UK Event Medical Services Limited

UK Event Medical Services Limited

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This service had not previously been rated. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Staff provided good care and treatment and gave patients pain relief when they needed it. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information.
- 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good 	This service had been inspected before but not rated. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. • Staff provided good care and treatment and gave patients pain relief when they needed it. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. • 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. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff 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 main service was urgent and emergency care. Where arrangements were the same, we have reported findings in the patient transport section. We rated this service as good because it was safe, effective, responsive, and well-led. Caring was not rated. However:

Summary of findings

- We saw evidence some mandatory training course attendance was below the providers attendance target. We did see a comprehensive plan to raise compliance which was planned to reach 85% by April 2022.
- We saw evidence overall staff appraisal rates were below the providers completion target. We did see a comprehensive action plan to raise the levels of staff appraisal completion to 85% by April 2022.
- Staff files for those recruited prior to September 2021 were not always complete. Although, since the appointment of a new compliance lead, a new process had been implemented and all new staff files were complete.

Patient transport services

Good

This service had been inspected before but not rated. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service 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 and assessed patients' food and drink requirements. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of 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.

Summary of findings

Staff 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

Contents

Summary of this inspection

Background to UK Event Medical Services Limited

UK Event Medical Services is registered with the CQC to provide the following regulated activity;

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

The provider has had a registered manager in post since December 2018.

The service was subject to a CQC focussed inspection in February 2020. The inspection looked at the safe and well-led domains. The service was not rated and there were no regulatory breaches identified.

UK Event Medical Services provided a full range of services including Non-Emergency Patient Transport Services, High Dependency Patient Transfers (Urgent Care), Secure Patient Transport, and Medical Repatriation. Medical Repatriation is not regulated by CQC.

The providers main operating base was in the Darnell area of Sheffield providing patient transport services. This was where the main administrative function of the provider was carried out. In addition to the main operating base the provider has five satellite stations listed below;

- Woodbourn Road in Sheffield providing emergency and urgent care and mental health patient transport. This satellite station is the location where staff received face to face classroom training.
- Cottingham providing patient transport services.
- Bridlington providing patient transport services.
- Elland providing emergency and urgent care and patient transport services.
- Barton-Upon-Irwell providing urgent emergency care, patient transport services and mental health patient transport.

The provider was on a framework agreement with an NHS ambulance provider for patient transport services (PTS) and urgent emergency care (UEC) services. Private providers on the framework have opportunities to bid on mini tenders which the NHS ambulance provider offered to independent providers as and when there was a business need.

The provider had a contract in place with an NHS ambulance provider and as part of that contract they carried out General Practitioner initiated patient transfers with technician support. The provider worked for another NHS ambulance provider through a digital broker system.

Transfers of mental health patients were arranged through the North of England Framework for Secure Patient Transport and a digital broker system.

The levels of regulated activity carried between September and December 2021 were as follows;

- Framework agreement with an NHS ambulance provider: Service provided seven days a week, on average 276 hours per day Mon-Fri and 200 hours per day over the weekend covering all areas of Yorkshire. On average 805 PTS journeys were made per week and 2679 UEC calls attended.
- NHS ambulance provider through a digital broker system: PTS ran five days per week, 60 hours a day. UEC ran seven days a week and 12 hours per day covering the Greater Manchester area. On average 220 PTS journeys were made per week and 2679 calls UEC calls attended.

Summary of this inspection

- North of England Framework for Secure Patient Transport: This service is nationwide on behalf of a South Yorkshire social care partnership, an NHS hospital trust and a Yorkshire teaching Hospitals partnership. Transfers could be completed 24 hours a day. Generally, the provider did not take `on the day` bookings' after 10pm, however if the transfer was pre-booked for a specific time after 10pm it would be completed. Between 1st August and 1st February 2022 there were 657 secure transfers and 53 non secure transfers made.
- GP transfers with technician support: This service was provided Monday to Friday between 9am and 7 pm covering the South Yorkshire area. Between September and December 2021 there were 758 calls attended.

The provider did not offer paramedic crews for any of the services provided.

Overall, the provider had a fleet of 60 vehicles, 15 of these could be used for higher dependency patients.

The provider employed on average 250 staff.

The main service provided by this provider was urgent and emergency care. Where our findings on urgent and emergency care for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the urgent and emergency care service.

How we carried out this inspection

The inspection was carried out by four CQC inspectors and one assistant inspector. The inspection was overseen by a CQC inspection manager.

During the inspection we spoke with two senior leaders, five managers and eight ambulance crew. We inspected ten vehicles. We inspected 4 locations, which were the providers registered location in the Darnell area of Sheffield and three satellite bases in; Sheffield, Elland and Bridlington.

We reviewed 14 vehicle records, 11 staff files, 10 patient record forms (PRF`s) and inspected ten vehicles.

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.

Outstanding practice

We found the following outstanding practice:

- The provider had moved from a paper based planning system to using a electronic tablets where the crew reviewed jobs. Each vehicle had a tablet with chargers. Managers could review the jobs in real time and track the locations of vehicles . Staff could make notes in real time. Managers told us this change had improved efficiency.
- Staff used the results from restraint audits they carried out to identify learning opportunities to improve the service, care for patients, and the safety of staff to make ongoing. Staff were able to give several examples of changes that had been made improvements and plans implemented for future journeys.

Areas for improvement

Action the service SHOULD take to improve:

Summary of this inspection

- The service should ensure the action plan in place to raise the levels of mandatory training compliance to target level is completed.
- The service should ensure the action plan in place to raise the levels of staff appraisal completion to target level is completed.
- The service should maintain a consistent approach to ensure all staff files contain the same required documentation.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	Inspected but not rated	Good	Good	Good
Patient transport services	Good	Good	Inspected but not rated	Good	Good	Good
Overall	Good	Good	Inspected but not rated	Good	Good	Good

Good

Emergency and urgent care

Safe	Good
Effective	Good
Caring	Inspected but not rated
Responsive	Good
Well-led	Good

Are Emergency and urgent care safe?

Good

This service had been inspected before but not rated. We rated it as good.

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- 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 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. Managers regularly reviewed staffing levels and skill mix.
- 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.
- The service used systems and processes to safely administer, record and store medicines.

Mandatory training

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

We reviewed the providers mandatory training policy which was in date. The policy had five main purposes, which were;

- To facilitate the systematic timely training and development of all UKEMS employees and detailed the responsibilities of personnel with regard to the management and delivery of personal development and identification of training needs.
- To ensure that key UKEMS aims, objectives and competencies were identified, defined and communicated to all employees and that the necessary training to achieve the required levels and fulfil the duties required by their position was received.

- To ensure that training carried out was reviewed and assessed / validated against appropriate standards and that records are maintained.
- To ensure that were applicable staff were maintaining their professional knowledge and skills, through a defined process of Continual Professional Development (CPD), in line with any relevant professional body registrations.
- To ensure that all training of personnel was co-ordinated fairly and consistently in line with regulatory and individual development requirements.

We saw evidence staff mandatory training was conducted on an annual basis; induction training was 12 weeks.

The provider used a mandatory training tracker to identify when refresher training was required to be completed.

The provider had recently appointed a quality lead who managed mandatory training as part of their role.

We saw evidence the compliance rates for mandatory training was 74% against a target of 85%.

Thirteen mandatory training courses were listed. We saw the compliance for four was above the 85% target, three were between 80-85% compliance, two were at 79% compliance and four were below 74% compliance. Even though some of 85% targets were missed patient safety was not impacted as the provider had high volumes of staff trained.

The compliance rate was under target due to the impact of COVID19 which had , reduced staff availability particularly in relation to face to face training.

We saw evidence of a comprehensive post COVID19 mandatory training recovery plan which included measures to raise compliance which was planned to reach 85% by April 2022. One example of the measures taken was that the provider offered staff an additional incentive payment to complete mandatory training on their days off.

We saw evidence mandatory training was delivered through a mixture of face to face and online learning. The online training was through an accredited external training provider.

Most training took place with several sessions in a day and managers managed staff rosters to enable staff to be released.

We saw evidence the provider had invested in a training resource building with several classrooms to deliver training at another site a short distance from the providers main operating base.

Staff we spoke with told us they were able to complete mandatory training and they told us the training received was applicable to the role they performed.

The mandatory training was comprehensive and met the needs of patients and staff.

Staff involved in transfers for patients suffering from mental health conditions completed training on recognising and responding to patients with mental health needs and restraint.

Managers monitored mandatory training and alerted staff when they needed to update their training. The provider had recently appointed a quality lead who managed mandatory training as part of their role

Safeguarding

Good

Emergency and urgent care

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

Staff received training specific for their role on how to recognise and report abuse.

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 identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff could explain what constituted abuse and gave examples of when they would need to report this. They understood their responsibilities in line with the safeguarding policies and procedures, including working in partnership with other agencies such as the police. They knew who to contact for advice or support, could explain the referral process, and knew how to access information and guidance from the provider.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The provider undertook work on behalf of NHS ambulance trusts. Staff reported safeguarding incidents internally and copied them to the trust. Paper copies of safeguarding referrals were retained at the provider's base until managers had logged details onto their computer systems. These copies were then destroyed as confidential waste. Managers had oversight of referrals and shared notifications with the CQC as per guidance.

All staff completed Safeguarding training to the level required by their role, with 87% trained to Safeguarding Children Level 2. Nine members of staff were trained to Level 3 and three senior members of staff, including the safeguarding lead, had completed Level 4.

We reviewed the providers safeguarding policy which was in date and followed intercollegiate guidance. The intercollegiate document provides a clear framework which identifies the competencies required for all healthcare staff. The policy was comprehensive and provided staff with clear information as to what a safeguarding matter was, how it should be reported and dealt with.

We saw examples of completed safeguarding referrals which evidenced staff knew what to report and how to report it.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

All areas inspected were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Good

Emergency and urgent care

We reviewed the providers overall infection prevent control (IPC) and hygiene policy which was in date. The provider also had three supporting IPC policies which were; infection prevention and control – people, infection prevention and control – ambulance and medical equipment and infection prevention and control – environmental management. The policies provided staff with clear directions to follow in relation to IPC.

We saw evidence of regular infection prevent control and hygiene audits which included vehicle and environment checks and staff hand hygiene audits.

During inspection we reviewed the providers COVID19 policy statement. This outlined what steps the provider would take to adhere to government guidance which was up to date at the time of the inspection

Staff used equipment and control measures to protect patients, themselves, and others from infection.

We inspected ten vehicles, a sample of five patient transport (PTS), two vehicles used to transport patients with mental ill health and three urgent and emergency vehicles (UEC) within the fleet at the base site (Sheffield), the training academy at Windburn and the satellite sites at Elland and Bridlington.

All vehicles inspected appeared visibly clean and we saw evidence daily vehicle and equipment cleanliness checks had been completed by the crew on shift for each vehicle inspected. All the vehicles we inspected had supplies of personal protective equipment (PPE) and replacement linen available.

The covers of the trolleys and seats in all the vehicles inspected appeared visibly clean and free from splits or breaks in the surface coverings.

The vehicles inspected had secure lidded clinical waste containers with a waste bag inserted to prevent the contents being spilled.

During the inspection we observed a crew completing the cleaning daily checks before leaving the base.

In addition to the ten vehicle we inspected, we reviewed 13 vehicle folders. Each folder contained documentary information about the vehicle. We saw evidence of recent deep cleans in 13 files we checked.

The deep cleans had been carried out be a specialist external cleaning company. We saw evidence of an audit spreadsheet for all vehicles with the planned and actual completion date of the deep cleans. None had been missed.

During inspection we reviewed the provider's vehicle cleaning audit spreadsheet. This evidenced which vehicle had been deep cleaned and the level of cleanliness audited by an external cleaning company. The deep cleans and audits were conducted on a monthly basis. Each vehicle audit was accompanied by a report which covered the areas audited.

The provider managed clinical waste streams in line with guidance. We saw clinical waste bins in the stations we inspected were stored safely and locked. The provider had a service level agreement in place with an external provider for the disposal of clinical waste.

The provider had processes in place to ensure safe handling of cleaning products. We observed safe storage of chemicals and cleaning equipment required for the cleaning of ambulances at the stations we inspected. There were notices displayed to explain to staff as to how to dispose of various kinds of waste safely.

Cleaning chemicals were supplied by an external specialist company. The cleaning chemicals were wall mounted in cylinders which on the press of a button delivered the correct amount to be diluted in a bucket of water.

We saw evidence of posters displayed which were colour coded. The posters explained to staff which cleaning product to use in which specified area which was colour coded.

There was evidence of use of disposable mop heads with replacement heads for staff to use. We did not observe any mops being stored with the heads attached. The mops were colour coded which corresponded to the same coloured bucket to use and the specified colour coded area to be cleaned.

We saw evidence of station cleanliness audits being carried out. The audits covered 12 different areas on each day of the week at varying times. The same audit was carried out in all the providers satellite locations as well as the registered location.

Staff we spoke with told us they could access replacement PPE and cleaning materials whenever they need them.

In the equipment storerooms at all four sites we inspected we saw evidence different consumable items were stored in plastic boxes with lids. This meant they were free of dirt and dust.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment.

The service had enough suitable equipment to help them to safely care for patients.

During inspection we reviewed the provider's quality environment safety and health policy statement. The policy statement explained how the provider would adhere to national workplace safety standards.

The environment of the four stations we inspected was properly designed, maintained and well ordered.

Managers at both sites we spoke with could explain the process surrounding vehicle servicing and repair.

All the providers vehicles were lease hired. If one broke down it would be replaced by the lease company with no impact on the service.

On inspection we reviewed 13 vehicle files. The files had evidence of current ministry of transport (MOT) test certificates and service and repair records for each of the 13 vehicles. It was evident the provider had a robust process in place to ensure vehicles were safe.

We inspected ten vehicles which were a mixture of five patient transport (PTS), two secure patient transport and three urgent and emergency vehicles (UEC) within the fleet at the base site (Sheffield), and three satellite stations at Windburn, Elland and Bridlington.

Good

Emergency and urgent care

All vehicles had evidence of daily checks of equipment carried out which had been completed by the crew on shift. We observed a crew completing daily checks of equipment at the time of inspection.

The urgent and emergency care vehicles we inspected all had six-point harness trolleys. They also carried paediatric equipment for the treatment and transport of children.

All the vehicles had up to date communication systems and supplies of consumable items for the treatment of patients.

During the inspection we checked five consumable items carried on each vehicle we inspected at random. All were found to be in date.

The automated external defibrillator pads (AEDs) on all UEC vehicles were found to be in date.

All vehicles had sharps bins, which were labelled and dated with last emptied.

Medical gases on all vehicles were securely stored.

Staff told us tablet devices were collected at start of the shift where a brief handover was discussed with the shift coordinator. The tablets were used to provide the crews with patients details and where to collect and take the patient.

Equipment carried on the vehicles had service stickers showing the date serviced and a unique reference number. The servicing was carried out an external company. The provider maintained an asset register which contained all equipment held recorded by a unique reference number and date of service.

The external servicing company arranged the annual servicing of equipment. Managers we spoke with told us they would be notified in advance when the servicing would be done, and this did not impact upon the service provided.

The contract was in place to ensure that all medical devices were regularly maintained and serviced in accordance with manufacturer's guidelines and where applicable in accordance with current governance, to ensure that all medical equipment purchased from the provider met with manufacturers guidelines and where appropriate met current British Standards (BS) standards.

All the equipment carried on the vehicles and in the station, we inspected which required portable appliance testing (PAT) displayed the test date.

Staff we spoke with told us they could always replace consumable items from the stock rooms at each site.

In the equipment storerooms at all four sites we inspected we selected at random, 10 different consumable items stored in labelled plastic boxes with lids. All the items selected were found to be in date.

Managers and staff, we spoke with explained the how the stock control system the provider had in place worked.

In the four stations we inspected we saw evidence of how the reporting and repair of equipment was carried out.

If an item of equipment was identified in the daily vehicle checks as requiring repair or replacement this was recorded. The completed daily check lists were reviewed at the start of each shift by a manager. The defective equipment was then given a red tag and placed in a designated area of the garage part of the buildings. The manager would then arrange the repair.

Staff we spoke with told us there was always spare equipment to replace any identified as being defective. We saw evidence of additional replacement equipment including, defibrillators, mobile phones and tablets.

We saw evidence in the four stations we inspected of multiple mobile phone charge points and chargers for equipment batteries.

We observed the environment of each station inspected and saw appropriate safe storage of cleaning equipment, PPE, medical gases, and replacement equipment for the fleet vehicles. There was Control of Substances Hazardous to Health Regulations (COSHH) information reference book available for staff in the offices of each station inspected.

There were locking boxes on the walls which contained the vehicle keys. The key for the locking box was kept in a filing cabinet with a number combination lock. The number was known to the staff.

In fleet vehicles and buildings, we saw fire extinguishers fixed securely on wall mounts, all had labels indicating they had been tested. The fire extinguishers were stored in accordance with the Fire Extinguisher regulations which form part of the Regulatory Reform (Fire Safety) Order 2005 which outlined to prevent fire extinguishers from being moved or damaged, they should be mounted on brackets or in wall cabinets with the carrying handle placed 3-1/2 to 5 feet above the floor.

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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

The service had 24-hour access to mental health liaison and specialist mental health support.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

We reviewed the providers deteriorating patient policy which was in date and contained information for staff to follow which explained how they should deal with a patient who deteriorates whilst in their care. The policy contained a flow chart of actions for staff to follow.

We saw evidence the provider followed the assessment, conveyance and referral of patients of one of the NHS ambulance providers who used the service.

Good

Emergency and urgent care

Staff told us if they were allocated to an emergency and urgent care call and it was identified the patient was a bariatric patient they would have to refer the call back to the provider requesting the service as the providers ambulances did not have bariatric trolleys. Not using a bariatric trolley would pose a risk to the patient and staff.

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.

Managers regularly reviewed and adjusted staffing levels and skill mix.

No paramedics were employed by the provider.

The managers could adjust staffing levels daily according to the needs of providers requesting the service.

At the time of the inspection the provider employed 250 staff.

The provider had undertaken appropriate pre-employment checks of staff. We saw evidence all staff had been recruited in accordance with Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The shifts for emergency and urgent care and patient transport were prescribed by the providers requesting the service.

The skill mixes on emergency and urgent care ambulances had been agreed with the two NHS ambulance providers which commissioned the service based upon the category of calls the staff would be allocated to.

In relation to emergency and urgent care managers and staff told us they would not ordinarily be sent to a category one call which required an immediate response to a life-threatening condition, such as cardiac or respiratory arrest. This was because the provider did not employ staff with the levels of skills or qualifications to deal with that category of call.

The only exception to this would be if the providers crew were closer to the call location than the NHS emergency and urgent care ambulance. The providers crew would attend and treat the patient in accordance with their training while they waited for the NHS emergency and urgent care ambulance.

Provider crews would be routinely allocated to a category two call which covers a serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport, a category three call which covers an urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting and category four call which is a non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic.

The staffing for transporting patients with mental ill health was based upon the patient risk assessment.

We saw evidence staff were rostered using an electronic rostering tool. Team leaders managed this system. They ensured the correct skill mix was rostered for every job. Staff could use this tool to request shifts and swap shifts. The rota tool could be accessed via computers and on staff phones. There was also a feature within this tool that allowed managers to communicate with staff and staff to communicate with each other.

Staff sickness had been an issue during the pandemic. Where suitably qualified staff were unavailable due to sickness the provider had contacted the provider requesting the service and outlined which shifts they could not fill so alternative arrangements could be made. Crews were double vaccinated and did daily tests to check for COVID19.

Managers told us when staff applied to work for the provider, they filtered the candidates by conducting recruitment checks clarifying, qualifications and identifying what training requirements were needed. Successful candidates were sent offer letters with induction course start dates.

Manager told us they had 215 staff directly employed by the provider. There were another 35 staff on zero hours contacts.

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.

Patient notes were comprehensive, and all staff could access them easily.

Records were stored securely.

During inspection we reviewed 13 vehicle files. Each of the files contained accurate records and documents to evidence the vehicles were safe for patients and staff to use.

On inspection we saw evidence there was some variation on how patient records were completed dependent on which NHS provider had commissioned the service. However, in the main records were completed on paper. Some were stored digitally including those used for mental health work.

We reviewed ten patient records, all were completed correctly and were legible.

We saw evidence of an audit programme to review the completed patient records. The audit had a scoring system to monitor compliance. If the quality of a patient record fell below 80% on the scoring system, then the staff member involved would be referred to managers and actions taken to improve. We reviewed three months of patient care record audits and the score was above 95%.

We saw evidence each paper record had a tick box to ensure that staff knew if a patient had a do not attempt cardiopulmonary resuscitation (DNACPR) in place. We saw records that had additional comments to show staff were aware of the DNACPR instructions for patients.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines safely.

Good

Emergency and urgent care

We reviewed the provider's medicines management policy. The policy covered supply, administration, storage, disposal and adverse incident reporting. The policy gave staff clear information to follow.

During inspection we reviewed storage of medical gases. The cylinders were stored in a lockable unit on substantial racking. Medical gases were stored safely in accordance with national guidance under the Health and Safety at Work Act 1974 and Health Technical Memorandum (HTMO2) guidelines.

Medical gases were stored in the provider's main operating base and staff travelled from the satellite locations to exchange empty medical gas cylinders for full ones through a prearranged appointment.

The provider had a contract with a nationally recognised supplier of medical gases to maintain their stock and exchange empty cylinders.

Staff we spoke with told us there was always enough full medical gas cylinders to exchange for empty ones.

We saw evidence training for medical gas administration was included in staff induction and mandatory training.

We saw evidence the provider was using mainly Schedule 19 of the Human Medicines Regulation 2012 exemption medicines which anyone could administer for the purpose of saving a life in an emergency.

In addition to these, the provider used over the counter medicines on urgent and emergency transports.

We saw evidence the provider had a standard operating procedure for staff to follow for the administration of Naloxone Hydrochloride (Narcan).

Medicines were stored in zip locked bags with a seal. Bags were locked in a cupboard when not in use on fleet vehicles. The key to the cupboard was kept in a combination locked key safe.

We observed the process whereby a used medicine bag would be sealed with a red tag highlighting the need for a re stock of the used medicines. Staff would leave the red tagged bag in the locked medicines cupboard after their shift. Team leaders would re-stock the bag and exchange the red seal for a green one to indicate the bag was ready to use.

Each bag contained a list of what medicines the bag should contain. Stocks of medicines were stored in a combination lock cupboard.

Staff we spoke with told us they system worked well, and the bags always contained what they should.

We saw evidence of monthly medicine audits being carried out.

Staff told us that they clarified with patients if they were experiencing pain. Ambulance technicians on urgent and emergency fleet vehicles were trained to administer Entonox gas and paracetamol.

We confirmed with the provider they did not stock controlled drugs or employed staff qualified and trained in administering controlled drugs.

Incidents

Good

Emergency and urgent care

The service managed patient safety incidents well. Staff recognised and reported 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.

Between September 2021 and December 2021 there were 32 non-clinical incidents reported and 16 clinical incidents reported.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour although they had not been required to use the principles.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Managers debriefed and supported staff after any serious incident.

Managers shared learning with their staff about never events that happened elsewhere.

We reviewed the providers incident and reporting policy. The policy provided staff with information as to the roles and responsibilities in incident reporting, what to report, how it would be investigated and what actions would result at the conclusion of the investigation.

During inspection we reviewed the providers duty of candour policy statement. This outlined the roles and responsibilities of staff and managers in applying the principles of duty of candour.

The provider used an incident reporting form that staff completed and submitted to their team leaders. Team leaders logged these incidents and acted dependent on the nature of the issue.

We saw evidence of minutes from meetings where reported incidents had been discussed.

Are Emergency and urgent care effective?

Good

This service had been inspected before but not rated. We rated it as good.

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

Good

Emergency and urgent care

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools.
- The service monitored and met agreed response times through the providers using their service so that they could facilitate good outcomes for patients.
- 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.
- 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 followed national guidance to gain patients' consent.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

When the service carried out regulated activity, they did not monitor performance or carry out performance audits taking account of care planning. This was carried out by the NHS ambulance providers who they worked on behalf of. Emergency and urgent care staff did treat patients in accordance with Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

We saw evidence current staff had access to all company policies and protocols online, through a computer system called Share Point. Staff could use IT systems to access forms, such as equipment checking logs, incident forms and safeguarding forms.

Completed risk assessment forms were saved and forwarded to the providers requesting the service for monitoring purposes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after it was identified they needed it, or they requested it.

Staff prescribed, administered and recorded pain relief accurately.

Good

Emergency and urgent care

We saw evidence the provider used a paediatric pain assessment tool which included Wong-Baker faces and the Abbey pain score.

We saw evidence of pain relief medication being recorded on the PRF `s.

Response times

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

The response times for urgent and emergency care for the two NHS ambulance providers were the same national response times dependent upon the category of the call as follows;

- Category1.An immediate response to a life-threatening condition, such as cardiac or respiratory arrest. Response time to 90% of all incidents 15 minutes.
- Category 2. A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport. Response time to 90% of all incidents 40 minutes.
- Category 3. An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting. Response time to 90% of all incidents 2 hours.
- Category 4 A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic. Response time to 90% of all incidents 3 hours.

The providers who requested the service managed response times. The model used was commissioners contracted the vehicle, with equipment, consumables and staff, they then utilised that resource through their own computer aided dispatch (CAD) system and they managed all the response timings.

The provider was subject to regular meetings with the two NHS ambulance providers which used their service to discuss performance. Managers informed us there has never been an issue raised about achieving response times. Managers highlighted to us that the provider had continued to be commissioned by both NHS providers for over three years which was indicative of satisfactory performance with response times.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

We saw evidence the provider there was a tracker system for appraisals. Appraisal completion varied between locations. Not all staff had had an appraisal but there was an action plan to remedy this. One site had completed over 78.8% of staff appraisals but two others were behind target at 47.8% and 23%

The overall rate was at 49.8%. The reason why the percentage completion rates appeared low was because the satellite stations had lower numbers of staff and a lower number of completed appraisals had a higher adverse percentage affect.

We saw evidence the provider had a comprehensive action plan in place to raise the staff appraisal rate to achieve the 85% target before the start if the next financial year.

Staff had an appraisal three months after induction and then 12 months after this. The appraisal template was generic to all locations and included staff objectives, well-being and a performance discussion.

Managers had increased staff pay in 2021 and were keen to retain employees. There was an appetite to have an established career pathway for staff. There were staff within the company who had progressed from transport work to managerial positions.

Staff told us that managers were keen to give them opportunities for career development. Some staff had been supported to undertake educational or professional qualifications that the organisation had funded.

We saw evidence of individual staff performance development plans with a section for the staff member and managers to add comments.

Team leaders managed lead drivers. These were staff who had job role experience and undertook additional roles and responsibility. The lead drivers were a source of knowledge and support for colleagues and more junior staff.

We saw evidence of staff driving assessments being carried out which covered 21 separate assessment areas. This was followed by a ten-question written assessment.

Staff induction lasted five days and once completed, staff went out on shift with a more experienced crew member. The staff member then had a probationary review after three months of work.

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. They used agreed personalised measures that limit patients' liberty.

Good

Emergency and urgent care

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

We saw evidence the provider had a care to care policy which was in date. The policy provided staff with guidance in relation to patient capacity and consent.

Are Emergency and urgent care caring?

Inspected but not rated

Due to the COVID19 restrictions in place during the inspection we were unable to observe patient care. Caring was therefore inspected but not rated.

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 understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff explained about transfers of mental health patients and even though various methods of restraint could be used, they used the method prescribed by the requesting organisation for the minimum amount of time possible to ensure safety of the patient and crew.

Patients said staff treated them well and with kindness. Staff told us that they provided sanitary products for female service users following feedback from patients and staff.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us all female secure transport patients were supported by at least one female crew member plus a driver. Staff could organise suitable toilet and food breaks for patients on long journeys.

Good

Emergency and urgent care

We saw feedback from a nurse from an NHS hospital to the provider about staff which had went above and beyond to help and elderly couple one of whom was in a wheelchair.

We saw an example of positive patient feedback from an extend journey where they expressed how safe they had felt.

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 took care to provide as much information as possible to patients and family members when transporting patients. Staff had a good understanding of a range of cultural and religious needs when supporting patients and families and staff regularly went out of their way to minimise distress. Staff carefully planned made arrangements for meal breaks and meal choices on long journeys.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. 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 trained and experienced in communicating calmly and effectively with patients, including those with mental health conditions. Some patients opted to travel in closed areas of vehicles for their own comfort and mental wellbeing.

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 provided examples of feedback obtained from patients and families that showed:

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. Most feedback was provided verbally to crews and this was relayed to team leaders in daily meetings. Team leaders and manager shared patient feedback to all staff involved and to the wider team.

Good

Emergency and urgent care

Are Emergency and urgent care responsive?

Good

This service had been inspected before but not rated. We rated it as good.

- The service planned and provided care 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.
- The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.
- People could access the service when they needed it, in line with national standards, and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received.

Service delivery to meet the needs of local people

The service planned and provided care 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, so they met the needs of the local population.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention.

The provider was on a framework agreement with an NHS ambulance provider for patient transport services (PTS) and emergency and urgent care (UEC) services. Private providers on the framework got opportunities to bid on mini tenders which the NHS ambulance put out to providers as and when there was a business need.

The provider had a contract in place with an NHS ambulance provider as part of that contract they carried out General Practitioner initiated patient transfers with technician support. The provider worked for another NHS ambulance provider through a digital broker system. Transfers of mental health patients were done through the North of England Framework for Secure Patient Transport and a digital broker system.

- Framework agreement with an NHS ambulance provider: Service provided seven days a week, on average 276 hours per day Monday -Friday and 200 hours per day over the weekend covering all areas of Yorkshire. On average 805 PTS journeys were made per week and 2679 UEC calls attended.
- NHS ambulance provider through a digital broker system: PTS ran five days per week, 60 hours a day. UEC ran seven days a week and 12 hours per day covering the Greater Manchester area. On average 220 PTS journeys were made per week and 2679 calls UEC calls attended.

Good

Emergency and urgent care

- North of England Framework for Secure Patient Transport: This service is nationwide on behalf of a South Yorkshire social care partnership, an NHS hospital trust and a Yorkshire teaching Hospitals partnership. Transfers could be completed 24 hours a day. Generally, the provider did not take `on the day` bookings' after 10pm, however if the transfer was pre-booked for a specific time after 10pm it would be completed. Between 1st August and 1st February 2022 there were 657 secure transfers and 53 non secure transfers made.
- GP transfers with technician support: This service was provided Monday to Friday between 9am and 7 pm covering the South Yorkshire area. Between September and December 2021 there were 758 calls attended.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. There was a telephone interpreting service that could be used contacted if English was not a patients first language.

Managers made sure staff, and patients, and carers could get help from interpreters or signers when needed.

Staff had access to communication aids to help patients become partners in their care and treatment.

We saw evidence the provider used the patient eligibility criteria used by the two NHS ambulance providers who commissioned the service.

The service transported children who were always accompanied by a parent, guardian or a member of hospital staff if transferring between hospital locations. The vehicles paediatric equipment suitable to transport children and booster seats would be used should a child need one if they weren't a stretcher patient.

We saw evidence the provider used language identification charts so patients could indicate which language they preferred to communicate in.

There was evidence staff undertook dementia training as part of their induction.

Access and flow

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

Staff supported patients when they were transferred between services.

Managers told us the service supported NHS trusts to ensure people could access the service when they needed it. The service recognised the volume of transport outlined in the digital platforms and framework agreements to be able to provide the service. The provider planned activity to deliver against contracts.

Good

Emergency and urgent care

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.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information in their ambulances about how to raise a concern in patient areas.

Managers understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The provider had not received any complaints in the six months prior to the inspection.

The provider had a complaints, comments, concerns and compliments management policy which was in date. The policy set out the process for the management of complaints about the service provided by UKEMS to all service users.

We saw evidence of a complaints process flow chart for staff and managers to follow. The flow chart outlined the various stages of the complaint investigation process and roles and responsibilities of staff and managers.

We observed complaints leaflets were in available in the vehicles inspected. The complaints leaflet explained the complaints process and how patient complaints would be reviewed and responded to.

Lessons learnt from complaints were documented and formalised. Care to Care guidelines were updated to incorporate new instructions and guidance for all staff. Staff told us all the guidance had been updated following complaints and incidents and staff experiences and was simple and straightforward to follow.

Are Emergency and urgent care well-led?

Good

This service had been inspected before but not rated. We rated it as good.

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and 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 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 understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture.

Good

Emergency and urgent care

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- 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. Data or notifications were consistently submitted to external organisations as required.
- Leaders collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service was led by a senior leadership team consisting of four Managing Directors. The team included an Operations Director who supervised the general managers of specialist transport and PTS, a Compliance/Human Resource Director, training and development Director and a transport Director. The provider employed a health and safety and recruitment lead who reported into the Directors.

The senior leadership team all had previous experience in health care provision and working in the independent ambulance sector.

General managers had responsibility for meeting regularly with providers that commissioned the service. General managers were also involved in logistics, operational matters, recruitment and engagement. Team leaders reported to general managers. Team leaders managed the road crew and day to day operations.

Responsibility for finance and IT support was outsourced.

During inspection we identified the leadership team had not been subject to fit and proper person checks which evidenced they were qualified, competent, sufficiently experienced, physically able to undertake their roles, and had no personal history of serious misconduct or mismanagement in carrying out a regulated care activity which would make them ineligible for the role.

After this was pointed out the provider took immediate action and we saw evidence fit and proper persons checks had been carried out.

Managers we spoke with all understood the challenges to quality and sustainability.

We saw evidence of the leaders being visible by one of them working on an emergency and urgent care shift. The leaders told us they took it in turn to visit the satellite stations, often turning up unannounced to support staff based many miles away from the providers operating base.

All the managers we spoke with could articulate what the providers priorities were.

Staff we spoke with told us managers were open, friendly and supportive. Staff said that managers were prepared to invest in training for them and if they had domestic or problems at work then they were accommodating. Two members of staff said that they loved working there so much that they 'would do anything for UKEMS'. Staff also said that they were proud of the company.

The last staff meeting had been in the Summer of 2020 although they had been more frequent prior to the pandemic. At this meeting, managers shared the vision and future for the organisation.

Staff received Christmas gifts and prior to the pandemic there had been staff Christmas parties. Managers also would sometimes order food for staff on shift as a thank you.

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 understood and knew how to apply them and monitor progress.

The providers mission was to deliver a high-quality, patient-focused experience that exceeds customers' expectations.

During inspection we reviewed the providers corporate social responsibility policy statement. This outlined how the provider would integrate social and environmental concerns into their business operations and interactions with stakeholders.

We saw evidence of a senior leadership objectives action plan which identified seven key business objectives with owners and what was to be achieved. There were review dates to monitor progress. At the time of the inspection the action plan had not been completed but progress had been recorded.

The business strategy was aligned to the requirements of the providers requesting the service.

Staff and managers told us the main focus for the business was stabilisation following the pandemic. There had been considerable financial investment in commercial growth and expansion.

Managers were keen not to overstretch the business which had grown over the course of the previous two years. The focus had moved to sustainability. Managers described the uncertainty that they faced as business contracts needed to be renewed or negotiated. Managers were conscious not to lose sight of the importance of providing an excellent safe clinical service in a commercial and competitive sector.

Culture

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

All the staff we spoke explained the provider had a very open culture where they felt they could raise any issues to managers without fear.

During inspection we reviewed the providers equality and diversity statement which set out how the provider would be inclusive and not discriminate against staff or the public.

During inspection we reviewed the providers bullying and harassment policy statement. This outlined the responsibilities of staff and managers to prevent bullying and harassment in the workplace and referred to the Equality Act 2010, Protection from harassment act 1997, Health and safety at work act 1974 as well the providers policies.

The provider told us they had never had to apply the principles of duty of candour.

Staff we spoke with told us they could speak to managers in confidence. Staff working in satellite stations told us they saw managers on a regular basis which made them feel connected to the overall service.

At the last staff meeting managers had shared the vision and future plans for the organisation.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The providers accountability was through the providers who requested the service through their policies and procedures.

We saw evidence of regular management meetings with a set agenda, minutes and actions recorded.

There was evidence of regular meetings between the provider and the providers who requested the service to discuss performance.

Directors and senior managers met together regularly to discuss the service, its development, compliance, performance and staffing. We saw evidence of regular management meetings with a set agenda, minutes and actions recorded.

There was evidence of regular meetings to discuss performance between the provider and the organisations that requested the service.

A clinical compliance manager had been appointed in September 2021 and had taken responsibility for compliance around recruitment, clinical audit, staff training, medicines management, occupational health, regulation oversight, risk assessment and policy reviews.

At the time of the inspection there had been significant progress made in each area. However, some governance processes were not yet fully embedded. For example, we found there was a new policy and a clear process for staff recruitment and files were complete for all new staff appointed since September 2021 but there had been no review of files for staff appointed prior to that date.

Good

Emergency and urgent care

We reviewed eleven staff files from a range of roles and specialties. Six files were complete and five had some elements missing, making these inconsistent and incomplete. Although managers kept a file for every member of staff and had carried out employment checks, some documents such as references had not previously been held in the files. We found no job descriptions within staff files. However, staff told us they had job descriptions and understood their roles and responsibilities.

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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The provider had risk register which at the time of the inspection had nine risks recorded. All had an owner, description, RAG status, mitigating actions and review dates. None of the risks were RAG rated red.

Managers were asked what they thought the top three organisational risks were. All said the same three which were on the risk register.

Risk was an agenda item at the management meetings.

There was evidence the provider had a systematic programme of internal audit.

The processes to manage current and future performance was through the providers requesting the service.

We saw evidence the provider had a service level agreement with an external company relating to all medical devices including servicing and maintenance. This reduced the risk of the provider being without equipment which could impact upon the ability to provide the service.

Staff knew how to escalate risks and a manager was always available to respond to these by telephone or in person. Staff gave examples of identifying and escalating risks including determining whether patients were safe to transport or not. For example, whilst on inspection, staff declined a transport job after learning that the requesting organisation had omitted to inform them a property had six steps and they did not have the correct equipment to ensure that the patient could move safely from home to a vehicle.

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. Data or notifications were consistently submitted to external organisations as required.

During inspection we reviewed the providers information security policy statement. This outlined how the provider would ensure the confidentially of the information it used would be used and stored in accordance with the legislation.

The provider relied upon the providers requesting the service to ensure the accuracy of KPI data which were their performance measures.

Good

Emergency and urgent care

There was evidence in the management meeting notes sustainability and quality were covered as agenda items.

There were effective arrangements in place with the providers requesting the service to ensure the information used to monitor, manage and report on quality performance was accurate. This was done through regular meetings, performance feedback and audits of PRF`s.

There was evidence of effective arrangements being in place to ensure data or notifications were submitted to external bodies. One example being the submission of patient restraint information.

Engagement

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

There was no evidence the service had carried out any public engagement. However, feedback forms were available on vehicles for patients to comment about the service. We saw positive examples from patients who were appreciative of the service.

During inspection we did see evidence of managers holding meetings with operational staff. The meetings had an agenda and had minutes recorded.

The last staff survey had been carried out in March 2018.

Notices and staff guidance were displayed around buildings and as well as policies and procedures.

When managers needed to alert staff promptly with new information, they could do this using a feature on the electronic rostering tool “What’s my Shift”. Staff also communicated with each other via closed groups on social media platforms.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The provider has moved from a totally paper based to using a ten-inch sized screen tablet where the crew reviewed jobs. Each vehicle has a tablet with chargers. Managers can review the jobs in real time and track where the vehicles are. Staff can make notes in real time.

Managers told us this change has improved efficiency.

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Inspected but not rated
Responsive	Good
Well-led	Good

Are Patient transport services safe?

Good

This service had been inspected before but not rated. We rated it as good.

For mandatory training, safeguarding, cleanliness, infection control and hygiene, environment and equipment, staffing, records and medicines, please see Urgent and Emergency Care.

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

Staff responded promptly to any sudden deterioration in a patient's health. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

We reviewed the providers deteriorating patient policy which contained information for staff to follow which explained how they should deal with a patient who deteriorates whilst in their care. The policy contained a flow chart of actions for staff to follow.

We saw evidence staff had training on how to manage a patient who became unwell and subsequently deteriorated during a journey. Staff and managers were able to explain what they would do. Staff would ring 999 to request an NHS emergency ambulance while utilising their basic life support training to treat the patient. Staff would take instruction from the NHS control room of the NHS ambulance service if working for them, on whether to drive the patient on blue lights, if the driver was suitably trained and qualified, to the nearest emergency department hospital or wait for an NHS emergency ambulance.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. For patient transport patients' assessments were primarily based on a person's transport and mobility needs as these patients were low acuity and were being discharged from hospital.

Patient mobility was assessed to determine if they could walk and those needing aids such as wheelchair, carry chair or stretcher.

Good

Patient transport services

Staff knew about and dealt with any specific risk issues regarding transfer of patients between mental health facilities and providers. Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

The provider completed robust risk assessments for mental health patients at point of referral from the NHS provider. A risk assessment was used to aide to decision making. Managers told us, and we saw evidence in the patient records for the transport of patients with mental ill health, the risk assessment highlighted the need to ascertain patient awareness of transfer collection, how many staff were required for support dependent on risk, what type of vehicle to use, what the patients' risks were, and what potential needs would be required during the transfer.

All risk assessments were screened by a coordinator at the provider's operating base. The provider carried out a second patient risk assessment following receipt of the risk assessment from the provider requesting the service. Managers and staff told us this was to check none of the risks had changed or additional ones had been identified.

It was explained that if staff attended a call to carry out the transport of a patient with mental ill health and the risk assessment initially provided did not cover the risks the patient posed when the patient was observed by the staff then they would not transport the patient. The provider requesting the service would be required to conduct another risk assessment and request the transport after that.

To enable staff to assess and respond to patient risk the provider ensured all mental health transfer staff completed a training course which covered non escalation, de-escalation, and restraint training.

Staff told us that any form of restraint was assessed and recorded. If restraint was highlighted as a risk, then a restraint form was created and attached to the job sheet. The form included a body map, restraint used, reasoning and justification. Staff kept a log of all incidents involving restraint including the reasons for using restraint, how long each method was used for, and actions taken to report each incident. All incidents were reported to the provider requesting the transfer.

All restraint forms and incident reports were sent to the NHS Trusts and other organisations who subcontracted work to this provider. The provider audited restraint forms, we reviewed the audit from January 2022 which showed seven records were checked and crews achieved a 93% compliance rate.

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. The provider used an incident reporting form that staff completed and submitted to their team leaders. Team leaders logged these incidents and took action dependent on the nature of the issue.

On inspection we saw examples of a completed incident forms and accompanying incident statements. In one case staff had experienced a minor driving incident due to driver error, and in another case, staff had collected the wrong patient from hospital because of not confirming the patients full name.

Good

Patient transport services

Staff raised concerns and reported incidents and near misses in line with provider policy. We reviewed the providers incident and reporting policy. The policy provided staff with information as to the roles and responsibilities in incident reporting, what to report, how it would be investigated and what actions would result at the conclusion of the investigation.

In the four-month period between 1 September 2021 and 31 December 2021 staff reported 48 incidents. Of these, 32 were non-clinical with themes and trends identified regarding damage to vehicles and staff accidents. A further 16 incidents involved deteriorating patients, patients refusing to travel and patient falls.

Managers debriefed and supported staff after any serious incident. Staff and managers told us they met to debrief following every mental health patient transfer and following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Managers used an incident analysis form and process to address each issue. Managers took action to share lessons learned and, following the incident regarding transport for the wrong patient, reminded all staff on how to check and identify patients before transporting them. The provider held regular incident review meetings to discuss recent incidents, lessons learned and any further actions taken as a result. Managers told us this was also an opportunity to identify any trends if they occurred and to establish a plan of action. The meetings were attended by the Quality, Environment, Safety and Health Lead; the Care, Quality, and Compliance General Manager; and the Operations Manager. We saw evidence of minutes from meetings where reported incidents had been discussed.

Staff understood the duty of candour. During inspection we reviewed the provider's duty of candour policy statement. This outlined the roles and responsibilities of staff and managers in applying the principles of duty of candour. However, staff and managers told us they had not needed to apply Duty of Candour as no incidents had occurred that met the threshold of severity or impact.

Are Patient transport services effective?

Good

This service had been inspected before but not rated. We rated it as good.

For response times and competent staff, please see Urgent and Emergency Care.

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Staff used the results from restraint audits they carried out to identify learning opportunities to improve the service, care for patients, and the safety of staff to make ongoing. Staff were able to give several examples of changes that had been made improvements and plans implemented for future journeys.

We saw evidence current staff had access to all company policies and protocols online, through a computer system called Share Point. Staff could use IT systems to access forms, such as equipment checking logs, incident forms and safeguarding forms.

Completed risk assessment forms were saved and forwarded to the commissioners for monitoring purposes.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Some transfers for mental health patients were over long distances and could take several hours. Staff planned journeys in advance to offer sufficient food and drink for patients and staff.

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.

The provider coordinated all transport journeys with various service commissioners. Handovers were taken and documented from either hospital staff, commissioners or care facilities. Staff visited the same organisations often to collect patients so had developed good working relationships with external providers.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff from various disciplines were involved in mental health transfer planning and the provider included families and patients when organising transfers where restraint may be required. Risk assessments were carried out in every instance by the commissioning organisation and again by the crew on arrival at the patient's location. The crew carried out their own risk assessments which involved information gathering from a range of professionals.

Staff described working together in positive terms and said there was 'a friendly atmosphere'. Company directors undertook operational shifts so worked regularly alongside their staff.

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. They used agreed personalised measures that limit patients' liberty.

Good

Patient transport services

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. In most cases the requesting organisation carried out full and comprehensive risk assessments. However, UK EMS staff also completed their own risk assessments before transporting any patient. Staff knew how to report omissions and to make decisions regarding safety of the crew if these had not been fully recognised in the original risk assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. When transporting mental health patients between organisations and for admission to NHS mental health care, staff discussed the use of restraint with patients only when this was appropriate. In most cases the requesting organisation assessed the level of restraint to be used.

Staff clearly recorded consent and the use of restraint in the patients' records and team leaders held a debrief with staff after every mental health transfer.

Staff supported children who wished to make decisions about their transport.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Are Patient transport services caring?

Inspected but not rated

Due to the COVID19 restrictions in place during the inspection we were unable to observe direct patient care, although we did find some examples of caring practice from discussions with staff and from documentation such as PRFs. Caring was therefore inspected but not rated.

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 understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff explained about transfers of mental health patients and even though various methods of restraint could be used, they used the method prescribed by the requesting organisation for the minimum amount of time possible to ensure safety of the patient and crew.

The service collected patient feedback and we saw thank you cards sent to the service. In these patients said staff treated them well and with kindness. Staff told us that they provided sanitary products for female service users following feedback from patients and staff.

Staff followed policy to keep patient care and treatment confidential.

Good

Patient transport services

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us all female secure transport patients were supported by at least one female crew member plus a driver. Staff could organise suitable toilet and food breaks for patients on long journeys.

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 took care to provide as much information as possible to patients and family members when transporting patients. Staff had a good understanding of a range of cultural and religious needs when supporting patients and families and staff regularly went out of their way to minimise distress. Staff carefully planned made arrangements for meal breaks and meal choices on long journeys.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. 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 trained and experienced in communicating calmly and effectively with patients, including those with mental health conditions. Some patients opted to travel in closed areas of vehicles for their own comfort and mental wellbeing.

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 provided examples of feedback obtained from patients and families that showed:

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. Most feedback was provided verbally to crews and this was relayed to team leaders in daily meetings. Team leaders and manager shared patient feedback to all staff involved and to the wider team.

A patient was known to be violent towards women but the crew needed a female member to be present so they acted as driver to ensure the patient's preferences were taken into consideration.

Staff told us how they spent time making arrangements with patients and their families to provide rest stops during long journeys. One patient staff told us about had a favourite takeaway service and they made the effort to find a franchise on the patient journey.

Good

Patient transport services

Are Patient transport services responsive?

Good

This service had been inspected before but not rated. We rated it as good.

For learning from complaints and concerns please see Urgent and Emergency Care.

Service delivery to meet the needs of local people

The service planned and provided care 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, so they met the changing needs of the local population. The service operated 24 hours a day, seven days a week. The provider tendered for work with an NHS ambulance provider, and worked together to provide long-term planning of PTS, and secure patient transport contracts with capacity to cope with differing levels and nature of demand in different localities across the differing sites.

Facilities and premises were appropriate for the services being delivered. The provider offered a non-emergency patient transport service and worked in both private and public health sectors, with knowledgeable, uniformed staff, and used vehicles that were configured to carry stretcher, wheelchair, and walking passengers. Patient transport service leads worked with safety and comfort at the forefront. The service offered highly qualified and friendly staff as well as safe, welcoming, and high-quality vehicles.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The provider offered a secure ambulance service that specialised in the transfer of children, young people and adults with challenging behaviours and mental health conditions and other areas of care or complex needs. The provider worked with a range of NHS providers, private hospital groups, Police, local authority, the criminal justice system, and social services. Staff are fully trained, recognising the needs and behaviours of individuals and the responsibilities involved in working with care workers and medical professionals.

The service had systems to help care for patients in need of additional support or specialist intervention. The provider transported patients with varied mobility, including reduced mobility, wheelchair users and those requiring stretchers.

The provider was on a framework agreement with an NHS ambulance provider for patient transport services (PTS) and emergency and urgent care (UEC) services. Private providers on the framework got opportunities to bid on mini tenders which the NHS ambulance put out to providers as and when there was a business need.

The provider had a contract in place with an NHS ambulance provider as part of that contract they carried out General Practitioner initiated patient transfers with technician support. The provider worked for another NHS ambulance provider through a digital broker system. Transfers of mental health patients were done through the North of England Framework for Secure Patient Transport and a digital broker system.

The service provided patient transport seven days a week. On average 805 PTS journeys were made per week. They worked with local NHS ambulance providers through a digital broker system.

Good

Patient transport services

The service also worked within the North of England Framework for Secure Patient Transport: This service is nationwide on behalf of a South Yorkshire social care partnership, an NHS hospital trust and a Yorkshire teaching Hospitals partnership. Transfers could be completed 24 hours a day. Generally, the provider did not take `on the day` bookings' after 10pm, however if the transfer was pre-booked for a specific time after 10pm it would be completed. Between 1st August and 1st February 2022 there were 657 secure transfers and 53 non secure transfers made.

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.

PTS vehicles could accommodate wheelchairs. A bariatric chair and stretcher were also available for those requiring specialist equipment.

The service transported children though children were always accompanied by a parent, guardian or a member of hospital staff if transferring between hospital locations. The vehicles had harnesses that were suitable to transport children and booster seats would be used should a child need one.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff undertook dementia training as part of their induction.

The secure mental health transport services offer a service whose primary focus is on care for the individual concerned. Utilising specially equipped vehicles the fully trained secure transport team assist with numerous types of journeys by providing a safe environment for travel. The secure transport services include travelling to and from hospitals, homes, police custody, prisons and more. The service was entirely bespoke, ensuring the individual needs of service users were met.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw evidence the provider used language identification charts so patients could indicate which language they preferred to communicate in. There was a telephone interpreting service that could be contacted if English was not a patients first language.

Patients undergoing long journeys were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

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

The provider adhered to the commissioner's processes surrounding discharge process and management of this. Staff told us they had no control over access and flow arrangements. The service recognised the volume of transport outlined in the tender and adhered to the contract agreement.

Good

Patient transport services

Staff supported patients when they were transferred between services.

Are Patient transport services well-led?

Good

This service had been inspected before but not rated. We rated it as good.

For leadership, vision and strategy, culture, governance, Management of risk, issues and performance, information management and engagement please see Urgent and Emergency Care.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The provider had moved from a totally paper based planning system to using a ten-inch sized screen tablet where the crew reviewed jobs. Each vehicle had a tablet with chargers. Managers could review the jobs in real time and track the locations of vehicles. Staff could make notes in real time. Managers told us this change had improved efficiency.

Staff used the results from restraint audits they carried out to identify learning opportunities to improve the service, care for patients, and the safety of staff to make ongoing. Staff were able to give several examples of changes that had been made improvements and plans implemented for future journeys.