Arriva Transport Solutions Limited

Arriva Transport Solutions - Canning Town

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Arriva Transport Solutions Ltd Canning Town is operated by Arriva Transport Solutions Ltd. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 23 and 24 January2018.

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

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

Services we do not rate

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

We found the following areas of good practice:

- The provider introduced a new system of incident reporting in July 2017 and we were told that the quality of recording had improved since in terms of timeliness and accuracy.
- There was an effective system in place for staff to report safeguarding incidents and staff were confident about how to raise a safeguarding alert.
- Each vehicle we inspected had a complete service history and 12 week safety check and was visibly clean and free from contamination.
- NHS commissioners told us the provider demonstrated a continued desire to improve the quality of the service provided.
- Staff had regular appraisals.
- Crews were made aware of special notes to alert them to patients with pre-existing conditions.
- There was a robust process of induction and newly inducted staff were assigned a more experienced member of staff as their mentor.
- We observed how staff were respectful and kind in their interactions with patients when waiting in the hospital transport waiting area.
- Patients told us "the driver could not be better if he tried", and "all the staff are absolutely fantastic; they always apologise when there are delays."
- Managers used a 'demand tool' to identify when demand for transport was heaviest and made adjustments to the staff rota accordingly to meet this fluctuating demand.
- There were systems in place to audit the quality of responses to complaints and monitor all actions and trends.
- Staff told us how a recent operational restructure significantly improved operational systems and lines of communication.
- There was a staff incentive scheme which rewarded staff for performance in different areas.
- There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions.

Summary of findings

- An NHS commissioner told us that the provider demonstrated commitment to address performance related issues.

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

- Risk assessments were not in place to support the decision that a director post was not eligible for a DBS check.
- The current fleet whilst well maintained showed signs of wear.
- One vehicle had the appearance of a high dependency vehicle rather than a patient transport vehicle only.
- The provider was not meeting their key performance indicators for inward journeys completed between 50 minutes before and 20 minutes after the appointment time and outward journeys collected within 60 minutes of planned or booked time.
- Many complaints related to late pick-up either from home or the hospital.
- Aborted journeys accounted for almost 10% of all journeys. These are journeys which were abandoned en route either by the patient or the commissioner.
- There was a low response rate to the provider's survey of patient experiences.

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 the patient transport service. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (London), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		**Safe:** **We do not currently have a legal duty to rate independent ambulance services.** **We found the following areas of good practice:** • **The provider introduced a new system of incident reporting in July 2017 and we were told that the quality of recording had improved since in terms of timeliness and accuracy.** • **Commissioners of the service told us the provider was open and transparent in relation to incident reporting and we were assured from discussions we had that staff understood what constituted an incident and how to report it.** • **We saw there was almost 100% compliance with mandatory training for all staff.** • **We were assured that safeguarding adults and children training delivered was aligned with national training standards.** • **There was an effective system in place for staff to report safeguarding incidents. Staff were confident about how to raise a safeguarding alert and told us they were actively encouraged by managers to report all safeguarding concerns.** • **Standards of cleanliness and hygiene amongst staff were maintained through a series of daily, weekly and monthly checks. We saw an audit for June to December 2017 which showed there was 100% compliance with infection prevention and control knowledge and hand hygiene.** • **Each vehicle we inspected was visibly clean and free from contamination. We saw there was a complete service history and 12 week safety check for each vehicle.** • **Medical gases were stored securely in compliance with guidance from the British Compressed Gases Association.**

Summary of findings

- **Crew could describe how to identify and respond to patients whose health deteriorated in their care and the process they followed.**
- **Managers told us staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times; and staffing rotas were reviewed against demand every three months. Crew told us there were enough staff to cover the work.**
- **The staff sickness rate was 1.2%, which was lower than the company target of 3%.**

However;

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

- **We saw one vehicle which had the appearance of a high dependency vehicle and was fitted with blue lights and emergency sirens. This could be mistaken for an emergency and urgent care vehicle and the service provider was not registered to provide urgent and emergency care.**
- **Managers told us the current fleet, whilst well maintained, was in need of replacement.**

Effective:

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- **There were up to date policies accessible to crew at the base, in the vehicles and in a pocket sized guide issued to all staff.**
- **NHS commissioners told us the provider demonstrated a continued desire to improve the quality of the service provided.**
- **There was an appraisal system and we saw that staff were regularly appraised.**
- **There was a robust process of induction and newly inducted staff were partnered with a more experienced member of staff who acted as their mentor.**

Summary of findings

- **Driver competence was continuously reviewed through a real time tracking system.**
- **The provider maintained regular contact with their commissioner in order to review the effectiveness of their service provision.**
- **Crews were made aware of special notes to alert them to patients with pre-existing conditions or safety risks and flags were placed on the patient record which automatically was added to the electronic job sheet.**
- **Staff told us the training they received in Mental Capacity Act 2005 (MCA) was good and gave them confidence when faced with a patient who refused to get into the vehicle.**

However;

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

- **Data for inward journeys completed between 50 minutes before and 20 minutes after the appointment time demonstrated an average compliance of 83%, which was slightly below the provider's compliance target of 85%; compliance with outward journeys collected within 60 minutes of planned or booked time during the same time period averaged 67% where the compliance target was 85%.**

Caring:

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- **We observed how staff were respectful and kind in their interactions with patients when waiting in the hospital transport waiting area.**
- **Crew told us they ensured they did all they could to maintain peoples dignity and had blankets on board to cover patients up.**

Summary of findings

- **Patients told us "the driver could not be better if he tried", and "all the staff are absolutely fantastic; they always apologise when there are delays."**
- **Crew told us whilst they were not always aware of the patient's condition, they ensured they did their best to be sensitive to the patient's needs.**

Responsive:

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- **The provider held one contract with a sole commissioner with whom they had frequent engagement and good communication.**
- **The provider conveyed patients with a range of needs, including those with learning disabilities and those living with dementia and ambulance crew told us their training gave them the knowledge and confidence to be able to support these patients.**
- **Managers used a 'demand tool' to identify when demand for transport was heaviest and made adjustments to the staff rota accordingly to meet this fluctuating demand.**
- **There were systems in place to audit the quality of responses to complaints and monitor all actions and trends. We saw that all complaints were dealt with in a timely manner and in accordance with the provider's complaints policy.**

However;

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

- **Aborted journeys currently made up for 9.7% of all journeys in the previous six months. These are journeys which were abandoned en route either by the patient or the commissioner.**
- **The main theme of complaints related to late or non-arrival of the transport.**

Summary of findings

Well-led:

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- **The operations structure was reviewed in June 2017. Staff told us this gave better consistency to working practices and line management and improved communication.**
- **Staff told us their local management team was very visible and approachable.**
- **The national and local leadership teams held an annual engagement event with staff in order to discuss annual performance and share ideas for the year ahead.**
- **The provider ran a staff incentive scheme which rewarded staff for performance in different areas.**
- **There was a monthly staff meeting at the base and a companywide newsletter issued each month to keep staff up to date on developments within the company.**
- **The values of the provider were widely displayed and included in the staff pocket guide.**
- **The provider initiated an improvement programme with the commissioner in March 2017 in order to understand reasons behind poor performance and identify areas for improvement.**
- **There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. These included governance meetings and processes, risk registers and reporting structures.**
- **Quality performance was reviewed on a regular basis and recommendations for improvement were made in those areas which were performing poorly.**
- **We were told by an NHS commissioner that the provider demonstrated commitment to address performance related issues.**

Summary of findings

However;

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

- **A risk assessment was not undertaken for a director position to support the decision that the post was not eligible for a DBS check.**
- **There was a low response rate to the provider's survey of patient experiences**

Arriva Transport Solutions - Canning Town

Detailed findings

Services we looked at: Patient transport services (PTS);

Detailed findings

Contents

Background to Arriva Transport Solutions - Canning Town

Arriva Transport Solutions Ltd Canning Town is operated by Arriva Transport Solutions Ltd. The service opened in 2013. It is an independent ambulance service in London. The service primarily serves the communities of Hackney and East London.

The current registered manager had been absent from their post due to long term sick leave, and the service had notified CQC of this. At the time of the inspection, a new manager had recently applied to take over the registered manager's post.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

How we carried out this inspection

During this announced inspection we inspected the ambulance base and visited the transport lounge at the hospital to and from which patients were conveyed. We spoke with members of the senior leadership and management teams and a hospital commissioning manager. We spoke with nine members of staff and two patients and inspected nine vehicles.

We also reviewed 13 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed nine electronic patient booking records, 18 incident reports and three complaints records

Facts and data about Arriva Transport Solutions - Canning Town

Arriva Transport Solutions Canning Town is part of Arriva Transport Solutions Ltd which is registered to provide non-urgent patient transport services. Arriva Transport Solutions Limited is a nationwide provider of

Independent, non-emergency patient transport services and is contracted to work with NHS hospital trusts. They provide non-urgent patient transport between people's homes and healthcare providers.

Detailed findings

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

In the reporting period January to December 2017, the service undertook 3,809 patient transport journeys, of which 337 were patients under 18 years old.

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 March 2014 which was unannounced and we found that the service met each of the five standards inspected at the time.

Track record on safety:

- The service reported no never events between January and December 2017.
- The service reported 18 incidents between January and December 2017.
- The service reported 30 complaints between January and December 2017.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

- The provider had a planned staff establishment of 32 full time equivalent (FTE) staff and there were 28.9 FTE in post at the time of this inspection.
- There were 19 patient transport vehicles in operation.
- The service did not store or administer any medications such as controlled drugs to patients.

Summary of findings

We found the following areas of good practice:

- We found the incident reporting system to be effective and a commissioner told us there was openness and transparency in how the provider managed incidents.
- All staff were trained to level 2 safeguarding children and adults and staff had a good awareness of how to report a safeguarding concern.
- Criminal records and background checks were carried out by the Disclosure and Barring Service for each member of staff, including the senior operations manager and control room staff since they occasionally conveyed patients.
- Annual driving licence checks were carried out to ensure drivers had a clean licence.
- The provider carried out random alcohol tests on staff each month.
- Staff had regular appraisals and their practice was observed.
- There was a two week induction process after which new members of staff were assigned a mentor who supported them to develop within their role.
- Medical gases were securely stored and regularly maintained.
- Vehicles were regularly maintained and there were audits of vehicle checks and service history.
- Staff ensured they did all they could to maintain peoples' dignity.

Patient transport services (PTS)

- We received positive feedback from patients about how crew members performed.
- Complaints were dealt with in a timely manner and in accordance with the provider's complaints policy.
- There was a robust risk management process in place where risks were regularly reviewed and shared with staff.
- There were systems in place to review the quality of service delivery and performance.
- There was an improvement plan to improve service delivery and NHS commissioners told us the provider demonstrated continuous improvement in the quality of the service provided and on key performance indicators.

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

- There were no individual risk assessments to support decisions to not carry out criminal records and background checks for roles that were not eligible for these checks.
- Some patients experienced long waits for their transport.
- Aborted journeys made up for 9.7% of all journeys in the previous six months. These are journeys which were abandoned en route either by the patient or the commissioner.

Are patient transport services safe?

Incidents

- No never events had been declared within the service in the reporting period January to December 2017.Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There was an incident reporting telephone line to which staff reported all incidents. This was operated by a third party company whose staff followed a script to gather relevant details from the staff member and then added it to the provider's electronic data recording system. This system of reporting was introduced in July 2017 as a way of reducing the workload of control room staff. We were told that the quality of recording had improved since staff were able to relay incident information over the telephone straight away rather than waiting until they returned to the base to write out an incident form.
- Feedback from commissioners of the service told us the provider was open and transparent in relation to incident reporting.
- We were assured from discussions we had that staff understood what constituted an incident and how to report it. They told us they understood how to report incidents and were encouraged to do so by the management team. The incident reporting line telephone number was included in the staff pocket handbook.
- We were told that staff working for third party providers subcontracted to Arriva Transport Solutions were expected to follow the provider's incident reporting policy. We were assured that third party providers knew how to report an incident. We saw examples of incidents which were reported by third party provider's members of staff entered on the incident log.
- There were 18 reported incidents between January and December 2017. This was benchmarked against a similar sized patient transport service within the wider company and the level of reporting was found to be similar. There were four open incidents at the time of this inspection, two of which related to concerns about

behaviours of hospital staff as witnessed by Arriva staff. There was no emergent theme from these incidents which also included where a car drove into a vehicle; one occasion where the crew had to call the police and an NHS ambulance; an incident with an aggressive patient and a witnessed fatal accident.

- We saw evidence of actions and learning from incidents; for example in one incident where a patient fell out of the provider's wheelchair which did not have a lap strap, the identified action was to fit lap straps on wheelchairs. We confirmed that all provider wheelchairs were subsequently fitted with lap straps and told that patient consent was required to use them. In another, a member of staff left the vehicle to get a wheelchair from the hospital. When they returned to the vehicle, the patient was on the floor.This resulted in a governance and quality notice issued to all staff about how to manage a similar situation.
- The duty of candour (DoC) 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. We were told that there had been no incidents in which the DoC applied.
- Staff and managers were clear as to who had responsibility for DoC in the event of joint responsibility between Arriva and the subcontracted company. Managers told us they retained overall responsibility, but would involve and update subcontracted services in investigations accordingly.
- Staff we spoke with were aware of their responsibilities regarding DoC. They were aware of the regulation and when to use it and understood the importance of being open and transparent with patients when things go wrong.They showed us the information card on their pocket handbook.

Mandatory training

- Mandatory training included modules on safeguarding (which incorporated Deprivation of Liberty Safeguards and the Mental Capacity Act 2005), basic life support which was externally accredited, and oxygen administration. In addition, there was vehicle cleaning and infection control, and patient handling which included bariatric patients. Mandatory training also included incident management, operational updates, information governance updates and fire safety updates. We were told the content of the yearly mandatory training reflected the needs of the service or incidents that may have occurred.
- The service had a dedicated training lead who was a trained instructor and assessor and was appropriately qualified to deliver training. They maintained all records and notified local managers when training was due. Staff received annual mandatory training updates in a one-day course run at weekends in order to capture most staff members. On occasions when any staff had training outstanding, they were booked into another training centre to complete it. Staff were paid for their time when on training.
- Compliance against mandatory training requirements was monitored in monthly reports and monitored centrally. We saw there was almost 100% compliance. Non-compliance with training was acted upon and we saw plans to address this with staff who were not up to date with their required training.For example, there were two members of staff whose mandatory training was outstanding and we saw they were booked to do this training at another training centre in February.
- We were told that drivers were not retested on their competency to drive. However, if they had two accidents within 12 months they were required to do a driver reassessment course, irrespective of how minor an accident may have been.

Safeguarding

- The provider told us of changes which were made to the content of the safeguarding training to ensure it met the legal requirements of level two adult and child safeguarding training. We were assured that safeguarding training delivered was aligned with national training standards.
- The safeguarding lead had level 3 safeguarding children training and we saw evidence that all but two staff had level 2 adults and children safeguarding training. We confirmed that these two staff members were booked to do this in another region within one month.
- There was an effective system in place for staff to report safeguarding incidents. Staff were confident about how to raise a safeguarding alert. There was guidance on

how to raise an alert included in the staff pocket handbook. They told us they were encouraged by managers to report safeguarding concerns. Managers told us they reinforced this message at every opportunity and discussed hypothetical scenarios with staff to develop their understanding of the different ways in which safeguarding issues can present.

- The provider recently published a governance and quality notification on 'transporting children and adults on the same vehicle' which stated that children under the age of 16 should be accompanied by a parent, guardian or other suitable adult at all times. Patients should not be mixed where either patient was profoundly medically or mentally unwell. In addition, there should be a member of staff in the rear of the vehicle as an additional escort in all circumstances where a minor was being conveyed. Staff were clear of these conditions when asked about them.
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Schedule 3) specifies the information required in respect of persons employed or appointed for the purposes of a Regulated Activity. The provider submitted data which confirmed that there was an in-date enhanced criminal record check carried out by the Disclosure and Barring Service (DBS) for each member of staff, including the senior operations manager and control room staff since they occasionally conveyed patients. The DBS check was renewed every five years in accordance with the contractual agreement with the service commissioner and the employee completed an annual self-declaration form which confirmed they had not acquired a criminal record.
- We looked at nine staff records and saw each member of staff had an application form and satisfactory evidence of conduct in previous employment and a full employment history.
- We saw the provider carried out random alcohol tests on one person per month. They told us this was part of their contract with an NHS commissioner.

Cleanliness, infection control and hygiene

- The provider had an up-to-date infection prevention and control (IPC) policy and staff we spoke with knew how to access it. Any information related to patient infection was relayed by the ward at the point of booking. This was then added as a 'flag' on the patient details and staff were made aware in advance.
- Each member of staff was questioned by a manager on a monthly basis about their understanding of IPC measures and their hand hygiene practice was observed. We saw examples of these interviews and an audit for June to December 2017 which showed 100% compliance with knowledge and hand hygiene.
- Standards of cleanliness and hygiene were maintained through a series of daily, weekly and monthly checks. For example, vehicles were subject to manager's weekly checks to ensure staff were following correct procedures; checks were recorded on a handheld device and we saw from the computer log that they happened regularly.
- We inspected nine vehicles and found them to be visibly clean and free from contamination. It was the responsibility of staff to clean their own vehicle in line with guidance. This was recorded on their handheld device once completed. If it was not done the handheld device raised an alert with a manager who followed up on reasons for the clean not being done.
- The provider had a contract with an external cleaning company which carried out a quarterly deep clean of the vehicles and we saw records for each vehicle to confirm this. There was a 24 hour call out contract with the same company to support decontamination cleans where a patient may have had an identified infectious disease or a serious spillage occurred.
- There was a plentiful supply of personal protective equipment including gloves, aprons and waterproof boots, although we noted there were no protective arm covers available for crew.
- Vehicles carried cleaning materials and alcohol hand sanitiser, as well as yellow bags to dispose of waste. Staff were able to explain to us how a vehicle would be cleaned following exposure to an infection risk.In the event of a spillage drivers told us they made sure the area was immediately made safe and hygienic; if it was a major spillage then they returned the vehicle to the station and if necessary, requested a deep clean from the contract cleaners.

Patient transport services (PTS)

Environment and equipment

- A central fleet department arranged MOT testing, 12 week safety checks and services for all Arriva stations. We spoke with the national fleet manager. They told us that service schedules were mileage based at 20,000 or 30,000 miles or two years to reflect manufacturer recommendations. Vehicle mileage was automatically uploaded to a centrally held record which alerted when the next service was due. The manager carried out monthly checks, which we evidenced.
- The provider had 19 vehicles which were parked in a large garage space and in the forecourt of the depot, both of which were lockable and secure. In certain circumstances, staff took their vehicle home. We saw no risk assessment for either the safety of the vehicle or the keys where the vehicle was parked outside a crew member's home.
- The provider published a governance and quality notification which set out expectations for cleaning vehicles during and at end of shifts and weekly cleaning. We inspected nine vehicles and found them to be generally clean and adequately stocked. We noticed there was a small tear in the mattress of the trolley on one vehicle which had the potential to increase the risk of contamination. The person who recently applied to be the registered manager told us this would be addressed.
- We observed that one vehicle had the appearance of a high dependency vehicle and was fitted with blue lights and emergency sirens. The provider told us it came from another part of the business, unrelated to the service we were inspecting. They were clear that the vehicle was never used for emergency work. We were told that all emergency equipment would be stripped out of the vehicle as soon as possible in order to avoid any confusion.
- When a crew started a shift, they were required to use an electronic system to 'log on' to a vehicle to show who was driving the vehicle. The location of each vehicle was monitored remotely from the control centre via global positioning software (GPS).
- We saw evidence that a manager carried out monthly spot checks. In addition to vehicle checks, spot checks ensured that drivers were doing their required daily check which they recorded on a handheld device. These included general cleanliness, tyre depth, accident damage and rust.
- We saw there was an adequate supply of child car seats. These were in two sizes for smaller and larger children and were in line with government guidelines for the safe conveyance of children.

Medicines

- No emergency medication was carried on the ambulances and staff did not administer medication.
- Medical gases were stored securely in compliance with guidance from the British Compressed Gases Association. There were large and small cylinders in use all of which were in date.
- Oxygen was routinely available on vehicles and all cylinders we inspected were in date and safely secured.
- Each vehicle was equipped with oxygen which staff were able to administer to patients if a doctor had already prescribed it. Staff were not allowed to alter the flow rate of the oxygen and could not administer more than four litres, in line with company policy.There was no place for staff to document whether they had given patients oxygen; however, this is not unusual in patient transport services.
- We found that consumable items were stored appropriately. The sterile items we checked were all in date with intact packaging and in 'as new' condition. These included oxygen masks in a range of sizes, nasal cannulas, vomit bowls, suction catheters and disposable blankets.

Records

- Patient records were created at the control centre and received by crews on their electronic handheld devices. Control room staff collected relevant information during the booking process about the patient's health and circumstances. For example any information regarding the patient's mobility and access to property. The process was designed to ensure crews were informed about any needs or requirements the patient may have during their journey.
- Staff told us when they collected a patient from a hospital or clinic, they were made aware by hospital

staff where there was a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order in place. The service had a policy on DNACPR, which set out the protocol on patients with DNACPR orders and recommended that the DNACPR order should travel with the patient whenever possible.

- Staff told us they ensured the original order was with the patient on the journey. In certain circumstances, they would accept a photocopy as long as they saw the original. We were told that where the hospital could not provide the DNACPR order, the patient would not be conveyed without it.
- Data with patient information were securely stored on electronic devices. Staff were aware of the need to protect patient data and told us this was set out in a governance and quality notice issued to all staff on 'protecting information – a legal responsibility for us all'.

Assessing and responding to patient risk

- Crew could describe how to identify and respond to patients whose health deteriorated in their care. They told us they engaged them in conversation and looked for any changes in behaviour as a way of assessing risk.Arriva had a resuscitation policy, which stated that in all medical emergencies, crew were to pull over their vehicle and call 999.
- Crew were clear that they would pull over and stop the vehicle safely and call 999 to request the emergency services. We were told if a patient became distressed or if their condition deteriorated they would either call 999 or take the patient to the nearest accident and emergency (A&E) department.
- Crew were reliant on risk assessments and information gathered by call centre crew at the point of booking to obtain as much information as possible. The provider did not carry out risk assessments of a patient's home; this was done by the hospital.
- The information shared by the booking hospital alerted the provider to issues which would make the journey difficult or put the patient at risk. For example, where the patient was bariatric, hospital staff assessed the home environment to be assured that the provider could safely move the patient.
- The provider completed a patient movement plan based on this information which included how many crew were required to move the patient and how to gain access to the property.
- Crew told us there were times when they were given insufficient or inaccurate information, especially where a patient required several people to move them. We saw one recorded incident where the hospital ward did not indicate how the patient must be positioned once on the vehicle. The vehicle which arrived to convey the patient could not accept the patient as it was not able to accommodate their needs and the journey was cancelled, which impacted on the patient's experience and waiting time.

Staffing

- The provider had a planned staff establishment of 32 full time equivalent (FTE) staff and there were 28.9 FTE in post at the time of this inspection. Managers told us staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. We saw a 'demand tool' which was used to plan staff allocation to those times when the highest numbers of bookings were made. We were told that staffing rotas were reviewed against demand every three months.
- Ambulance crew told us they were adequately supported out of office hours and some of the staff covered shifts throughout a 24-hour period. Staff who worked outside normal office hours were supported from the control centre based in Bristol. We saw the provider's lone working policy which stated that staff never worked alone at night.
- There were arrangements in place to ensure the safety of staff. Each vehicle had GPS tracking and an estimated time of arrival at the destination; if the vehicle did not arrive at the appointed time, the GPS would indicate where it was. In addition, there was an alarm button on the hand held device which when pressed alerted the control centre directly. A message appeared which asked whether assistance was required and whether the member of staff could speak or not; the response was given by pressing a button. The call centre staff may call the police or if during the day, the base dependent on the received response.

- Crew breaks were automatically scheduled by the electronic dispatch system in order to ensure full cover at all times.
- The most recent staff sickness rate was recorded as 1.2%, which was lower than the company target of 3%.

Anticipated resource and capacity risks

- Members of the senior leadership team told us of the challenges they faced to recruit new staff. In order to mitigate this, they had a third party agreement with another transport company whom they used in instances where demand exceeded capacity.
- Managers discussed how the current fleet of vehicles, though safe, appeared worn and in need of replacement. However, this was not economically viable at the present time since their contract with a local NHS hospital trust was renewed on an annual basis. This gave no long term guarantee with which to invest the required amount of money to buy new vehicles.

Response to major incidents

- There were arrangements to respond to emergencies and major incidents, which were practised and reviewed. As an independent ambulance service, the provider was not part of the NHS major incident planning. However, they had a major incident plan in place and they were available on the instructions of the local clinical commissioning group to provide additional transport services in the event of a major incident. Commissioners told us members of the senior leadership team engaged with them in major incident planning and exercises.
- We saw a governance and quality notification issued to all staff following a major terrorist incident. This reminded staff that in the event of a terrorist attack, they were likely to be called upon to convey patients, but they must only work within their scope of practice.
- The business continuity plan for the service covered loss of information systems, building security, staff and vehicles. The service had identified the risks in relation to these aspects of the service and set out what the potential impact on the organisation would be and identified what resources would be needed for the recovery of each aspect of the business.
- Staff understood their role in major incidents was to transfer suitable patients from and between hospitals to make capacity available for emergencies according to instructions from hospital staff.

Are patient transport services effective?

Evidence-based care and treatment

- Patients had their eligibility for the service assessed by call handlers, who used standardised questions to continually assess eligibility criteria. These questions helped call handlers determine the most appropriate type of vehicle required for the individual, based on their mobility and individual needs.
- Printed copies of organisational policy documents were located in the staff area at the base and were easily accessible. These included policies for safeguarding, infection control, DNACPR, incident reporting and lone working. We saw that up to date copies of these policies were also stored in a check box kept on each vehicle.

Assessment and planning of care

- Patient needs were assessed at the point of booking when patient details were recorded as well as their specific transportation needs. For example, if they required a vehicle which could accommodate a stretcher. This information was uploaded to the handheld electronic devices.
- Staff told us problems arose when inadequate information was given by the hospital ward which made the booking. They told us there were times when they had to abandon a job because they did not have the vehicle appropriate to the patient's transportation needs.

Response times and patient outcomes

- The provider had four key performance indicators linked with the contract it had with an NHS commissioner. These included planned journeys which were booked up to 16:00 the day prior to travel; outward Journeys collected within 60 minutes of planned or booked time; inward journeys collected within four hours of the booking being placed and outbound journeys collected within four hours of booked ready time.

- The provider collected information for planned journeys which were booked up to 4:00pm the day prior to travel; there was a total of 35,974 journeys made between January and December 2017.
- Data for inward journeys completed between 50 minutes before and 20 minutes after the appointment time demonstrated an average compliance of 83%, which was slightly below the provider's compliance target of 85%. The compliance target was reached just four times in this period.
- Outward journeys collected within 60 minutes of planned or booked time between January and December 2017 averaged 67% where the compliance target was 85%, which was not achieved during this time period. The senior leadership team showed us records of engagement meetings with the commissioner of the service where ways in which to improve on these targets were discussed.
- The provider submitted data for responsive journeys which were booked after 16:00 the day prior to travel between January and December 2017 where the compliance target was 85%. The total number of responsive journeys was 5,215, which represented 14.5% of the total annual journeys.
- Data for inward journeys collected within four hours of the booking being placed showed that this was achieved 96% of the time and outbound journeys collected within four hours of booked ready time was 90%. The target of 85% was exceeded in eight months out of this 12 month period.
- NHS commissioners told us the provider demonstrated continuous improvement in the quality of the service provided and on key performance indicators (KPI).They initiated a performance system in July 2017 to ensure the provider met all of their KPIs related to the contract. Weekly meetings were held to ensure that continuous contract performance was delivered and where required, mitigation provided and actions assigned to both parties to ensure steady continuous improvement was achieved.
- Managers acknowledged that they had a clear responsibility to provide good patient experience. In response to this, they had considered some of the contributory factors to the poor performance in relation to planned journeys. Some of these included late cancellations by the commissioning hospital when the vehicle was en route. In other instances, insufficient patient information details were given which meant either the wrong vehicle was not sent or there were insufficient staff to move the patient. There were times when the patient was not ready for discharge when Arriva staff arrived to the ward to collect them as booked.
- In order to improve patient experience the regional manager held a series of transport planning meetings (operational user forum) with key hospital staff in a bid to reach an understanding of how best to work together. There had not been any significant improvement in response to these meetings and the next planned stage was to meet with hospital management in a bid to consider how the hospital makes patient transport bookings.

Competent staff

- Staff were appraised every six months. The personal development review was done on a one to one basis with a manager and covered aspects of their role. All staff apart from two had been appraised and we saw this was scheduled to take place soon after this inspection.
- The provider operated a robust induction process for new staff which included a two week residential course. During this time, staff covered mandatory training and company policies and procedure.
- The service had a mentorship programme to ensure staff were competent and supported during their probation period as a new crew member. Mentors would pass on and support new crew through a competency based system of achievements and operational procedures.
- Once the induction was complete, the new member of staff shadowed a mentor on a vehicle for four weeks. During this time they learnt how to secure a wheelchair and use the handheld device on which they recorded all aspects of their work; during the fourth week with their mentor, they drove the vehicle.
- A manager did 'spot checks' of crew practice and told us they joined crews at the hospital transport office to observe their practice which included accompanying

them on journeys. They also did spot checks of control room staff performance. We saw samples of observed practice in staff records and were shown a schedule of planned observations to be carried out.

- Driver competence was continuously reviewed through a real time tracking system which monitored driver behaviour, including speeding, erratic braking and unexplained stoppages. Managers were alerted via e-mail by the system when any of these occurred and the driver would be asked for explanations. This record would be reviewed where accidents may have occurred.
- The provider carried out driving licence checks on all employees driving their vehicles. This check involved accessing the Driver and Vehicle Licensing Agency database to obtain up to date information on driver records and any endorsements that may have existed. Licences were also checked manually during the induction process to ensure they were valid.

Coordination with other providers

- The provider had regular contact with the local NHS hospital trust with which they had a contract. There were regular meetings in which performance was reviewed and any recurrent problems discussed. This commissioner told us the provider continued to work in partnership with the trust to continue to drive performance forward.
- The provider worked with two third party providers – a patient transport service and a taxi company in times of high demand. We saw evidence whereby the provider carried out compliance checks on thethird party provider's Disclosure and Barring Service (DBS) checks, vehicle roadworthiness or MOT testing, motor insurance and driving licences. These checks included any recorded road traffic accidents and in the case of the ambulance service, random drug and alcohol tests.
- We were told that the taxi company was expected to follow the provider's safeguarding policy and raise concerns in the same was as Arriva staff would do.

Multi-disciplinary working

- There was evidence of good multi-disciplinary working between staff of differing roles within the service. Staff told us it was essential they worked together to deliver a good quality service. We saw regular communication between the dispatcher and crews out on the road; crew came into the office to give or receive updates and office managers engaged in conversations and responded to any arising queries.
- We observed hospital staff as they handed over patient information to ambulance crew. One crew member queried a piece of information they were unsure about and then confirmed they understood it to the nurse.

Access to information

- There were information and record systems that supported the delivery of effective care. Each vehicle had an allocated handheld device that was carried by the crew during each shift. This enabled crew to see the patient record, for example if they were mobile or waiting to pick up a patient and relayed any delays they encountered.
- Crews were made aware of special notes to alert them to patients with pre-existing conditions or safety risks. In addition, we saw that flags were placed on the patient record which automatically was added to the electronic job sheet. Staff we spoke with showed us records where flags had been added. These included a patient living with dementia who had challenging needs and a bariatric patient who required a four person crew.
- Policies were located in the staff area at the base and were easily accessible to staff. These included safeguarding, infection control, DNACPR, incident reporting and lone working. These polices could not be accessed remotely whilst the crews were on the road. Instead, a check box was kept on each vehicle, which contained up to date policies and information. We saw that boxes contained current information and policies; this was part of the regular vehicle checks done by crew.
- Staff carried a pocket guide, which was a quick guide to policies and procedures related to how to raise a safeguarding alert and report an incident, as well as how to log on to their handheld device and important contact telephone numbers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance,

including the Mental Capacity Act 2005 (MCA). They told us about the training they received which gave them confidence when faced with a patient who refused to get into the vehicle.

- It was not the responsibility of crew to obtain consent in accordance with the MCA; this was carried out by hospital staff. In instances where the patient refused to be conveyed, staff were clear they would not proceed with the journey.
- An NHS commissioner told us they had no concerns about the provider's consent process.

Are patient transport services caring?

Compassionate care

- We did not have the opportunity to go out on vehicles to observe crew-patient interactions; however, we spent some time in the hospital transport waiting area. We observed ambulance crew as they handed over patients to hospital staff. They introduced the patient and gave any update which they had. We saw crew greeting patients waiting to be conveyed home. They engaged with patients and showed an interest in how their appointment had been.
- Patients told us "the driver could not be better if he tried", and "all the staff are absolutely fantastic; they always apologise when there are delays."
- There were196 responses to the providers recent Friends and Family test. Results showed that 86% of patients would recommend the service to others. CQC sent the provider comment cards which were given out by crews to patients in advance of this inspection. There were 13 responses some of which included, "the best crew ever", "staff treat patients with kindness, care and a dose of laughter" and "I have always been treated with dignity and respect."
- There were disposable blankets in each vehicle for patient use to ensure their dignity was maintained as far as possible during transport in and to and from a vehicle.

Understanding and involvement of patients and those close to them

- We saw staff ensured patients understood what they said and what was occurring. They gave them updates on potential delays when in the waiting area and demonstrated understanding when patients expressed their frustrations with these delays.

Emotional support

- Staff understood the impact that a person's care, treatment or condition could have on their wellbeing and on those close to them, both emotionally and socially. They told us whilst they were not always aware of the patient's condition, they ensured they did their best to be sensitive to the patient's needs.
- CQC asked the provider to distribute 'tell us about your care' comment cards to patients in advance of this inspection. Comments written by patients included, "the staff really understand the problems I face with my ill-health and disability", and "they [crew] made my very sick husband feel comfortable and not a burden."

Supporting people to manage their own health

- Staff told us whilst they had limited input on how a patient chose to manage their health, they offered encouragement where possible. For example, one patient was struggling with smoking cessation and the crew member told us they shared their own personal experience of this with them.
- We were told that in certain circumstances, patients would be signposted to the hospital patient advocacy and liaison services.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The provider operated one contract with a sole commissioner with whom they had frequent engagement. We saw minutes of meetings which evidenced good communication and there was a regular transport working group which aimed to reach agreement about how to continue improving the patient experience. This included discussions with

hospital staff about how best to log a transport request in order to capture all patient details and physical needs; as well as an accurate time when the patient was fully ready to be discharged.

- The working group also shared any views about what did not work well and what caused the most difficulties. This included a review of all cancelled bookings and reasons for these. The provider told us they acknowledged that a proportion of cancellations was their responsibility. However, they also highlighted there were times when they arrived to transport the patient at the appointed time only to discover that the patient could be still waiting for their discharge letter or medication. In such instances, the booking had to be cancelled as a long delay affected the rest of the scheduled jobs.
- However, there were no communication aids or information for patients who were visually impaired, hard of hearing or who had learning disabilities.

Meeting people's individual needs

- The provider conveyed patients with a range of needs, including those with learning disabilities and those living with dementia. Ambulance crew told us their training gave them the knowledge and confidence to be able to support these patients. There were occasions when a baby in an incubator was conveyed. They always travelled with a paediatric nurse from the transferring hospital in a vehicle which had a power supply where the incubator would be plugged in.
- We saw that patient's preferred name was on their electronic record. We were told this was a very important way to help the patient to relax since the trip to hospital could already be stressful for them.
- The staff told us they tried to be aware of the different religious celebrations in order to be sensitive to any specific needs at that time. They also said it was important that they drove with care in order to make the journey as smooth as possible for patients.
- Drivers told us the largest challenge they faced was heavy London traffic. This affected their scheduling and was a source of concern to them where they had a patient already on board or they were on the way to collect a patient. Where possible in such circumstances, they used their GPS to find the quickest route to the patient.
- CQC asked the provider to distribute 'tell us about your care' comment cards in advance of this inspection. There were five comments made about long waits for transport both to and from the hospital.
- Crew were able to access translation services via telephone for patients whose first language was not English.
- The provider told us they did not transport patients who were under section in accordance with the Mental Health Act (MHA).

Access and flow

- The provider had a controller who oversaw all bookings which were managed via an electronic dispatch system. This system identified the progress of all vehicles at any given time and reallocated slots as appropriate.
- We saw a 'demand tool' which identified patterns where demand for transport was heaviest at different times of the day. Managers told us they reviewed this against shift patterns every three months and made adjustments accordingly. It meant that at times, staff rotas would change slightly. Where major changes were required, staff were given 30 days notice of this.
- In addition, we were told that discussions had begun with the commissioner to see whether changes could be made so that requested time slots were more evenly distributed rather than clustered at 'pinch points'. This would enhance patient experience as there would be a reduction in delays.
- There were 2,389 aborted journeys between July and December 2017, which represented 9.7% of all journeys.
- On the day bookings (reactive rather than planned) accounted for 14.5% of daily bookings annually. Patients could make bookings directly via a central call centre who could add the request to the provider's booking system. In cases where demand exceeded capacity, jobs were allocated to third party providers.

Learning from complaints and concerns

- There were systems in place to audit the quality of responses to complaints and monitor all actions and trends. A manager showed us a complaint audit tool which was implemented in November 2017 and was required to be completed by the person answering the complaint. Once completed, the patient advisor team quality assured it for timeliness and quality of reply. The manager then audited 10 complaints per month, as well as dealing with all 'level five' complaints which included complaints made by Members of Parliament, serious adverse incidents, gross misconduct, injury or death.
- The provider's complaints policy had a target of 28 working days to conclude a complaint. This included three working days to acknowledge receipt of the complaint and 25 working days for the investigation to be concluded and response sent. We saw that the provider responded to all complaints within this time period.
- Complaints were received by the patient advisor team whose job it was to try and resolve matters as they were reported. The complainant received an acknowledgement within three working days.
- In cases where the complaint needed further investigation, an alert was sent to the managers in Canning Town. There were three open complaints at the time of our inspection and the office received 30 in total between January and December 2017, which was benchmarked against a similar sized service and shown to be an expected number of complaints. The main theme of complaints related to late or non-arrival of the transport.
- There was a weekly call with the base manager and regional manager in which all complaints were discussed, trends identified and whether they within their target completion date.We saw a follow-up e-mail from one meeting which set out what was discussed including trends, all outstanding actions and date of the next call. The manager told us this helped to focus everyone on their individual responsibilities in relation to complaint management.
- All complaints were reviewed every three months. Learning and actions were logged which enabled managers to track progress.

Are patient transport services well-led?

Leadership of service

- There was a managing director who had overall responsibility for the quality, safety and sustainability of the patient transport service. The operations structure was reviewed in June 2017 in order to bring consistency in working practices and controls across all patient transport contracts.
- The restructure brought operational disciplines under single functional leaders; these included an operations director, head of operations and a senior operations manager for the Southern region which included Canning Town. We were told the head of operations had recently agreed to apply to become the registered manager of the service and had been successful in their application to the CQC.
- The Canning Town base was directly managed by an operations manager and an operations supervisor. They had support from a central human resources department and training department; as well as a head of quality and standards; a quality improvement and audit manager and an incidents and complaints manager.
- We saw evidence of implementation of learning from incidents. For example, there was an incident where an unattended patient in the vehicle slipped to the floor. We saw a governance and quality notice issued to staff which outlined measures which crew members should take to maintain patient safety at all times.
- Staff told us that changes initiated by senior managers in the nine months before our inspection gave the service a better structure and made it more organised. There was much improved communication and they told us they felt confident to raise any concerns or issues with the local leadership team, who had an open door policy.
- As part of the HSCA 2008 (regulated activities) Regulations 2014, providers are required to demonstrate how individuals who hold eligible roles are of good character to hold that role. We found during an inspection of the Arriva Transport Solutions South West location that no Disclosure and Barring Service (DBS) check was undertaken for a director position within the organisation. Senior managers told us they decided that as the role did not involve direct physical contact with

patients, the post holder was not eligible for a DBS check. We asked to see the written assessment which assured them that the person was of good character to hold that role, however an individual risk assessment to support their decision had not been carried out.

Vision and strategy for this this core service

- Arriva Transport Solutions Canning Town shared the values of the wider company of 'one Arriva; great customer experience; doing the right thing; thinking beyond.' This was included in the staff pocket handbook and on various posters and publicity on the premises. The management team we spoke with told us they promoted the vision at staff engagement meetings.
- Whilst many staff we spoke with did not directly refer to these values, these same values were reflected in how staff described their commitment to their work and the organisation. They told us their role was to promote good, safe practices in patient care and to value all aspects of their work.
- The provider showed us an operational improvement programme dashboard initiated in March 2017 with the commissioner in order to understand reasons behind poor performance and identify areas for improvement. We were told this was a major piece of work which necessitated amongst other things, a management restructure and different working practices. All aspects of this improvement plan were signed off as completed by the provider and commissioner in July 2017. Updated tracking of those areas which were identified as problematic showed improvements, for example, staff sickness rates had dropped and vehicle utilisation had increased.

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

- There were arrangements for identifying, recording and managing risks, issues and mitigating actions. These included governance meetings and processes, risk registers and reporting structures.Risks were identified and control measures put in place to mitigate the risk. We found that there were reviews of items on the risk register and risks identified by operations managers were reflected on the corporate register.
- There was a robust system in place to measure quality and this was reviewed in different forums on a regular basis. For example, senior managers with national responsibility met each month to review quality and performance throughout the company in several areas. This included level of patient feedback; staff sickness; collisions; numbers of vehicles off the road; number of journeys; and vehicle idling time.
- Performance improvement or deterioration was evidenced and each base could see where their performance level was in relation to other bases. Each meeting resulted in actions, one of which we saw related to how to improve patient feedback. This information was distributed to base managers who shared it in meetings and comments and suggested improvements were invited.
- An NHS commissioner told us in their view; the provider demonstrated commitment to address performance related issues. They engaged with the trust and stakeholders on matters such as lessons learnt and taking prompt action to rectify arising issues and embed improved practice.
- We saw a letter issued to all staff which informed them of the management restructure and changes to working practices. The reasons for this were clearly set out in the letter and included the need to secure the future of the business and how staff practice would contribute to this.
- A local audit of the base was carried out in December 2017 by the regional manager. We saw that this included actions to be taken, by whom and within what time frame.

Culture within the service

- We observed the leadership team at all levels to be open and transparent. Staff told us they felt valued in different ways; for example there was investment in their training and development and they believed their own personal input contributed to the success of the business.
- There was a staff incentive scheme where staff members were nominated by managers and colleagues for an 'employee of the month' award. We saw this was acknowledged in a letter of congratulations by the head of human resources. In addition, their profile was

included in the monthly staff newsletter and they received a framed edition of this. Their names went forward for employee of the year which had a monetary prize. There were also incentives for no vehicle accidents.

- Staff told us they felt valued by the company and referred to the incentive scheme as evidence of this. They also said they appreciated the training they received which gave them a sense of pride in their job. Staff told us they believed the company was honest with them and kept them informed of developments; there was transparency about how well the company performed.

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

- The provider carried out a survey of patient experiences between March and July 2017 in order to ascertain patient's experience of the service provided. There were 400 questionnaires distributed and 16 returned, which represented 4%. The main theme of the survey related to patient dissatisfaction about length of waits and general lack of timeliness of transport.
- Managers told us they were working with the commissioning NHS trust to be included in the patient forum. In this way, they hoped to be able to engage in direct dialogue with patients and gather feedback about the service and respond accordingly.
- The base was tasked with the development of an action plan to improve punctuality and patient satisfaction. We were told that punctuality continues to be a challenge for a variety of reasons; actions taken include regular engagement with the NHS commissioner.
- All members of staff were invited to meet with the national and local leadership team as part of an annual 'roadshow'. They presented how the base and the wider company performed in 2017 and shared their plans for 2018. Eleven staff attended and they were given the opportunity to raise any concerns and questions they had in relation to their work.
- Staff concerns were mainly about the recent introduction of a computer aided despatch and planning system. We saw that these concerns were listened to and a manager agreed to contact the creators of the system to discuss adjustments specific to Arriva Transport Solutions Limited requirements.
- There were monthly staff meetings held at the base in which updates were shared about the performance of the base and any updates to policies and procedures. These meetings were an opportunity for staff to discuss any challenges to their work and discuss solutions. Most members of staff told us they found staff meetings were informative and gave updates of any policy changes. They said they felt able to give their opinions and were listened to.
- There was a monthly newsletter distributed to all company staff which highlighted any policy changes, as well as news items. We saw there was an article on the staff survey, interviews with a variety of staff, updates on new procedures and an update on business plans and developments.
- There was a social media group which staff could use to communicate and voice their thoughts and opinions. We found that this was not widely used within the staff group for a variety of reasons, in particular that it was not a chosen method of communication for many of them.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The provider had a robust way in which to induct new crew; this included an intense residential period of training and subsequent mentoring prior to them working alone with patients.
- Driver competence was continuously reviewed through a real time tracking system which monitored driver behaviour, including speeding, erratic braking and unexplained stoppages. This enabled the provider to maintain oversight of safe driving.
- The provider introduced a computer aided despatch and planning system in July 2017 which we were told had contributed to improved efficiency of the service.

Outstanding practice and areas for improvement

Outstanding practice

- The provider recorded patients' preferred name on their electronic record. Crew told us they found this was a very important way in which to help the patient to relax since the trip to hospital could already be stressful for them.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that robust processes are in place to make sure that all available information is gathered to confirm persons are of good character, and ensure that risk assessments are undertaken for those roles where DBS checks are not considered eligible.

Action the hospital SHOULD take to improve

- The provider should take action to reduce delays to the planned journey patient pick up times.
- The provider should take action to reduce the number of aborted journeys.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors No disclosure and barring service (DBS) check was done for a director position within the organisation. Senior managers told us they decided that as the role did not involve direct physical contact with patients, the post holder was not eligible for a DBS check. We asked to see the written assessment which assured them that the person was of good character to hold that role. A risk assessment was not undertaken for the director to support the decision that the post was not eligible for a DBS check. This is a breach of Regulation 5(3)(a)