

E-Zec Medical Transport Services Ltd

E-Zec Medical Transport Services Ltd - Worcestershire

Inspection report

Unit M2 and M3
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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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. 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 and treatment. The service mostly met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent.
- 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 local 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 and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff mostly understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service

Patient transport services

Rating

Good



Summary of each main service

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. 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 and treatment. The service mostly met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent.
- 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 local 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 and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff mostly understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

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Summary of this inspection

Background to E-Zec Medical Transport Services Ltd - Worcestershire

E-Zec Medical Transport Services Ltd-Worcestershire is operated by E-Zec Medical Transport Services Ltd. The service provides non-urgent, planned transport for adults and children with a medical need who need to be transported to and from NHS services, who are registered with a GP. Patients need to meet the eligibility criteria agreed with the Integrated Care Boards.

E-Zec Medical Transport Services Ltd Worcestershire fleet consists of 38 vehicles, including cars, vehicles for transporting people in stretchers, and vehicles with wheelchair access. The service has a main base in Worcester and satellite bases in Kidderminster and Redditch. We did not visit these other bases.

The location was registered with the CQC in April 2021 and the current Registered Manager has been in place since October 2021. At the time of inspection, the service had two registered managers. This was raised at the time and one has since de-registered. Registered Managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 31 August 2022.

How we carried out this inspection

We inspected this service on 31 August 2022. This was an unannounced comprehensive inspection looking at all aspects of the service. We visited the main base of this location in Worcester and the control room in Shrewsbury.

The team that inspected the service comprised 2 CQC inspectors, and a specialist advisor with expertise in patient transport services.

During our inspection we spoke with 14 staff members including ambulance care assistants, control room staff, supervisors and managers. We checked 5 vehicles and reviewed 5 patient records. We accompanied 1 crew who were transporting patients and observed patient care.

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 is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **SHOULD** take to improve:

Summary of this inspection

- The service should ensure that staff are up to date with their mandatory training, including safeguarding and mental capacity act training.
- The service should monitor that clinical waste storage and disposal processes for vehicles are effective.
- The service should ensure that infection prevention practices are robust including equipment is fit for purpose such as mattresses.
- The service should ensure that staff follow the infection control policies within the local environment such as wearing masks within the acute setting.
- Leaders should consider ways to be more visible for all staff in the service.
- The service should ensure that the strategy is communicated effectively to all staff.
- The service should continue to work with the Integrated Care Boards to identify and resource excess demand.






Our findings

Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|----------------------------|------|-----------|--------|------------|----------|---------|
| Patient transport services | Good | Good | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

Patient transport services

| | |
|------------|--|
| Safe | Good  |
| Effective | Good  |
| Caring | Good  |
| Responsive | Good  |
| Well-led | Good  |

Are Patient transport services safe?

Good 

We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff however not all staff were up to date with mandatory training. A plan was in place to improve compliance with training

Not all staff were up to date with mandatory training. Staff took part in an annual skills development (ASD) day whereby they completed their yearly mandatory training. This was face-to-face training such as basic life support and staff were required to complete additional e-learning modules around their role.

Training documentation showed that 90% of staff had completed the ASD. However, only 69% had completed their e-learning. The process for managing staff attendance on the ASD was robust. We were told that 19 staff members were booked onto the ASD course within the next 3 months. However, as staff were required to work independently to complete e-learning, managers found this more difficult to ensure compliance. Managers told us that they had an improvement plan in place for increasing e-learning compliance. However, they had found it difficult due to an increase in activity levels and staff annual leave over the summer. They planned to give staff more downtime whilst on shift to complete their e-learning. After the inspection, the service provided an update to show improvements in training compliance had been made and a robust improvement plan was being monitored.

Staff we spoke with were familiar with the mandatory training modules and told us they had completed them. The mandatory training was comprehensive and met the needs of patients and staff. We saw modules included conflict resolution, capacity of consent, safeguarding adults and children, infection prevention control and equipment familiarisation.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Ambulance care assistants were trained in dementia, autism and learning difficulty care.

Patient transport services

Managers had a manual system to monitor the uptake of mandatory training against the providers' target. This, however, did not contain the e-learning modules. This meant that the e-learning figures were much lower than the figures for the ASD. Staff told us they got reminders to complete their training via email. Training updates were sent weekly to the compliance manager who increased the dates for training when required. The managers stated that they planning to bring the ASD training in-house to provide more opportunity for it to be completed by the staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff were up to date with their training on how to recognise and report abuse. However, a plan was in place to improve compliance with training.

Operational staff received training specific for their role on how to recognise and report abuse. The ambulance care assistants, local managers and control room operators were trained to level 2 in safeguarding adults and children. The provider wide safeguarding lead was trained to level 4. This was in line with the provider's policy which stated that 'all staff are trained to level two in safeguarding children and adults at risk. Registered paramedics are trained to level three'. Appropriate protocols were in place and detailed in the provider's policy to ensure any concerns were raised immediately to keep people safe.

The service had clear systems and processes to safeguard adults, children and young people from avoidable harm, abuse and neglect in line with legislation and local safeguarding arrangements. The service had an up to date safeguarding policy.

Data showed that 54.9% of staff members had completed training for safeguarding adults' level 2 and 52.7% had completed safeguarding children level 2. After the inspection, the service provided information to show that training compliance had improved by 25% and that a robust improvement plan was being monitored. As well as online learning, a safeguarding scenario was included in the annual skills development (ASD) training. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff at the service had access to a 24-hour safeguarding telephone line which they could call to report concerns. Staff would also report safeguarding concerns through the personal digital assistants (PDA), handheld electronic devices, which they took on each shift. In July 2022, 8 safeguarding referrals were made by the staff. We saw these were logged on the monthly quality log which allocated a level of risk and had the outcome. For example, a patient was discharged home following an overdose and when the staff arrived at the home, they were concerned at the number of medications around the house and social services were contacted.

Staff followed safe procedures for children using the service. Children were always required to be accompanied by a parent or carer.

The service conducted Disclosure and Barring Service (DBS) checks on all operational staff prior to them starting their role. We saw evidence from a random selection of 5 staff records that appropriate DBS checks had been carried out.

We saw a safeguarding policy was in place at the service.

Patient transport services

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff mostly used equipment and control measures to protect patients, themselves and others from infection. They generally kept equipment, vehicles and the premises visibly clean. However, we did identify a few areas where infection control risks were not managed well.

All areas were clean and had suitable furnishings which were clean and generally well-maintained; This included the garage which housed vehicles.

The vehicle garage had a 'make ready' area where vehicles were cleaned by staff. All cleaning equipment was colour-coded to ensure staff used the correct equipment on the correct part of the vehicle. The service used disposable mop heads to avoid any contamination. Cleaning products were risk assessed and stored as required in line with 'Control of Substances Hazardous to Health (COSHH) requirements.

During our inspection we checked 5 vehicles. All vehicles had a good supply of personal protective equipment (PPE), body spill kits, clean linen and hand cleansing gel. We found plentiful supplies of decontamination wipes. We found 2 mattresses within a stretcher ambulance had small tears in the mattress cover. This was highlighted to staff at the time.

Data showed that 61.5% of staff had completed their infection control training. This was included as part of their induction and annual mandatory training. A plan was in place to improve this over the next 3 months. This included giving staff protected time to complete their training.

Staff told us advice and support for infection control matters was available on their compliance system 'Radar'. Bulletins were circulated to staff via their emails covering areas such as national guidelines and learning from incidents. Urgent important changes were communicated by the road base supervisors or location managers; staff were required to sign to say they had read and understood the content of these controlled memos.

Systems were in place to prevent and protect people from healthcare associated infection and COVID-19. Staff were aware of COVID-19 precautions and these were in place, where necessary. The provider did not have any recent COVID-19 outbreaks.

The premises were clean and generally had suitable furnishings which were clean and well-maintained. However, wheelchair seats were fabric and stained. This meant that they were hard to clean, and patients complained about their cleanliness.

The premises were cleaned by external contractors. Touch points, areas which were frequently touched by staff members for example door handles and computer keyboards, were cleaned twice a day by staff members. This reduced the risk of infections spreading, such as Covid-19. Each premises had a base supervisor who was responsible for checking the quality of the cleaning, auditing the cleanliness and monitoring the cleaning completed by external contractors. The service were not happy with the standard of clean provided by the external contractors. One of the base supervisors said they often had to do further cleaning themselves as the standard was not always good. This had been escalated and raised with the company including evidence of the poor cleaning. The company were in the process of allowing the cleaner time to improve their standards as per the contract.

The service generally performed well for cleanliness. We saw the service used daily and weekly cleaning check sheets to monitor the base cleaning levels.

Patient transport services

Cleaning records were up-to-date and demonstrated that all areas of the base were cleaned regularly. Deep cleans of the vehicles were undertaken by a third-party provider every 12 weeks. At the time of our inspection; all vehicles were compliant with the deep clean schedule. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The compliance and quality manager did monthly checks to ensure that the cleaning records were up to date.

Provisions within the organisation promoted good hand hygiene in line with best practice. Staff followed infection prevention control processes in place to minimise the chance of cross infection. All staff we saw were bare below the elbow.

Staff generally followed infection control principles including the use of personal protective equipment (PPE). Staff we spoke with were familiar with how to use PPE. Staff driving the vehicles had access to antibacterial gel in the cab areas. However, we did see 2 crew members within the hospital who were not wearing a mask whilst transporting a patient, which was not in line with policy.

Ambulance vehicles were clean and in good repair. Crews wiped down vehicles in-between patients and cleaned vehicles at the end of each shift. We saw crews submitted a weekly vehicle cleaning checklist. A small sample of these were checked by service leaders each week to ensure compliance. We inspected 5 vehicles and found them to be clean and in good condition.

As the service completed only pre-planned transfers, staff were informed of any communicable infection risks prior to completing the transfer.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff mostly managed clinical waste well.

The design of the vehicles followed national guidance. At the time of our inspection the service had 38 vehicles across the 3 sites that were suitable for use. During our inspection, we checked 5 vehicles. We found that vehicles were road worthy, well stocked, and most of the equipment was working and well-maintained. However, in 2 out of 5 of the vehicles we checked we found torn material on the trolleys. The vehicles were in good condition with only minor cosmetic damage. However, this did mean there was a risk of infection spreading. The fleet supervisor stated that hand sanitiser had been damaging the seating within the ambulance and they were changing their sanitising agent to try to improve this.

Staff completed a vehicle checklist at the start of their shift which required them to report stock, mileage, and any issues with the vehicle. In addition, staff completed weekly vehicle checks. Staff told us there was a defect reporting process and they had to complete a form when they identified a defect with their vehicle. Maintenance concerns were generally responded to in a timely manner. Vehicles were taken off the road when faults were reported. The faults were managed by the fleet supervisor. The service used local garages to carry out repairs to vehicles. The fleet supervisor was trained in vehicle maintenance and able to quickly identify faults. There was a 'vehicle damage flipchart' displayed in the staff areas. It had laminated photographs showing known damage to vehicles.

Ambulance compliance checks were completed by the managers on a regular basis. Actions were taken if the ambulance was found to be non-compliant. For example, we saw that during the compliance check they found an out of date oxygen mask which was removed and replenished with in date stock.

Patient transport services

At the time of our inspection, there were 6 vehicles which were taken off the road for repair. The manager had arranged for 3 vehicles to be borrowed from another site to ensure that the service could continue to run without delays.

Staff used personal digital assistants (PDA, handheld electronic devices) to obtain patient details, be directed to their patient pick-ups and to communicate with the control room. Staff could also use these devices to report incidents, safeguarding concerns or complaints. Each vehicle had a PDA assigned. Each vehicle was also fitted with an internal satellite navigation system and dashboard cameras.

All staff attended an 'Additional Skills Day' (ASD) which included the completion of operational competencies. These included the use of stretchers, wheelchairs, carry chairs and site-specific equipment.

Staff carried out safety checks of specialist equipment. Staff checked equipment such as consumables and oxygen cannisters weekly. Patients often used their own wheelchairs whilst travelling on the vehicles. These were checked by staff for crash testing and if this had not been completed, the patient used the service's wheelchair. We saw staff secure the wheelchairs to the floor of the ambulance correctly.

Clinical waste was not always stored appropriately. We saw clinical waste bags were tied onto the back of chairs within the vehicle whilst transporting a patient. These were not secure. This meant that there was a risk that clinical waste could fall from the bag. This was raised at the time of the inspection and rectified immediately.

The management of control of substances hazardous to health (COSHH) standards within the organisation was in line with best practice. The equipment was locked away and stored appropriately.

The service had enough suitable equipment to help them to safely care for patients. All equipment was serviced annually and up to date with their safety checks. The service held a log of when equipment was due to serviced or had been serviced. They acted upon concerns raised by the companies who serviced the equipment. We were told that the servicing was in date.

Staff used paediatric equipment to safely support children who travelled on the vehicles.

The quality and compliance manager completed a monthly safety check and an annual health and safety compliance audit. The monthly safety check was 100% for August, July and June 2022. The annual health and safety compliance audit included checking the fire risk assessment, the evacuation plan, appropriate signage within the building and annual inspections of the building and safety equipment were up to date. This was completed in June 2022 and the service were 98% compliant. An action plan was created for the items that they were not compliant with.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service provided by this location was patient transport services delivered by ambulance care assistants for patients who were not acutely unwell. Staff did not take routine observations of vital signs for standard patient transport journeys but were aware that if a patient became unwell on a journey, they contacted the ambulance service by ringing 999. This was in line with the E-Zec policy.

Patient transport services

Staff completed risk assessments for each patient on booking and reviewed this regularly for patients who undertook regular journeys. Ambulance care assistants (ACAs) knew about and dealt with any specific risk issues. Control room staff completed risk assessments for all planned activities. This included any potential risk factors such as if a patient had additional needs or used specialist equipment.

ACAs reviewed the electronic patient records prior to picking patients up to identify any potential risks or areas of additional needs. This enabled ACAs to review risk assessments and notes about the patient. Staff also completed access visits, when required, to ensure that access was available prior to the booked journey.

The booking staff triaged all patients to assess whether they were suitable to travel with other people in terms of clinical vulnerability. ACAs also escalated to control staff if they felt a patient was not appropriate for travelling with others and their record was updated to reflect this.

The service, as part of its contract, transported patients undergoing treatment for mental health conditions on a voluntary basis (not detained under the Mental Health Act). The service required that these patients using the service were accompanied by an escort (such as a member of staff from the sending establishment) or carer. We saw staff had access to training on caring for patients with a mental health diagnosis. The senior leadership team told us at the time of the inspection the service did not transport patients who were detained under the Mental Health Act. However, they were looking at offering secure transportation of patients detained under the Mental Health Act in the future.

Staff shared key information to keep patients safe when handing over their care to others. ACAs spoke with staff, family or carers when collecting a patient to gain a handover and ask relevant questions. When dropping patients off, ACAs escorted patients into the building. If ACAs were taking a patient to their own home, they entered the home with the patient to ensure the environment was suitable and safe, particularly if the patient had spent some time in hospital.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Supervisors regularly reviewed and adjusted staffing levels and skill mix.

The 'front line' staffing establishment of ambulance care assistants (ACAs) was 62 full time equivalent posts, with three current ACA vacancies. At the time of the inspection, there were sufficient staff on duty to meet the patients' needs. They had 3 vacancies and used bank staff regularly to fill outstanding shifts. Sickness rates were 3.19% during August 2022 and 4.5% on average for 2022. The management stated that none of these sickness absence episodes were related to stress.

To mitigate the gaps in staffing, the service had used a third-party independent patient transport provider. As the staffing numbers rose, this company was required less. This was funded by the Integrated Care Board (ICB) from July 2022 until September 2022 due to the increased activity levels. The ICB completed checks and approved any third-party providers that were used.

Control room supervisors allocated ACAs to shifts. New staff were not permitted to work alone until signed off as competent and were allocated to work with staff who had worked in the role for a longer period.

There were no vacancies in the office/support staffing establishment, which included a contract manager, an operations supervisor, a base supervisor and a fleet supervisor.

Patient transport services

Records

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

During our inspection we looked at 5 patient records. Patient records were appropriate, and all staff could access them easily. Records were stored securely. Patient records were electronic and initiated by the control room operatives when taking a booking. Ambulance care assistants (ACA) could access these via PDAs which they took on each shift.

The records contained relevant information to enable ACAs to safely transport patients. This included details of the patient and their journey, details of any vulnerabilities, risks and the patients' Covid-19 status.

Medicines

The service followed best practice when administering, recording and storing oxygen.

Oxygen was the only medicine used at the service. Staff stored and managed this safely. Full and empty oxygen cylinders were stored separately in locked cages and clearly labelled. A system was in place to check the oxygen cylinders and ensure they were in date. Oxygen was only given to patients in an emergency or if it was documented within their patient notes.

Patients could bring their own medicines with them, for example if being discharged from hospital. These were kept with patients' belongings and were the responsibility of the patient.

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. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy, including serious incidents. Staff reported incidents electronically using the PDAs, which they took on each shift or via an electronic system. Managers were alerted to each incident report and were able to immediately view and act upon the incident. All incidents were assigned a risk score which determined their response level from the service. This risk scoring also triggered an action plan and learning outcomes. The manager stated that common themes would be logged onto the risk register. At the time of the inspection, there were no common incident themes what warranted being added to the risk register.

Staff we asked were familiar with the duty of candour; we saw staff received training in this. Supervisors and managers apologised when things went wrong and where appropriate in complaint responses. Managers exercised the legal duty of candour in line with the CQC regulations.

Most staff said that they received feedback from investigation of incidents, both internal and external to the service. Managers emailed staff to alert them to any learning following incidents. Staff and managers were aware of incidents that had occurred, and staff told us they received feedback after incidents. For example, we were told that a patient's journey did not go ahead, and this patient was living with autism. This cancellation had an impact on the patient both mentally and physically. Their story was shared with the staff on site and at the control room. Staff said this helped them to understand the impact of cancellations and poor job allocations.

Patient transport services

Staff did not meet to discuss the feedback and look at improvements to patient care. At the time of our inspection, team meetings were not embedded with all staff. Managers discussed incidents at a more senior level internally and externally to the service.

There was evidence that changes had been made as a result of feedback. For example, we saw a 'lessons learnt' board and safety bulletins highlighting recommendations for staff following incidents. Within the May 2022 newsletter, an issue with slide sheets was identified and this was shared at provider level to ensure there was learning at all provider sites. They also had 'toolbox talks'. These were learning sheets produced from incidents where further improvements and learnings were needed. All staff had to sign an evidence sheet to show they had read the 'toolbox talks' information. For example, in May 2022, an update was provided for all staff regarding the use of patient heaters within the vehicles following a patient burn.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. During our inspection we reviewed a sample of incidents reported and investigated. We saw managers followed a structured process to ensure incidents were investigated depending on their severity. This process was easily tracked via the electronic reporting system which sent reminders to staff to complete activities in order to complete the investigation. The managers were able to oversee the incidents and had a good understanding of what was going on at both site and regional level. The Quality and Compliance manager collated the incidents across the region and looked for themes. These were documented within a monthly quality account. This meant that lessons learned were shared and themes were collated.

We noted that no concerns had been received about the timeliness of dialysis patient transport journeys in the period 1 July 2022 to 31 August 2022.

Are Patient transport services effective?

Good 

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had electronic access to the provider's policies to support their roles. Staff were sent up to date policies and guidance to read via their electronic compliance system. Managers were able to see when staff had accessed policies and prompt them when required.

Staff followed NHS England eligibility criteria for patient transport service to ensure they transported appropriate patients.

When handing over care, staff routinely referred to the psychological and emotional needs of patients. Staff spoke with hospital and care home staff, carers and family when collecting or dropping off patients. They shared information about the patient relevant to the patients' needs.

Patient transport services

Nutrition and hydration

Staff provided water for patients on board vehicles.

Due to the nature of the service, food and drink was not routinely served to patients during journeys. However, bottled water was available for patients going on longer journeys. Some patients were given food by the hospital if needed. Staff also liaised with carers and hospital staff to check if there were any special requirements in relation to nutrition or hydration.

Within the service's monthly managers' meeting, a complaint was discussed where a patient was 'nil by mouth' for a long period of time due to delays with transport. As a result, the service had asked call takers to ask patient if they had any specific dietary needs, such as starving pre-operatively, when booking transport.

Response times

The service monitored agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

Managers monitored performance against 8 key performance indicators (KPIs) set by the Integrated Care Board (ICB) which included response times.

- KPI 1a: Time on Vehicle (TOV) – Up to 30 miles within 90 minutes. The target was 75%. As of July 2022, the service had achieved 97.45% compliance.
- KPI 1b: TOV – Between 30 and 70 miles within 140 minutes. The target was 75%. As of July 2022, the service had achieved 98.38%.
- KPI 2: Inward journeys arrive within 60 minutes before and 10 minutes after the appointment time. The target was 90%. As of July 2022, the service had achieved 82.09%. This had improved since June 2022 which was 79.42%.
- KPI 3a: Pre-booked Outpatients, after Treatments and Day Cases collected within 60 minutes. The target was 75%. As of July 2022, the service had achieved 84.68%.
- KPI 3b: Pre-booked Outpatients, after Treatment and Day Cases collected within 90 minutes. The target was 95%. As of July 2022, the service had achieved 90.61%.
- KPI 4a: On the Day (OTD) Discharges from Emergency Departments collected within 60 minutes. The target was 80%. As of July 2022, the service had achieved 59.72%.
- KPI 4b: OTD GP 'Urgents' collected within 180 minutes. The target was 95%. As of July 2022, the service had achieved 100%.
- KPI 4c: OTD Outpatients, after treatments and Day Cases collected within 120 minutes. The target was 90%. As of July 2022, the service had achieved 98%.
- KPI 5a: Pre-booked Discharges collected within 120 minutes. The target was 65%. As of July 2022, the service had achieved 71.38%.
- KPI 6a: OTD Discharges collected within 180 minutes. The target was 80%. As of July 2022, the service had achieved 79.89%.
- KPI 7a: End of life (EOL) Patients collected within 2 hours. The target was 75%. As of July 2022, the service had achieved 100%.
- KPI 7b: EOL Patients collected within 4 hours. The target was 100%. As of July 2022, the service had achieved 100%.
- KPI 8a: Calls answered within 120 seconds. The target was 95%. As of July 2022, the service had achieved 54%.

Managers identified reasons for not achieving KPIs which included increase in activity levels.

Patient transport services

The service discussed performance monthly with the ICB and identified areas of improvement through an action plan. For example, we saw in July 2022 minutes, they discussed all KPI's including KPI 8a where performance had decreased. They stated that 2 call operators had left the team without working their notice period and they were struggling to recruit into this position which meant calls were not answered as quickly.

In August 2022, the service made 128 dialysis patient journeys, an increase from 97 in April 2022. From information provided, we saw the service regularly exceeded its KPI performance targets for collecting patients within the required defined timescales.

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.

Staff had the right skills and knowledge to meet the needs of patients. Staff employed by the service were trained to carry out their roles.

Managers gave all new staff a full induction before they started work. Ambulance care assistants (ACA), who were new to the service, underwent an induction training which comprised classroom-based induction and driving training. The classroom training was a combination of face-to-face training such as basic life support and manual handling, and e-learning. Following this, new staff members were allocated to shifts with more experienced ACAs. New crew members were not permitted to work alone until they were signed off as competent. Senior ACAs signed new staff off as competent following assessment shifts. A member of staff we spoke with had recently completed their induction and felt confident to complete their role following their training. The manager had created a competency checklist for new starters to be signed prior to working alone. We saw a completed checklist and the staff member had completed 12 shadow shifts prior to be signed off as competent.

There was a new 3-week induction programme that was being developed at the time of our inspection. This included 2 days of driving training. It also included a new final review before the staff member started to ensure they were confident in their role. New starters were assigned a mentor and had to complete 120 hours prior to solo driving. If a staff member had an incident relating to driving, they were required to complete a re-assessment.

New starters underwent a probationary period of 6 months to ensure they were performing in line with the service requirements. They had meetings at regular intervals within this period to discuss their performance and to ensure they were being supported.

All vehicles used by the service were under 3.5 tonne at the time of our inspection. This meant they could all be driven on a standard UK driving licence. Driving licence details were checked prior to ambulance care assistants starting in the role. The service used an electronic system which monitored staff driving licences therefore if staff accrued points or convictions relating to their driving, the service would be made aware. Staff were expected to disclose if they received any driving convictions whilst in the role. The service also required ambulance care assistants to undertake a driving assessment as part of the interview process to ensure they had the necessary skills to undertake the role.

Managers supported staff to develop through yearly, constructive appraisals of their work. The target for appraisal completion was 85%. At the time of our inspection, 73% of staff had completed their appraisals. The service held records which showed when appraisal dates were scheduled to ensure all staff would be compliant by the end of the

Patient transport services

year. The Quality and Compliance Manager completed a monthly quality account and the low appraisal compliance was discussed. They stated that there was evidence of a schedule for completion in place in line with the cohort start dates. Since then, the compliance had increased by 10%. Staff said that the appraisals were supportive and highlighted areas for development and progression.

Provider wide trainers delivered annual skills development (ASD) days to support staff completion of mandatory training. The trainers included registered paramedics. The service wanted to bring the ASD trainers in house to site level to enable training to be delivered flexibly.

Staff were encouraged to develop and progress. For example, Level 3 First Response Emergency Care (FREC) was being offered to all ambulance care assistants (ACA). This would enable the business to provide secure mental health transfers. The managers who worked at the service had also developed since starting within the service. We spoke with 2 managers who had both started off as ACA's and been encouraged to progress to management level.

The service was hoping to provide mental health secure transfers. Three members of staff had received further mental health training and 2 more were attending the training course in September 2022.

The teams did not have team meetings at the time of our inspection. Supervisors emailed information to inform staff of updates or changes.

Managers identified poor staff performance promptly and supported staff to improve. We saw evidence of managers acting on poor performance within appraisal paperwork. Where poor performance was identified, the senior ambulance care assistants or supervisors could observe shifts to provide supervision and support.

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.

Staff worked alongside health care disciplines and with other agencies when required to care for patients. The service had a patient transport liaison officer (PTLO) at each of the local NHS acute hospitals to support the hospital staff with appropriate bookings. Staff liaised with the hospital staff closely to ensure patients being discharged were collected as responsively as possible. Staff said that they had built up a good rapport with the hospital staff through regular contact.

Managers worked with clinical team leaders at the local NHS acute trust to determine which patients to prioritise when the demand for the service outweighed the available vehicles and crews. The managers reported they had a good relationship with the trust and issues were raised and dealt with promptly.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Staff were able to signpost patients where further support was required.

Patient transport services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The Deprivation of Liberty Safeguards were not applicable for this service.

Staff gained consent from patients for their journey in line guidance. Staff had access to an up to date policy on consent. Where patients with capacity to consent declined to go on the transport, staff respected this decision although did try to encourage patients to make the journey.

Staff received training in the Mental Capacity Act. At the time of inspection, 48.4% of staff had received their training. After the inspection, the service provided information to show training compliance had improved to 62% and a robust plan to continue to improve this was in place. The service transported patients who were voluntarily attending treatment for mental illness. Staff engaged with hospital staff and escorts to ensure the patients' rights were upheld.

Staff gained consent from escorts or carers if they deemed a patient to not have capacity. We acknowledged that patients with more severe dementia who were less likely to have capacity were usually supported by carers on the journey therefore asking registered carers in the best interests of the patient was appropriate.

Control room operatives clearly recorded if the patient had a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). This enabled ACAs to know whether to resuscitate a patient if they went into cardiac arrest. Staff transported a patient with a ReSPECT form from a care home and this was clearly documented on their PDA.

Are Patient transport services caring?

We rated it as good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff described how they worked with patients, and their carer's, who had additional needs such as dementia or learning disabilities. We saw staff speak to patients in a calm and caring manner to ensure the journey went as well as possible. Staff we observed did not introduce themselves to the patients, however, they treated them with care and respected their comfort throughout the journey. We brought this to the attention of managers.

Patients said staff treated them well and with kindness. We saw a member of staff approach a member of the public within the hospital who was struggling with their mobility. The staff member gave them assistance to ensure they were supported to their destination.

Patient transport services

Staff followed policy to keep patient care and treatment confidential. Staff accessed patient records electronically therefore maintaining other patients' confidentiality.

Staff we spoke with understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when discussing patients with mental health needs. Staff we spoke with during the inspection presented with a non-judgemental approach at all times when describing the patients, they worked with.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff showed understanding of equality and diversity and how this applied to working with patients.

We saw a compliment from May 2022 where a patient had described the staff as 'kind, caring and patient' and 'very pleasant journey back after what seemed a tiresome long wait but because of the lovely staff I felt so relaxed'. There were 4 compliments in July 2022 which all described the staff as 'kind and caring' and the patients stated that the staff made them feel very comfortable.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were able to build supportive professional relationships with regular patients and understood how having long-term health conditions impacted upon a person's life.

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 made sure patients and those close to them understood their care and treatment. Staff told us they spoke with families and carers to ensure they could be involved in the patients care either before the journey or at the end of the journey.

Staff talked with patients, families and carers in a way they could understand. We observed a call where a control room operator took a booking. The operator introduced themselves by name and spoke politely throughout. They reconfirmed all details with the patient to ensure a full understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Managers actively sought feedback from patients.

We saw an example where staff listened to a relative and responded to their needs. They were attending an outpatient appointment with their partner as their carer and expressed to the staff that they were struggling to look after them. The staff contacted the patients next of kin, with consent from the partner, who in turn contacted social services to provide the patient and their partner with assistance.

Patient transport services

Patients gave positive feedback about the service. The service completed a survey of 21 patients who used the service in June 2022. This was done on a monthly basis. The survey showed 90% patients were very likely to recommend the service to their friends or family, and 5% were likely to recommend the service. Patients said the service was “fantastic” and the staff were “very understanding and helpful”.

Are Patient transport services responsive?

Good 

We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided transport in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the changing needs of the local population. E-Zec Medical Transport Services Ltd - Worcestershire registered in April 2021 and had successfully bid for a contract from the local integrated care board (ICB). The service was planned according to the requirements set out in the contract designed by the ICB. Eligibility criteria included being registered with a GP in Worcestershire, although on occasion the service went outside this by exception to support patient needs.

The service had started completing catheter laboratory transport. This had started in August 2022. The ICB asked E-Zec to take over the contract from its previous provider. This required the staff to undertake further training to first response emergency care (FREC) level 4. The service outsourced the transport to a third-party provider who had staff who were skilled to this level. They had received good feedback from the ICB that the response times had improved since they had taken over the contract.

Senior leadership of the service had future plans to expand the service, if supported by the ICB, into specific areas to support the needs of the local population. For example, providing secure mental health transport. They had previously added in an overnight ambulance crew to help support the emergency departments and provide transport out of hours.

Facilities and premises were appropriate for the services being delivered. The base in Worcester was spacious, modern and had an adequately sized vehicle garage. Staff had space to clean vehicles, store equipment and consumables and to take breaks. There was space for training rooms, hot-desk work and staff facilities such as lockers. Patients did not visit the base. Staff we spoke to told us that the bases at Kidderminster and Redditch were fit for purpose. We did not visit these bases.

The service had equipment to suit the needs of different types of patients including paediatric and bariatric patients.

Managers told us that patients who did not attend appointments for transport were contacted. Staff would first try to contact the patient, or next of kin. If they could still not contact the patient and were concerned for their safety, staff escalated this so that managers could ensure welfare checks took place.

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.

Patient transport services

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Control room operatives requested that patients with additional needs, including children, be accompanied by an escort to ensure the patient was supported throughout the journey. Control room operatives documented this within the patient notes. Therefore, staff were aware of any additional needs prior to picking the patients up.

The service had recently included autism and learning disability awareness in their inductions. All staff completed this when they started with the service and then annually.

The service did not provide additional communication tools to support patients who did not communicate verbally or who had cognitive impairment. However, the control room operators recorded information about any communication needs for patients so that staff were aware of this and could liaise with family or carers as appropriate.

The service completed risk assessments of the patient's property prior to a journey being booked if they were unsure of access. This was recorded on the patient record. The control room looked at this when making a booking to ensure that the patient had the right number of crew members, equipment and vehicle for their journey

The service ensured space was available for assistance dogs if required.

The service had access to a 24-hour foreign language interpreter telephone line if required. They also liaised with families or carers to support patients who did not speak English.

Access and flow

People generally could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Managers monitored waiting times and generally made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service saw approximately 8,000 to 9,500 patients per month. Senior leadership attended meetings daily with the ICB and the local acute NHS trust to maximise patient flow.

Staff told us they were concerned about the length of time patients were waiting to be taken home after an outpatient appointment. The service worked to improve this. They had, within the previous 2 weeks, started to schedule pre-planned appointments prior to midday and then had an open diary to schedule calls appropriately, according to their priority, throughout the rest of the day. This meant that patients were only booked for their transport when they were ready. This saved on wasted journeys. This also allowed for flexibility with the schedule and enabled the patients to be allocated to the best crew for the job.

Managers received communications called 'SitRep' emails 3 times a day. This was shared with the ICB, NHS trust and transport teams. These updated the teams on the current capacity, number of vehicles available and the level of activity. The manager acted upon this information as required. There had been an increase in activity levels within the NHS Trust which had meant that there was an increase in capacity for patient transport services. The ICB had offered extra support and resources to support this. The service had recently outsourced several additional vehicles and staff, funded by the ICB, until the end of September 2022. The manager had also increased the capacity within the rota to reflect this, where possible, with the number of vehicles available.

Managers monitored waiting times but did not always make sure patients could access services when needed and received their transport within agreed timeframes and national targets. We saw that on the day discharges with 60

Patient transport services

minutes had declined over the last few months. In May, 71% of patients were collected within this timeframe, and in July, this reduced to 59% of patients. Managers stated that there had been an increase in activity and emergency departments had started to block book patients for their transport. This had an impact on waiting times. The service had assigned a dedicated Emergency Department vehicle for each shift to try and assist with the discharges and the flow through the department. The ICB were also liaising with management to improve this target. Senior leadership attended a monthly meeting to discuss targets with the ICB and local acute NHS trust to maximise patient flow.

The control room operators scheduled patients in advance where possible, for example patients who were attending a prearranged outpatient appointment. However, due to the demands upon the NHS trust, the trust often prioritised patients needing to be discharged over pre-booked outpatient journeys. The reason for this was to ease the flow of patients moving through acute NHS hospitals. However, this meant some patients experienced additional delays before being collected before or after an outpatient appointment. The service discussed this regularly with the ICB and the trust. Staff at the hospital told us that journeys were not always planned efficiently. For example, we saw that a patient was booked for an x-ray. This meant that they were in the department for less than 5 minutes. They then had to wait for several hours to go home as the crew were only booked as an 'inbound journey' rather than a 'wait and return'. This was rectified by the ambulance team at the time who spoke to the control room to book the journey back.

The service aimed to collect patients identified at the end of life within 1 hour of the booking to support the patients to get to their destination as quickly as possible. Data showed that this happened 100% of the time in July.

Managers told us that if clinics were running late, they were not informed by the department. This resulted in a wasted resource and the ambulance reallocated. The manager was working with the trust to improve this.

The service monitored the number of aborted journeys. This is the terminology used to refer to those journeys which were not carried out. We saw that reasons for staff aborting a journey included patients not being ready to travel at the time of collection, too ill to travel and the appointment cancelled with no notice. Data around aborted journeys was collected and reported to the Integrated Care Boards. We saw the service aborted 8 - 9% of journeys monthly within 2022. This was a total of 5,352 aborted journeys in 2022. In August 2022, 743 journeys were aborted which was 9.3% of all journeys. The target for this was 3 - 5 %. The managers were working with the ICB and trust to improve this through dynamic booking and increasing capacity.

The service monitored journey activity via the personal digital assistants (PDA). The staff used this to state their arrival and departure of journeys. They also used this to communicate with the control room when there were any changes to their schedule or delays. This helped the control room staff manage the journeys dynamically to reduce the delays to patients. Staff said poor signal within the rural areas meant that messages were not always picked up in a timely manner which could cause communication delays.

The service always made sure that it had 3 vehicles that were road worthy on site which could be used if an ambulance was taken off the road. This meant that the service was not affected by vehicle breakdowns.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patient transport services

Patients, relatives and carers knew how to complain or raise concerns. If a patient, family member or professional rang to complain, the control room supervisors supported staff to take the call.

The service had complaint leaflets which staff could provide if a patient wished to complain.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes, and patients received feedback from managers after the investigation into their complaint. Complaints were collated on an electronic system and managed by the central quality team. Managers reviewed each complaint and investigated as necessary. The service complaints' policy specified that managers should respond to patient complaints within 25 working days. We saw examples of complaints which had been investigated and where a response had been provided. We also saw the associated lessons learned documents for staff to read.

Responses we saw included an apology and an explanation of the situation. Managers told us that they phoned patients who had complained to discuss their complaint with them and to try and resolve it where possible.

The service had a 'service recovery board'. A patient was added to this board when they had made 3 upheld complaints, or they had resulted in a missed appointment or treatment due to a journey error. This board was managed by the central quality team and it notified the managers to ensure that the patients' subsequent journeys were not aborted. There was an alert in the patient notes for control room and the staff to ensure the journey went ahead. The aim was to have 5 perfect journeys before they were removed from the board. At the time of the inspection, there were no patients on the service recovery board.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with told us they mostly got feedback or learning following a complaint. Managers also sent out updates and learning following complaints via emails and bulletins. Staff were able to give us examples of changes made within the service following a complaint. For example, a wheelchair user had an appointment cancelled due to their chair not being crash tested. All staff had since been re-trained on how to check whether a wheelchair has been crash tested. In addition, a prompt had been added onto the patient record for control room operatives to ask the patient about their wheelchair being crash tested.

Are Patient transport services well-led?

Good 

We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were not always visible but were approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had a clear leadership structure in place. The newly appointed registered manager was supported by a regional manager and a compliance manager. They had supervisors who worked at each base. Supervisors included the fleet supervisor, base supervisor and control room supervisors; these oversaw the day to day running of the service and worked directly with staff. The other registered manager, who no longer worked in this service, informed us post inspection that they were going to submit an application to deregister.

Patient transport services

All local leaders we spoke with presented as competent and able to run the service. All were able to describe the service priorities and any risks or concerns.

Leaders and staff told us that the managers had an open-door policy. On the day of our inspection we saw that leaders were visible and accessible to staff. Local leaders made efforts to introduce themselves to new staff starting during the training programme.

The managers had progressed into their management positions from ambulance care assistants (ACA's) and therefore felt that they had good insight into the role of their staff and the challenges they faced.

The managers had an on call weekly rota to support staff out of hours as there was one crew scheduled to work each night.

The manager of the service had not received leadership training. They had started it within their previous role but was not given the opportunity to complete it on commencing within this role.

Staff told us they were generally well supported by the managers. For example, a staff member said that management arranged their journeys to be closer to their home location before their baby was born; They felt that this was very supportive.

Staff did not feel that senior leaders within the business were visible. Within the staff representative meeting in May 2022, staff asked if senior management would make more of an appearance at base locations. Staff told us that they did not see the senior leadership team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff mostly understood and knew how to apply them and monitor progress.

The provider had recently introduced a new vision and strategy across all their sites. Not all staff we spoke with were familiar with this although we saw it was displayed clearly in staff areas. Some staff were aware that the provider wanted to deliver more aspects of transport such as mental health secure transport and high dependency unit transport. The managers worked closely with the integrated care boards (ICB) to ensure that they were adapting to meet the increased activity levels and the needs of the patients.

The vision was 'to be the leading provider of patient transport by embracing change and innovation through a culture of continuous improvement'. The values included:

- We Listen, We Learn, We Adapt.
- Committed to Care.
- People First.
- Pride in Service.
- One Team.

The manager's local vision was to provide the best service to patients and give them the best journey.

Patient transport services

The service was looking at developing a strategy that focused on becoming an armed forces covenant. This meant that they would proactively demonstrate their commitment to engage with the wider communities, encourage rescue service and support employment of veterans.

The service had highlighted their environmental strategy within the August 2022 Newsletter. They were shortly introducing a new fleet telematics system to help with reducing their carbon footprint.

Culture

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

Staff mostly felt valued and respected by the service. Staff told us that managers were mostly supportive and fair.

Some staff told us they did not get adequate breaks throughout their shifts. The control room staff scheduled the breaks for the ACAs into their working day; some staff chose to build their own breaks in between patient journeys. The control room staff said that they worked with the ACAs to ensure that they had their break at a suitable time. ACAs told us that this did not always happen. We were also told that the staff often finished late due to the allocation of jobs from the control room staff. The manager of the control room stated that the staff were new within the control room and that they were aware that there had been some issues with job allocations. They had added a supervisor role into the team to assist with the day to day activity and liaise with the managers at base to resolve any issues.

Staff told us they generally felt valued by the service, were able to go to managers if they had concerns and felt that changes were well managed. One staff member reported that they had received negative reactions from supervisors when broken equipment was reported. However, staff generally felt that they had good support.

The manager had completed mental health first aider training. This meant that they were able to support their staff with their mental health. We saw a thank you card from a staff member who felt that the manager had supported them with their mental health and as a result had taken on further training and gained confidence in themselves.

Staff told us they worked as part of a team to support each other such as in the event of a vehicle breakdown.

The service worked with staff who had health conditions to support them to continue working. There were opportunities for staff to progress for example from an ACA to a senior ACA. Both the manager and the quality and compliance manager had progressed from ACA into their role. They felt supported and encouraged to do so.

The service had a staff representative who met with the manager on a monthly basis to discuss topics on behalf of the staff. We saw minutes which showed discussions included pay, break allocation, uniform issues and increase in activity levels. These were acknowledged by the manager and an action put in place to respond to the staff on these points if the answer was not known. The August 2022 newsletter stated that managers had listened to staff concerns about uniforms and had recruited uniform champions. They were going to help bring about the proposed changes by the end of the year. Staff representative meeting minutes were circulated to staff. There was a post-box within the base room to enable confidentiality for the staff when raising their concern. Generally, staff said that they felt their concerns were listened to by the local managers and action was taken.

Patients and those who were around them were able to complain to the service. We saw feedback was reviewed openly and learning shared as necessary.

Patient transport services

The provider had a 'shining star' monthly award. Staff were nominated anonymously, and the senior leadership team selected their shining staff. The manager had nominated 2 members of staff who won the shining star award in May 2022 for supporting a member of the public during their night shift with their mental health.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, staff did not have regular opportunities to meet, discuss and learn from the performance of the service as a team.

Leaders operated effective governance processes. We saw there were clear lines of governance to enable effective monitoring of performance and quality. A regional manager, quality and compliance manager and central quality team oversaw incidents and complaints. Staff received feedback from these through bulletins, newsletters and emails. Staff were able to give us examples of things that had changed and that they had learned. The service did not hold team meetings, but this was something they were aiming to introduce.

The service had a monthly meeting with the ICB which discussed contract performance and reporting, quality, finance and any other issues. The managers acted on information where improvement was needed. They had an action log which we saw was updated monthly and actions were completed in a timely manner.

The service had an electronic compliance system where all incidents, complaints, policies and bulletins were managed. This system prompted managers when they had a task to do, such as, complete a review for an incident. This meant that tasks generally did not become overdue. The central quality team assisted the managers with information gathering and complaint responses. The quality and compliance manager completed a weekly check and a monthly review of the service. The monthly quality account included data regarding training and appraisals, complaints, vehicles, patient feedback, compliments, incidents and any themes. This meant that they had a good overview of the service's performance. They also planned to complete mock inspections of the service to ensure compliance against the regulations and create action plans to improve compliance. They had not yet completed this for this site. We saw that this had been completed for another site and the results were shared with the team within the quality report.

Radar prompted staff to read bulletins, complete training, read new guidelines and policies. It enabled managers to see when staff had read the up to date policy or guidelines.

Supervisors and managers were aware of their roles and accountabilities. They understood the service requirements and worked to provider wide standards.

The provider had a robust recruitment process to ensure ambulance care assistants and other operational staff were suitable for their roles. The service also required ambulance care assistants to undertake a driving assessment as part of the interview process to ensure they had the necessary skills to undertake the role.

The provider's chief executive officer (CEO) had online calls for the staff to dial into. Staff we spoke to, however, did not mention these calls.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Patient transport services

Leaders met with the ICB monthly to review performance. We saw meeting minutes for May to July 2022. Agenda items included performance against key performance indicators (KPIs), complaints, incidents, liaison with CQC and other ongoing issues or concerns. The minutes reflected feedback provided to the service from the ICB.

The service worked with partner organisations to support the local system and improve patient experience. For example, the service had recently taken on the local catheter laboratory transport contract. The department had fed back that this had improved their service.

The service had a risk register which was held on their electronic monitoring system. The register reflected the risks we saw within the service on inspection.

The managers described how they had an issue with the operational effectiveness of base due to its location on an industrial estate. They had an incident where the switchboard on the estate was being repaired which could have affected the service. However, they had a mitigating plan in place to keep the service running and this therefore did not affect them.

The service used an electronic system to report, investigate and monitor incidents, complaints, and safeguarding referrals. We reviewed this system and found it enabled supervisors and managers to undertake appropriate investigations where necessary. We reviewed 2 entries on this system and found that each had been well reviewed and escalated where required.

There were audit systems in place, and we saw examples of these being effectively carried out and the results acted on.

To support the business the service used a third-party independent ambulance provider. Managers told us about the due diligence checks completed on both organisations prior to using these. This was funded by the ICB and was in place until the end of September 2022.

The service had business continuity policies in place to cope with unexpected events.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. However, notifications were not always submitted to external organisations as required.

The service collected reliable data using the electronic system as described above. This allowed managers to review performance, risk and quality and to produce clear reports for the ICB and provider.

Information such as patient details was kept securely on electronic systems. All operational staff could access the information they needed to do undertake their jobs.

At the time of our inspection, there were still 2 registered managers for the service. This was escalated at the time of inspection. The service has since sent a notification for one registered manager to be removed.

Engagement

Leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patient transport services

Whilst managers tried to show themselves as visible and having an open-door policy, there was no active local engagement such as team meetings with ACAs.

A provider wide staff survey had been conducted in April 2022; with headline results demonstrating how staff across the provider felt about working for the organisation. At the time of the inspection, the results were not at location level. We saw the provider level results were mixed for example 78% of staff felt confident in successfully undertaking their role. However, only 29% of staff felt valued for the work they did.

Managers at the service were actively working with other stakeholders and local organisations to improve the service of patients. For example, managers had been working with the catheter laboratory department at a local NHS trust and had regular meetings which incorporated the ICB and the local trust.

The service made effort to engage with patients to get feedback. Staff called patients after they had used to service to ask the patients to give feedback. Managers used the information to produce reports to encourage learning and to report to the ICB.

The provider had introduced a new benefits programme called 'HAPI' which was accessed via an application on the staff's personal phone. We saw that this was communicated to staff via the June 2022 Newsletter. It had a range of discounts and benefits. It enabled managers to gift staff with a voucher if they felt they had gone above and beyond. The application also had a wellbeing section which contained an online general practice (GP) and money advice. Staff we spoke to were aware of the application but had not started using it. We saw information displayed around the base about it and its benefits.

Learning, continuous improvement and innovation

Managers were committed to continually learning and improving services.

The service had future plans to develop patient transport into different services, such as mental health secure transport, to support the needs of the local population.

Managers had operation meetings in different locations to see good practices and enable improvement within their own locations.

The service had plans to trial an electric ambulance in early 2023 to improve sustainability.

The provider rewarded innovation and improvement ideas. Two members of staff had received a reward from the provider for developing an application which showed the site maps of frequently visited locations. This supported staff to transfer patients to their designated areas for care quicker and confidently.