Excellence (NICE) and the Independent Ambulance Association. The provider maintained policies and protocols in a staff handbook. Each member of staff held a copy and each vehicle had a copy for reference.

The manager maintained an audit trail of changes to policies and procedures and ensured staff read and signed an update sheet whenever something changed. We looked at records for the last 10 policy updates and saw all members of staff had signed it confirming their understanding.

Staff adhered to the provider's safe transport criteria that meant only medically stable patients could be carried.

Response times

The manager arranged patient pick-up times in advance and provided estimated drop-off times, which were subject to change based on traffic or other local conditions. Where transfers were provided under a service level agreement or contract, the manager monitored compliance with expected performance.

Staff recorded key times during a journey, including arrival time at the pick-up location and the start and finish time of each journey. Staff communicated delays with the manager on duty and used a satellite GPS system to navigate routes effectively.

Service level agreements and ad-hoc work was based on specific pick-up times. There was no documented requirement or expectation of response times.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, there was limited assurance of effectiveness and documented evidence was inconsistent.

Staff had the right skills and knowledge to meet the needs of patients. New staff undertook an induction that included completion of mandatory training and a period of shadowing an experienced member of staff. The provider had documented inductions of all staff previously recruited although a new recruit had no documented evidence of starting an induction after three days working for the service. The manager said induction included a review of logistics of the service, an orientation for each individual vehicle and training on vehicle management and safety. Staff we spoke with confirmed they had undertaken this induction.

The registered manager and their deputy carried out annual practical supervisions of staff during patient transfers. This helped the senior team to monitor standards of care. Although this reflected good practice, the manager did not always document supervisions and there was no record of outcomes.

Staff undertook an annual moving and handling simulation training day. This reflected good practice and enabled staff to practice and build competencies in supporting patients to access ambulances safely. The training included safe users of chairs and stretchers and meant staff were certified to safely use appropriate equipment.

The manager rotated staff between types of journeys to ensure they maintained a broad range of skills, including communication skills with patients with specific needs.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Requires Improvement

Patient transport services

Staff described effective handovers with hospital staff and care home staff when they took patients to other providers for appointments or continuing care. Staff telephoned care providers if there was a delay with the transfer of a patient or an issue that needed to be resolved, such as confirmation of a care plan.

The registered manager had worked with local adult social care and NHS services to ensure bookings were appropriate. For example, staff did not provide any kind of clinical intervention and patients needed to be medically stable before they could be accepted for transport. The manager had completed engagement work with local providers after a series of referrals were deemed unsafe.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Where a patient was known by the referrer to have mental health needs or to be living with a managed condition such as dementia, this was declared at the time of booking. All staff had training in providing support to people living with dementia and they ensured they understood consent processes in advance of a transport starting. Staff facilitated the transport of a patient's escort or carer where this would help deescalate distress or confusion.

Staff demonstrated a clear understanding of consent processes in the context of patient transport services. For example, one member of staff said they approached people with support by asking questions such as, "Would you like me to support you while you stand", instead of the more instructive, "Let me help you." Other staff said they always asked before offering help and gave a key question example as, "How do you want to be helped?"

Staff undertook training in the Deprivation of Liberty Safeguards (DoLS), dementia, learning disabilities and the Mental Capacity Act. Although the service did not provide a dedicated mental health transport service, training meant staff were able to provide safe and effective care to patients with diverse needs. For example, patients living in an adult social care setting with a DoLS authorisation in place would be escorted during their transfer and it was important staff understand the role of the escort and had techniques to communicate directly with the patient.

Staff did not undergo training in communicating with, or obtaining consent from, patients with mental health needs. While patients had to be medically fit for transport before the service could offer transport services, it was not clear patients would have mental capacity and the ability to consent. One member of staff said they would rely on their experience to communicate with patients in such circumstances. Less experienced staff would rely on referral or policy documents or a phone to a senior member of staff for support in such circumstances.

Are Patient transport services caring?

Insufficient evidence to rate

As we did not observe any patient interactions during this inspection, we were unable to rate caring.

Compassionate care

Requires Improvement

Patient transport services

Staff spoke about patients with compassion and kindness, showing they respected their privacy and dignity, and took account of their individual needs.

Staff described how they were discreet and responsive when caring for patients. Staff said they took time to interact with patients and those close to them in a respectful and considerate way. Feedback from patients supported this information and the provider had received dozens of letters and emails of positive feedback. One patient noted, "You made a challenging need a pleasure to resolve."

Patients and their loved ones said staff treated them well and with kindness. The registered manager maintained a record of compliments and feedback received by the service. Unsolicited messages from patients and their relatives were consistently positive and referred to the kindness and service of staff. and one relative thanked staff for, "…caring for [patient's] comfort and dignity."

Staff described how they ensured patient's privacy and dignity during transferred. For example, they covered patients with blankets when moving them to and from ambulances in order to maintain their dignity. They paid attention to detail when working with patients. For example, they ensured the ambulance temperature was appropriate for each patient's comfort.

Staff who carried out long distance transfers worked with patients to ensure their needs were met throughout. Staff recognised long journeys could be distressing or boring and ensured they provided compassionate care in line with each individual's expectations. For example, some patients wanted pre-planned comfort stops and others wanted to stop to use facilities at service stations on request. Patients did not need to leave the ambulance if they did not wish to and staff said they brought patients drinks and refreshments on request.

Staff built relationships with patients who regularly used the service, which provided consistency. One member of staff said they had recently collected a patient from a hospital ward who remarked, "Oh, it's you! I'm so glad!" when they arrived to collect them.

One relative contacted the service to thank the ambulance crew for waiting with their loved one at home until they arrived. The relative had been delayed on the way and was grateful their loved one had not been left alone. They noted, "They had a ball."

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff understood the impact that patients care, transfers and condition had on the patient's wellbeing. Staff we spoke with stressed the importance of treating patients as individuals with different needs.

The registered manager said staff were trained to deliver care with care, attention and humour. Staff we spoke with had patients' wellbeing and best interests at heart and understood they could be transferring patients for treatment that was challenging or upsetting. Feedback from patients and their loved ones indicated staff delivered consistent standards in this area. One person wrote to the service to thank staff for, "Caring for [relative's] comfort and dignity." Another relative wrote to the service and asked the manager to, "Thank them [staff] for their care, attentiveness and good humour."

Requires Improvement

Patient transport services

Staff planned transfers to maximise privacy and dignity. For example, they ensured a female crew member was always assigned to transfers for female patients. Staff proactively offered this arrangement as an element of the service.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff carried visual prompt cards to help them communicate with patients who used British Sign Language and had access to online or telephone language translation services.

Patients and their families could give feedback on the service and staff supported them to do this. Staff encouraged feedback in any means convenient for the individual, including e-mail, contact form, telephone or letter.

Patients gave positive feedback about the service. We saw extensive evidence of consistently positive feedback from patients and their loved ones.

Many patients were regular clients of the service and staff built a rapport and good levels of understanding with these individuals. Staff described positive relationships such as when collecting a patient they knew from an inpatient ward who saw the crew and said, “Oh, I’m so glad it’s you!”

Staff were aware of the need to adhere to privacy and dignity when transporting patients. For example, they offered patients a choice of male or female crew and worked to meet individual requests that would help people feel more at ease.

Staff limited the capacity in each ambulance due to COVID-19 restrictions to three people. One member of the crew always travelled in the patient cabin, which meant two patients, or one patient and their escort, could be transported at the same time. Staff said they always tried to accommodate escorts if notified in advance.

Staff demonstrated they were a close-knit team that cared about patient’s safety and experiences and knew each other’s strengths and weaknesses.

The service specification and staff training directed the standard of privacy and dignity. The manager said they expected staff to offer a calm and reassuring approach when supporting patients to mobilise on and off an ambulance. A key part of the service was to empower patients to direct the pace of movement before and after a transfer and to lead staff in initiating movement and their level of comfort.

Are Patient transport services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

Requires Improvement

Patient transport services

The service planned and provided care in a way that met the needs of people who used the service.

Managers planned and organised services, so they met the changing needs of the people who used the service. The service provided non-emergency transfers between a range of locations, including care homes and hospitals. Journeys could be booked in advance or on an ad-hoc basis. Staff worked across the whole spectrum of transport needs to ensure they maintained a range of skills.

The service did not operate a waiting list. Crew and vehicle availability was established in advance in line with service level agreements of commissioning providers with additional capacity for unplanned bookings.

The service was equipped for long journeys. Staff told us they had undertaken skin integrity training to help them support patients during long journeys. While this reflected good practice, training records did not indicate this had been completed.

The service ensured those booking transport understood the criteria for referral including that staff did not provide any clinical interventions and patients must be medically stable. Where information in a booking was incomplete or inaccurate, staff assessed if it was safe to transport the patient as planned. The managed documented each instance of inaccurate referral information and worked with each organisation to improve the accuracy of the information they provided.

The senior team made adjustments to the service to reflect learning from previous delays to journey times. For example, where journeys were booked from a hospital discharge lounge, the staff incorporated additional time to each transfer to ensure patients had time to wait for their to take away (TTA) medicines to be prescribed before they left the hospital. This reflected good practice and reduced stress and anxiety on patients and time pressures on hospital and ambulance staff.

Each crew carried a RADAR key, which enabled patients to use disabled-access toilets at service stations or other public areas during transfers.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff established each patient's needs in advance. This included if they would be carrying oxygen, if they needed specific support or equipment during a journey. For example, staff could carry a bariatric wheelchair to support mobility.

All vehicles were wheelchair accessible and the service provided carry chairs or trolley beds.

Staff built supportive relationships with patients who used the service regularly, such as those who were transported for renal treatment. Staff said they tried to book the same crews for the same patients, which helped build trust and understanding of individual preferences.

Ambulance crews ensured patients could make requests during longer journeys, including stops at service stations for refreshments and to use the facilities.

Requires Improvement

Patient transport services

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They carried visual communication aids with them to support interaction with people who could not communicate verbally.

Patients living with learning difficulties or dementia were identified at the time of booking so that staff could plan any additional resources or considerations needed for the journey. All staff were trained in the safe transport and care of patients living with these conditions.

A member of ambulance crew always travelled in the patient cabin of the ambulance to attend to their needs and ensure their safety.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service operated on a pre-planned and on-demand basis. The registered manager planned shifts one week in advance for specific transfers and to meet pre-planned demand. They supplemented this with a three-monthly advance workplan with generic capacity, which meant they could provide short-notice transfers.

The service provided one ambulance and a crew under a contract to a Clinical Commissioning Group (CCG) on behalf of an NHS trust to increase capacity as part of their COVID-19 contingency strategy. Other work completed by the service was varied and included private bookings and transfers booked by healthcare providers and adult social care services.

Ambulance crews liaised directly with the hospital trust's control centre to plan transfers. This improved efficiency and accuracy because staff could arrange specific times and pick up locations themselves.

Journeys were booked in advance with the requesting service and the manager planned availability three weeks in advance. Flexible planning meant staff and vehicles were often available for short notice bookings. However, the service did not formally monitor response times to provide assurances of reliability.

The registered manager built additional time in bookings where crews picked patients up from an inpatient spell in hospital. This reflected unpredictable waiting times for TTA (to take away) medicines from hospital discharge services.

The service facilitated long journeys and out-of-hours journeys where these could be carried out safely. Staff followed a safe driving policy that limited their continuous driving time to three hours. All journeys out of area or overnight had two crew members to ensure they could manage driving time between there. A manager was on duty and contactable at all times crews were in operation. When staff experienced delays or disruption, they liaised with the manager on duty to coordinate alternative routes and mitigate the impact on the subsequent journeys.

During our inspection, we observed the booking process. The manager obtained critical information for the transfer at the time of booking and checked details such as level of mobility, if people could walk unaided and if they needed use of equipment such as a wheelchair.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The manager knew how to treat concerns and complaints, investigate them and share lessons learned with all staff.

Requires Improvement

Patient transport services

Patients, relatives and carers knew how to complain or raise concerns. Staff carried printed information on how to complain or contact the manager in each vehicle. This information was also available on the provider's website and was issued to corporate users of the service, such as NHS ambulance trusts.

We spoke with staff who were able to identify how to support a complaint, be it informal or formal, and how it was escalated and managed by the manager.

Formal complaints were very rare, and the majority of feedback received by the service was positive. There had been no formal complaints in the previous 12 months. People frequently contacted the service to thanks staff for their work. One recent piece of feedback read, "Your responsiveness has been much appreciated." Another patient said, "I just wanted to say how impressed we were by the service provided – excellent staff and time-keeping."

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Are Patient transport services well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

We were not assured leaders had the skills and abilities to run the service consistently. While they understood and managed the priorities and issues the service faced, there were gaps in safety management and governance. They were visible and approachable in the service for staff.

The registered manager was solely responsible for all leadership aspects of the service. They also coordinated bookings, responded to staff queries and managed governance. However, there were gaps in oversight of safety management, performance management, and governance. For example, the manager did not adhere to the provider's own safe recruitment policy and there were unmitigated safety risks in the garage. Governance practices did not ensure the service mitigated risks effectively.

The owner of the service (the provider) was also the registered manager. They had the skills, knowledge, experience, and integrity needed to meet patients' needs. The manager had been in post since 2013 and was the responsible person for meeting legal requirements under the Health and Social Care Act (2008) (Regulated Activities).

The manager had a good understanding of the needs of the local community and had developed the service to effectively and safely meet demand. They noted a continuous increase in pressure on the service during COVID-19 lockdowns and worked to ensure this could be addressed without unsustainable impact on staff or service quality.

A deputy manager was in post and was the main point of contact for staff, patients, and providers in the event the manager was unavailable. The individual had the required skills and experience to fulfil this role.

Staff spoke positively about the senior team and said they were approachable and supportive.

Requires Improvement

Patient transport services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The organisation's vision and statement of values was central to everything it did, including staff training and patient care. The vision focused on the comfort, dignity, and safety of patients and guided staff in centring compassion in all aspects of their work. Staff we spoke with understood the vision and ethos of the service and described their role in achieving them.

The manager had a good grasp of the commercial elements of the business and the need for it to remain competitive. They maintained a diverse portfolio of clients and had worked with local NHS services to support capacity during COVID-19 pressures. The manager demonstrated a good understanding of the needs of the local population and had planned service responsiveness to meet these. For example, they provided ambulance capacity at times they knew people living in care homes typically preferred to be transferred. The manager had worked with the CCG to establish the COVID-19 capacity response service level agreement that meant the service was planned to meet peaks in hospital demand.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with were proud of the work that they carried out. They enjoyed working for the service and were enthusiastic about the care and services they provided for patients. They described the service as a good place to work.

Staff said they felt that their concerns were addressed, and they could easily talk with their managers. Staff reported that there was a no blame culture when things went wrong.

Staff demonstrated a positive working relationship with each other and said they felt supported by the senior team. They felt involved in the operation of the service and felt confident in making suggestions for change.

The senior team felt staff morale was good and that the busy momentum of the service throughout the pandemic had contributed positively to their wellbeing.

Governance

Leaders operated governance processes although these were not always effective. Staff were clear about their roles and accountabilities. Opportunities to meet were frequently available although there was limited evidence of learning from performance of the service.

The service did not have effective systems, such as audits and risk assessments, to monitor the quality and safety of the service. For example, there were no audits in place to ensure the provider's safe recruitment policy was always applied. This meant the senior team was unaware of the range of gaps we found in recruitment records.

Requires Improvement

Patient transport services

Governance and risk management systems had not identified gaps in infection prevention and control standards and practices which could present a risk to people being transported. However, the manager provided evidence of immediate action to rectify these issues after our inspection.

The provider was compliant with the Provision and Use of Work Equipment Regulations 1998 (PUWER) and the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) and held certification in both. Both certificates were held appropriately with vehicles in the garage.

The service had governance processes for staff to be employed jointly with NHS services. This had previously been the case when the service employed an emergency medical technician jointly with an NHS ambulance trust. There were no staff currently employed under such arrangements, but the governance framework meant it remained a possibility.

A copy of the employee handbook was stored in each vehicle. This included copies of policies and protocols and the manager ensured each version was replaced with each update.

Management of risk, issues and performance

Systems were not in place to manage performance effectively. Managers identified relevant risks and issues and identified actions to reduce their impact but did not use an effective monitoring tool. They had plans to cope with unexpected events.

There was no risk register in place to identify and track risks. However, the manager used a series of risk assessments to manage risk. They updated these according to a pre-planned time scale and more regularly in response to incidents or changes in practice.

We saw evidence crews did not carry out transfers where they deemed this would be unsafe. Staff said this most often occurred where a referral form indicated the patient was medically fit, but they found this not to be the case on arrival at the pick-up location. For example, staff had recently refused an unsafe referral where the patient did not meet the transfer criteria. The crew would have been unable to safely support this person as they did not have the necessary equipment to safely support mobilisation.

The registered manager maintained a series of policies and risk assessments to mitigate additional risks associated with out-of-hours journeys and long-distance journeys. The service had contingency plans were, including a communication and coordination plan, for adverse events such as extreme weather or road closures. The provider's risk plan for long-distance journeys meant drivers were required to swap or take a break after each continuous three-hour period of driving.

The provider held liability insurance for the public and equipment and medical malpractice insurance.

Information Management

The service did not collect reliable data or perform analysis. The information systems were integrated and secure.

Requires Improvement

Patient transport services

The service had limited understanding of operational performance and did not monitor metrics such as numbers of journeys completed on time or factors that contributed to delays. However, the registered manager maintained continual oversight of feedback from service users and referring organisations, including through public social media reviews.

Staff undertook information governance and data security training. This included their responsibilities for confidentiality and under the General Data Protection Regulations (GDPR). The manager was responsible for data control and stored records appropriately. Paper records were stored securely with restricted access and digital records were encrypted and accessible only by authorised staff.

Public and staff engagement

Leaders and staff actively and openly engaged with patients and staff, to plan and manage services.

Staff said they received regular wellbeing updates. For example, information on maintaining mental health during the COVID-19 pandemic. This was part of a wider approach to open and honest communication from the manager.

The service engaged with potential clients and patients using social media and the provider's own website. Online reviews were consistently positive, and patients rated the service as the maximum five stars for care.

The service was a member of the Independent Ambulance Association and accessed training and support from the group. For example, staff were undertaking webinar groups in new national sexual safety standards.

The service did not formally engage with stakeholders regarding performance. However, the CCG had extended a service level agreement with the service, based on their satisfaction with the service. We also saw evidence of positive written feedback from stakeholders such as care home managers.

Learning, continuous improvement and innovation

There was limited evidence of a commitment to continuous learning and improving services.

Staff were clearly invested in the service and were proud of its reputation and impact on the local community. A continuous stream of positive feedback demonstrated how well the service was thought of in the region. The manager understood the improvements needed to ensure care remained safe and well led.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • There were gaps in the consistency and documentation of infection prevention and control standards. • The manager was not assured new staff were competent and safe drivers. • Clinical and hazardous waste was not stored and disposed of in line with national safe standards of practice. • Oxygen in the garage was not stored according to national safe standards.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not consistently follow sure safe recruitment practices. Not all staff had an appropriate Disclosure Barring Service (DBS) check, appropriate references, or appropriate employment checks. • Staff did not consistently follow the provider's policy guidance when manoeuvring vehicles in cluttered areas.