ERS Transition Limited

ERS Medical North

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?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this service stayed the same. 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. The maintenance and use of vehicles and equipment kept people safe. Staff assessed risks to patients and acted on them. 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 followed relevant national guidance. 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. Feedback from patients was consistently positive about the care and service they received.
- 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 transport.
- 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. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to ERS Medical North

ERS Medical North is operated by ERS Transition Ltd. It is an independent ambulance service providing non-emergency patient transport throughout the north of England from bases at Leeds, Manchester and Crewe. The service had conducted 47,863 patient transports in the 12 months prior to the inspection. They transported both adults and children. They had approximately 119 operational staff. The service had a registered manager who had been in post since August 2020.

The service is registered to provide the following regulated activities:

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

How we carried out this inspection

During this inspection we visited the Leeds and Manchester operations bases. We visited two hospital sites where patients were being conveyed and spoke with staff who worked at Leeds, Manchester and Crewe operations bases. We spoke with 21 staff, including 14 ambulance care assistants, two operations managers, two team leaders, the regional manager, operations lead and a member of the quality and governance team. We observed the care of four patients and reviewed four patient records. We inspected nine vehicles and reviewed a range of governance records including policies, vehicle maintenance records, operational reports and meeting minutes.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that vehicle checks, and cleaning processes include cleaning of door recesses in all vehicles.
- The service should ensure that checks of spare defibrillator pads include a check of expiry dates.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Patient transport services

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

Are Patient transport services safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Mandatory training was delivered as part of staff induction. Staff attended annual mandatory training updates. Compliance was high with more than 98% of staff having completed updates in the last year.

The mandatory training was comprehensive and met the needs of patients and staff. This included moving and handling, health and safety, infection control, adult and paediatric basic life support, information governance and managing deteriorating patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. A log of training compliance was maintained, and staff were booked onto a training update session when their training was due. Update sessions were held regularly throughout the year. We saw that some staff had training due and managers told us they were booked onto the next session. Staff confirmed they had access to regular training. Managers told us that if staff failed to attend their training updates then they were taken 'off road' until this was complete.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff were trained to level two child and adult safeguarding and training compliance was over 98%. The medical director was the organisational safeguarding lead and was trained to safeguarding level four.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples where they had identified safeguarding concerns. This included where they transported to patients' home and found their living conditions were not fit for purpose or where there was evidence of potential neglect. For example, where there were issues with a lack of heating. They worked with the referring service to ensure that patients were not left in circumstances where they could be at risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding referrals were made to the local authority on the same day. Staff had access to an incident hotline run by the provider and incidents including safeguarding concerns were recorded on the internal reporting system. Senior staff were alerted to incidents raised by an automated email and staff discussed safeguarding concerns with their line manager to ensure appropriate action had been taken.

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.

Vehicles and equipment appeared clean. Touch areas within vehicles were wiped down in between patient use and there were cleaning records that showed vehicles and equipment were cleaned at the end of each shift. There was a deep cleaning process carried out every 90 days through an external contractor. Where vehicles were contaminated, staff carried out an initial clean and the vehicle was taken off the road until a deep clean could be completed. Data for May 2022 showed 100% compliance with vehicle cleaning.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Daily, weekly, monthly and quarterly checks were in place that included regular cleanliness inspections and there were records of this. Monthly audits of hand hygiene, uniforms and vehicle cleanliness were carried out. Compliance was high with audit areas within the North region achieving 100% between January 2022 and May 2022.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed good use of PPE including the use of face masks when interacting with patients or walking into hospital wards. We observed staff appropriately cleaning their hands and staff had access to a range of PPE for use, depending on the specific risks identified for individual patient transports. Infection risks were identified at the point of referral as part of the service's triaging process. In addition, staff sought a handover from ward staff that included the identification of any infection risks.

Spill kits (for use when cleaning body fluid spillages) were held on each vehicle and were seen to be in date. There were vomit bowls, couch roll (for covering patient stretchers), clinical cleaning wipes, clinical waste bags and a full range of PPE. The provider's infection prevention and control policy included guidance for staff on laundering of uniforms and the use of PPE.

There were clear processes in place to reduce the spread of infection. For example, staff received updates from managers on the requirements relating to COVID-19. We saw that staff undertook twice weekly COVID-19 testing and this was recorded on the human resources management system. There was an infection control lead within the care quality team who staff could approach for advice.

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.

Good

Patient transport services

Staff carried out daily safety checks of specialist equipment. Staff were given fifteen minutes at the beginning and end of their shift to carry out safety checks. This included ensuring that all equipment was working safely and that the vehicles and equipment were clean and fit for purpose. Emergency equipment was checked as part of the safety checks. We saw records that demonstrated this. However, we saw one spare set of defibrillator pads that had expired a few days prior to the inspection.

The service had enough suitable equipment to help them to safely care for patients. All equipment was maintained by an external contractor and the service maintained an asset register with details of equipment maintenance. We saw that equipment was regularly maintained and there were records of safety checks. There were clear quarantine areas at each base to segregate equipment that required maintenance. There was clear labelling of equipment in the quarantine area to ensure it was not used.

Staff were trained to use equipment as part of their induction and their annual moving and handling updates. The training included competency assessments relating to safe patient transfer and use of equipment.

We saw there was access to a harness system that allowed children to be transported on adult stretchers. We viewed a 'toolbox talk' training document on the use of the system, however, records demonstrating the completion of the training were not available. The registered manager told us they had taken the decision to provide training in the use of the system at the point when a transport request for a suitably sized child (generally under five years of age) came in. This was because there were very small numbers of children who were suitable for transfer with the use of the harness and that staff required instruction immediately prior to the transfer. There had been a total of 196 paediatric (under 18) transfers across ERS Medical North in the twelve months prior to the inspection. This was 0.4% of the total transfers undertaken. There had been no instances of the paediatric system being used on adult stretchers during this time. The service had suitable equipment available for the transfer of children including seatbelts and chairs. The service had access to bariatric equipment.

Most vehicles used by ERS Medical North were ambulances providing wheelchair access and manned by two crew members. In Crewe there was one vehicle manned by one crew member as agreed within the contract and one patient 'bus', manned by two crew members which could take two patients at a time, including a stretcher.

The service used a third party provider to monitor vehicles including servicing, tax, MOT, or whether vehicles were off road. The service kept a record of the maintenance and repair of each vehicle. There were electronic servicing schedules with automated alerts. Safety inspections were completed every three months.

Safety and servicing records were saved to the electronic fleet system. Servicing was completed according to the manufacturer's guidelines. No vehicles were overdue inspections or safety checks at the time of our inspection. If inspections or safety checks became overdue, then vehicles were taken off the road until these were addressed.

Vehicle packs included records of insurance, a crew handbook and incident reporting forms. There were clear processes to contact the control room in the event of a breakdown and arrangements for a second vehicle to be sent if a patient was on board.

Staff mostly disposed of clinical waste safely. Each vehicle had a supply of clinical waste bags and staff were aware of how to use them. However, we found one pair of used disposable gloves in a door recess in one of the vehicles at the Leeds base. This was addressed by the manager at the time of our inspection.

The provider had a service level agreement with a clinical waste contractor. Locked clinical waste bins were stored at each vehicle base and waste was collected weekly as part of the contract. We saw that clinical waste was stored securely.

Medical consumables, such as oxygen tubing and masks were available on vehicles and those we checked were in date.

Fire extinguishers were available on all vehicles. These were regularly maintained as part of the service's fire safety processes and were included in the daily vehicle checks. All extinguishers in the vehicles we checked were within their expiry date.

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 had received training in adult and paediatric basic life support including the use of an automated external defibrillator. There were defibrillators stored at each base and on some of the vehicles. In the event of a patient deteriorating staff dialled 999 for an emergency ambulance and sought support from the control room.

Staff completed risk assessments for each patient when a transfer was requested. Bookings were taken by call centre staff who completed a patient transfer request form. There was an electronic booking system and call centre staff were prompted to ask questions about patient's current status such as mobility, infection status, disabilities or if there were for resuscitation. Risks were recorded and decisions taken about the appropriateness of the transfer. For example, higher risk transfers were reviewed by a clinician to ensure they were appropriate. This included mental health transfers as staff were not trained in the use of restraints, therefore, the service only transferred lower risk patients. They would sometimes request a mental health specialist nurse to accompany the patient, based on the risks identified. Vehicle crews were sent the information and then took a handover for the patient when on site, checking the information received to ensure that the risk assessment and transfer were appropriate.

Staff ensured that handovers included all necessary key information to keep patients safe. Staff had copies of the information obtained during the booking process. We observed staff receiving handovers from hospital staff on transfer. They asked appropriate questions to ensure they had the information to transfer patients safely. This included clarification about the patient's resuscitation status and checks that the patient had a copy of any 'do not attempt resuscitation' order as appropriate.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough ambulance care assistants (ACA) to crew the vehicles and keep patients safe. Patients were allocated to each ACA and vehicle according to the time needed for each journey. Once the ACA and vehicle was allocated to a transfer, no further patients were accepted, unless the vehicle was designed to take more than one patient.

Good

Patient transport services

Records showed that staff had been recruited safely and had received the required training in key skills. We looked at the recruitment records for ten members of staff and found these were comprehensive. They included employer references, driver checks, disclosure and barring service (DBS) checks, right to work and checking for any gaps in employment. The provider audited staff records to provide assurance that all the appropriate checks had been done. We reviewed evidence of this and saw 100% compliance for staff working at ERS Medical North.

The manager could adjust staffing levels daily according to the needs of patients. If a journey took longer than expected, for example, unexpected traffic jams, remaining journeys were reviewed for that staff member. In addition, they used bank staff and had flexible workers who stepped in when needed. All bank staff completed the same induction training and mandatory training updates as permanent staff.

The service had a staff turnover rate of 15% between January and May 2022. This was a slight increase when compared with 2021 and like the 2020 rate. The service analysed the staff turnover, including collecting data on the reason for termination and the length of service prior to termination. We saw that most staff left for personal reasons or to start a new job role.

The service had reducing sickness rates. When ERS Medical took over running the service in 2017 the average sickness rate was 13 days annually per staff member. In 2022 the target was 10 days annually per staff member. The service had plans to reduce the sickness rate over time and we saw that in April 2022 the rate for ERS Medical North was an average of three days.

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.

Records held by crew members varied depending on the contract with the specific NHS trust. For example, with some service contracts, the NHS ambulance trust downloaded records to a personal digital assistant (PDA) held by each crew member. When the crew member logged on to their PDA at the start of their shift, they could see how many journeys they were due to undertake, the name and address of the patients, any risk factors, and the addresses of each location. Other service contracts relied on paper records to provide details of the calls to the crew member.

Records were stored securely. When used, staff were allocated a PDA with a unique sign on number. They carried these with them for the duration of their shift. Personal information about the journeys they had undertaken was deleted at the end of each working day. Computer systems used by the service were secure and password protected. Where paper records of calls were used, these were disposed of in confidential waste bins at the base at the end of the shift.

Staff were required to complete a patient review form for all patients who required clinical assessment or monitoring during the journey (a patient review form documented important information such as a patient's vital signs, mental capacity and pain score, as well as having space to document any changes or concerns about a patient's condition during a transfer). We reviewed four patient review forms and found that these had been completed appropriately and comprehensively.

Records were stored securely.

Medicines

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

Good

Patient transport services

Patient transport vehicles did not carry any medicines and except for oxygen, the provider did not store any medicines. They carried oxygen on vehicles and crew members received training in the administration of oxygen as part of their induction and ongoing mandatory training updates. Oxygen cylinders were stored securely on vehicles.

There was a clear standard operating procedure specific to the administration of oxygen. This guidance was developed in line with the Joint Royal Colleges Ambulance Liaison Committee and Resuscitation Council (UK) guidance.

Oxygen cylinders were available and stored securely on the vehicles. Each site had clear oxygen storage facilities. This included segregation of full and empty cylinders in line with the manufacturer's medical gases safety data sheet. Oxygen was checked regularly to ensure there was enough supply and cylinders on vehicles were seen to be within date.

Staff were required to complete a controlled drugs transport form on occasions when patient's own controlled drugs were transported as part of a journey. Staff we spoke with were aware of this requirement and signed the forms to confirm the issuing NHS staff member, the name of the ambulance staff accepting the medicines for transport and details of the name, dose and number of medicines being transported with the patient.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They had a clear understanding that any incident or near miss required reporting and they were given time and support to do so. We saw that 58 incidents had been reported within ERS Medical North between January and May 2022. These were categorised into headings such as care quality, health and safety, transport and business continuity.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff

raised concerns through the provider's incident hotline. They completed the incident report form

and this was then allocated to a manager to investigate.

Staff understood the duty of candour. They were able to describe the importance of being open and honest with patients and their families.

Staff received feedback from investigation of incidents, both internal and external to the service. A company wide memo was issued with information about incident trends or issues so that learning could be shared across the provider organisation. Monthly regional meetings were held where incidents were discussed and learning shared.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were collated within the reporting system and incident reports discussed at various governance meetings. This included a governance and performance review meeting where incidents were discussed locally between the registered manager and operations managers. In

addition, incidents were reviewed by the corporate patient safety committee and suggested actions cascaded to managers and staff following this. A service fleet report collated information on transportation incidents, including where vehicle accidents had occurred. Operations managers shared information with staff at team meetings and through regular newsletters. Staff told us they felt able to contribute to learning when things went wrong.

There was evidence that changes had been made as a result of feedback. This included sharing information and updates on the use of equipment, including additional training for staff following an incident where required. We were also told of an example of an incident occurring in another provider location where information had been cascaded to staff about the incident and to remind staff to use the appropriate moving and handling equipment when transferring patients.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. All incidents were investigated by a service manager initially. The investigation included discussions with the ambulance crew, patient and where appropriate their family or others involved in the incident. Following the initial investigation an incident underwent a technical review. This involved a second review of the incident by a subject matter expert to identify any further learning from the incident. We saw an incident relating to an injury sustained by a patient while being transported had been thoroughly reviewed and that senior staff had involved the patient in the investigation. This included a visit from the quality and governance manager.

Managers debriefed and supported staff after any serious incident.

Are Patient transport services effective?

Good

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

Evidence-based care and treatment

The service provided care and 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. The service did not provide clinical treatment for patients and so opportunities for evidence-based practice were limited. However, we viewed policies that were based on national guidance. This included reference to the national End of Life Care Strategy and recognition of rapid transfer for patients at the end of life and the role the service played in this. Their deteriorating patient's policy referenced guidance from the Resuscitation Council (UK), and their oxygen policy was based on Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We observed crew members addressing the emotional needs of patients to ensure their comfort during the journey. They reported any concerns to care workers and clinical staff.

Staff did not transfer patient subject to the Mental Health Act at the time of our inspection. However, the provider had relevant policies in place that focused on protecting the rights of patients and following the Code of Practice.

Good

Patient transport services

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed ambulance crews seeking handovers from hospital staff and communicating about psychological and emotional needs, as well as physical.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Staff made sure patients had enough to eat and drink. Staff called ahead to patients who were about to have a long journey. They advised them to have something to eat before the journey or to bring a snack with them. They also scheduled planned journey breaks as appropriate. All vehicles carried bottled water for patient's use.

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.

We saw that monthly mission performance review meetings included a review of key performance indicators (KPIs). KPIs were recorded for every patient journey and crews were time stamped on their journey running sheets to demonstrate when activities had completed.

The KPIs were reviewed by managers internally and with the service commissioners. Not all contracts had KPIs associated with them, however, managers met with commissioners to review activities and at the time of the inspection we were told there had been no concerns about response times raised by commissioners or identified by the provider.

The provider had different key performance indicators (KPIs), for example, in Manchester the KPI was for time spent on the back of the vehicle with a target of less than 90 minutes. We saw that this had been achieved in more than 99% of patient journeys in February and March 2022.

In Leeds, the service aimed for a four hour response time for patient discharges. At the time of the inspection the KPI had been suspended by the trust due to the COVID-19 pandemic, however managers still used the KPI for monitoring performance.

Managers completed exception reports in the event of a KPI being missed for individual patients, including an explanation as to the cause. We saw that these included issues such as pressure from the COVID-19 pandemic, patient delays and other patients being prioritised by the hospital. Data we reviewed showed there had been a few exceptions reported in April 2022 and performance against KPI was 83%. However, we also saw that the reasons for this were largely due to pressure from COVID-19 and decisions from the NHS trust to prioritise or delay patient discharges. Performance in February 2022 was at 90% and in March 2022 was at 89%.

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. All ambulance care assistants (ACAs) had completed a level three award in non-urgent care course. In addition, the provider was in the process of implementing level 3 first response in emergency care (FREC) training for all ACAs.

Managers gave all new staff a full induction tailored to their role before they started work. This included mandatory training, completion of the level three non-urgent care services course, competency assessments and working shadow shifts. This was generally completed over a three week period, but managers told us there was flexibility for new staff to work additional shadow shifts until they felt competent and confident.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with confirmed they received an annual appraisal. We reviewed appraisal data and found that across ERS Medical North 95% of staff and 99% of managers had a completed appraisal in the last year.

The clinical educators supported the learning and development needs of staff. They adapted training to meet the needs of staff and undertook regular assessments of competency. This included annual driving assessments to ensure that staff remained competent and aware of their responsibilities.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. This included regular newsletters that contained update information for staff. We saw that up to date information was stored in crew rooms and staff told us they felt informed of changes and that communication was good.

Managers identified poor staff performance promptly and supported staff to improve. We saw evidence that poor performance was addressed appropriately. There were systems in place to monitor performance in relation to driving. This included an automated system that monitored the quality of driving. Staff were asked to log onto the system at the beginning of the shift and this monitored aspects of driving such as speeding, and harsh acceleration, cornering and braking. Performance was analysed and issues were addressed by line managers and additional training as appropriate.

Multidisciplinary working

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

Staff described good teamwork between different groups of staff. Ambulance crews communicated effectively with other healthcare providers in order to deliver good patient care. Managers held monthly meetings with contracting NHS services to share information about the service.

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.

Records confirmed that staff had received training in mental health awareness which included subjects such as living with dementia, informed decision making and gaining consent. The service would be informed in advance if a patient was likely to be confused because of mental ill health. Staff facilitated the transport of a patient's escort or carer where this would help reduce distress or confusion. The service had a policy to transport patients with impaired cognition such as dementia with a two person crew to ensure safety.

Staff we spoke with demonstrated a good understanding of the Mental Capacity Act and their responsibilities to gain consent. They told us that in the event of a patient not wanting to be transported then they would feed this back to hospital staff and not take them. We observed staff gaining patients' consent before moving them into a vehicle and giving a full explanation as to what they were doing and what to expect.

Good

Patient transport services

The service did not transport patients who were subject to the Mental Health Act or a deprivation of liberty authorisation.

Are Patient transport services caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff taking the time to communicate with patients, ensuring that they understood what would happen during the transfer and answering any questions they had. They made every effort to protect patient's dignity while transferring them, for example, we observed staff moving a patient to a side room in order to transfer them onto a trolley.

Patients said staff treated them well and with kindness. One patient told us that staff had been 'very gentle' when moving them. Another patient told us that staff had been 'very kind'. Written feedback from one patient included that the friendliness of staff and their 'chatty' approach helped them to feel less nervous.

Staff followed policy to keep patient care and treatment confidential. They understood the principles of patient confidentiality and knew that personal details should not be shared with unauthorised persons. Handovers were conducted discretely to ensure confidentiality.

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 gave us examples of where they had taken action to support patients who were vulnerable or with additional needs. This included taking time to support patients to settle in once they were taken home. We observed staff asking patients about their needs and saw this was done with patience and kindness.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff had received training in equality and diversity. We observed staff being respectful of patients needs and beliefs. Staff we spoke with demonstrated a good level of understanding of the diversity of individual needs and beliefs and they consistently told us they treated patients as individuals. They were seen to take time to ask patient's questions to better understand their individual care needs.

Emotional support

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

Good

Patient transport services

Staff gave patients and those close to them help, emotional support and advice when they needed it. They demonstrated an understanding of the importance of emotional support on patients' wellbeing. Staff consistently told us they enjoyed their job because of the support they were able to offer people and we saw this in action during our observations.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff had a good understanding of privacy and dignity and we saw that they spoke to patients in a way that minimised the potential for distress, using a calm tone and a friendly manner. Staff told us that if a patient became distressed, they would sit with them and provide support as much as possible. They shared examples of when they had done this.

Understanding and involvement of patients and those close to them

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to a language app to aid communication. They also had a list of the most common basic phrases in different languages and used flash card pictures to support communication. They were aware of the need to adhere to privacy and dignity when transporting patients. For example, they offered patients a choice of male or female crew and worked to meet individual requests that would help people feel more at ease.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had an onboard patient experience survey and staff encouraged patients to use this to share their experience. Results of the survey were consistently positive about the service received from staff from all the bases in the north. For example, in Manchester 98% of patients surveyed said the service was good or very good. Comments from patients included that staff were 'lovely and bubbly', 'calm', 'excellent', 'friendly and professional, and 'a credit to ERS'.

In Leeds the results were 99% and comments included that staff were 'kind and understanding' and the service was 'first class'. One patient stated they 'had a good talk and felt safe' and a relative said staff were 'absolutely wonderful with my husband'.

In Crewe survey results were 100%. Comments included that staff were 'excellent, professional and friendly', and that they 'transferred me with dignity and care'.

Are Patient transport services responsive?

Good

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

Service delivery to meet the needs of local people

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.

Good

Patient transport services

Managers planned and organised services, so they met the changing needs of the local population. The service provided non-emergency transfers between a range of locations, including hospitals, treatment clinics and patient's homes. Journeys could be booked in advance or on an ad-hoc basis. They had NHS contracts in Leeds, Blackburn and Chester and the service worked closely with the local NHS ambulance trust to help with the discharge of patients from local emergency departments and hospitals. Managers provided a flexible service and re-deployed nearby crews to ensure they were responsive to changing needs and unexpected demand.

Managers met regularly with NHS service commissioners to support the safe discharge of patients and to avoid delays for patients leaving the hospital.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had multi-use vehicles that included both wheelchair and stretcher patients.

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.

Crews were made aware of patients with complex needs through the booking in process where assessments were carried out through clear identification of patient's individual needs. There were processes to share information about patients with learning disabilities, dementia, older people with complex needs and those requiring access to translation.

All patient transport staff had received training in equality and diversity. This included the care of patients with dementia, learning disabilities, bariatric patients and paediatric care. Staff gave examples of where they had taken action to respond to the needs of patients with compassion. For example, one crew were asked to transfer a bariatric patient in a hospital corridor. They understood that there was a risk of compromising the dignity and welfare of the patient so refused to do this, instead asking that a side room be made available for the transfer.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff we spoke with understood the steps they would take to support patients with difficulties including visual or hearing impairment. Staff had access to an app to aid communication and had picture prompts within their packs and a translation app.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had information on how to do this available to them and staff we spoke with understood the process for this.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and within agreed timeframes and targets. There were service level agreements in place with key targets for patient waiting times for transport. Due to the nature of the contractual arrangements, the commissioning trust had control over the number of bookings and in some cases changed bookings in order to prioritise other patients. The service monitored this and provided feedback to commissioners about waiting and response times.

Good

Patient transport services

The provider tracked where crews were, and crews provided availability updates to the control room. The level of crew resources was agreed as part of the service level agreements in place.

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.

The service clearly displayed information about how to raise a concern in patient areas. There was information about this on the vehicles. Complaints could be raised directly with crew members, through the service website or by phone.

Managers investigated complaints and identified themes. The provider's complaints team collated complaints and coordinated investigations and responses. We reviewed the complaints policy and saw there were clear timelines for acknowledgement, investigation and responding to complaints. We viewed complaints including a complaint about a crew member's driving. We saw that the investigation involved a review of the driving technique using the provider's on-board system. This involved the identification of issues with acceleration, harsh braking and cornering. Complaints were reviewed at the monthly governance and patient safety committee meetings and locally within the ERS Medical North operations team.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff involved in a complaint were interviewed by their line manager and statements obtained. Feedback included a discussion of learning and ways to prevent recurrence. For example, staff received support on improving communication and approach in an incident where a patient was unhappy about a staff members attitude.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was identified and shared amongst team members. This included learning from complaints that had occurred within the provider's other services.

Are Patient transport services well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

There was a corporate leadership team that consisted of the chief executive officer, chief operating officer, medical director and a quality and governance director. There were also directors for finance, communications, human resources and training, business relations and development. There was a senior operations manager for the North who was also the CQC registered manager. Each base had an operations manager and a team leader role, providing operational leadership to staff daily.

Good

Patient transport services

The senior leadership team met regularly and set clear objectives for service priorities and there were systems and processes for addressing issues the service faced. Operational service managers met regularly and reviewed priorities, performance and issues.

Staff told us that leaders were visible and approachable. They told us they felt confident in the support they received from operational managers.

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 service had a vision to 'be recognised as a leading provider of health and social care services in the UK by 2025'. They had developed a strategy in consultation with stakeholders, where the development process included analysis of the health transport and health and social care sectors. There were clear priorities such as service delivery, quality, finance and commercial, people, environmental and digital considerations.

The senior leadership team created an annual mission statement. The mission statement for 2021 was to 'grow a profitable, patient focused business' in order to achieve their 2025 vision. We saw there was a 'mission analysis' (regional development plan) for the North relating to the current year. This included the identification of potential barriers to success, focused actions, personal actions and the identification of support needed to ensure the actions were completed. Key performance indicators were identified as a measure of success. For example, in relation to human resources, mandatory training, personal development plans and vehicles and events.

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.

The identified service purpose was 'to provide a reliable, caring service that puts people at the heart of everything we do.' They had values of integrity, compassion, respect, professionalism, patient focus, innovation and working in partnership.

Staff we spoke with understood the values of the service and they demonstrated these during our observations. We saw that the values were displayed within the crew areas at the bases.

Staff told us they enjoyed working for the company and felt supported by their line managers. They described a team approach that was friendly, compassionate and supportive and we observed this during the inspection.

Some career development opportunities were available, where staff could take on more senior roles and were supported to do so. However, some staff spoke of the limited opportunities available to them. We also saw that this was an issue identified in the staff survey. Managers recognised this as a limitation of the service provided and they informed staff at the point of recruitment that opportunities related to patient transport and courier services as these were the areas the service was contracted to deliver. We saw that leaders understood that development opportunities were important to staff. For example, where staff had previously completed a level three award in non-urgent care services, a

decision had been made to provide new ambulance care assistants with the opportunity to complete a first response emergency care (FREC) training course. There was an intention for existing staff to complete this training, however, this had not yet begun. In-house leadership development training was available for those staff in leadership roles, including those in 'acting up' roles.

Patients, their families and staff could raise concerns without fear. There was an identified Freedom to Speak Up Guardian so that staff could raise concerns outside of the line management structure of the organisation. Patients and their families were encouraged to raise concerns when they arose. We saw evidence of concerns being addressed and discussed as part of the quality and safety committee meetings and there was clear action taken when this was needed.

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.

There were clear governance processes and structures within the service. There was a committee structure where issues and performance were discussed, and local managers provided reports to inform decision making.

Quarterly patient safety committee meetings took place across the whole of ERS Medical. We reviewed minutes of patient safety committee meetings and saw that these included a review of risks, compliance, information governance, shared learning and feedback, incidents and complaints and the identification of trends.

A regional governance and performance review meeting was held monthly. This included attendance from operations managers and fed into monthly corporate governance and performance meetings. Issues such as audits, incidents, safeguarding, complaints, patient experience surveys, vehicle compliance and an analysis of trends were reviewed. Monthly governance and performance review reports were collated to provide data and evidence of performance.

The Chief Operating Officer for ERS Medical held a weekly operations meeting with all senior operations managers across the regions. The senior operations manager also held calls three times a week to discuss operational issues with their operations managers. Staff meetings were held on a minimum of a quarterly basis within each base. These were held virtually or in person depending on the level of risk associated with Covid-19. We reviewed minutes of staff meetings and saw that issues such as vehicle cleaning, driver standards, contracts, incidents, training and other areas of performance were discussed.

Policies were generated at a corporate level and shared with staff. We saw that policies were held within crew rooms and accessible electronically. We reviewed eleven policies including complaints, infection control, deteriorating patients, medicines management (oxygen), safeguarding and business continuity. We saw that all policies had been reviewed and were based on relevant national guidance and best practice.

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.

Risks were appropriately identified and escalated. Risk registers were maintained and included risks associated with the COVID-19 pandemic and operational risks. For example, we reviewed a risk relating to the use of hospital porter chairs that did not have lap belts and presented a risk to patients and staff. Action included informing staff not to use porter chairs when transferring patients and placing signs on vehicles as a reminder to staff.

Operational risk assessments were carried out within each base and mitigating actions were identified. For example, we saw evidence of monthly water testing, flushing and temperature checks in line with a legionella risk assessment. We also saw that control of substances hazardous to health (COSHH) risk assessments were maintained and that fire safety actions including alarm checks and extinguisher inspections were completed. Monthly health and safety audits and walk arounds were completed by operations managers.

Performance and compliance were monitored with data collated centrally and shared with operations managers. This included information relating to incidents, complaints, training compliance, recruitment, patient experience, driver performance and performance against key performance indicators (KPIs).

Performance reviews against the organisation mission were completed at every level of the organisation. Senior operational service managers set their own focused actions against the mission, identifying potential barriers and required support to address them. Monthly progress reports were completed, with monthly targets and actions were reviewed.

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.

Appropriate and accurate information was effectively managed. ERS Medical had integrated computer based business management systems to support the service.

The systems produced accurate real time reporting of information which allowed senior managers to track performance and support decision making. Information was broken down for each region and we viewed data for ERS Medical North on a range of performance areas. This included performance against KPIs, incident and complaints data and compliance in relation to training, human resource processes and appraisals.

Vehicles had a tracking system in place which provided data on driver performance, including incidents of speeding or harsh acceleration, cornering or braking. Information from this was collated into a regular ‘fleet’ report where driver performance was reviewed alongside reported vehicle incidents. The system provided information on driver safety and performance and managers identified the highest and lowest performing staff in relation to this to aid performance management.

The use of data enabled managers to identify priorities and areas for improvement. Operations managers were able to access data in real time and they used this to address issues.

Managers understood their responsibilities in relation to the submission of notifications to external organisations. This included notifications to CQC about serious incidents and safeguarding concerns.

Good

Patient transport services

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 information available to patients on board vehicles to encourage them to communicate with and provide feedback to the service. The review of patient experience was an agenda item on meeting agendas so that feedback was shared, learned from and used to improve services.

Operations managers met at least quarterly with staff. We saw from minutes we reviewed that staff had the opportunity to ask questions and raise topics for discussion during this meeting. Staff we spoke with described a positive atmosphere in the bases they worked in. They told us they felt listened to by line managers and able to raise issues when they needed to.

A quarterly 'in touch' staff newsletter was produced. Information included updates on new contracts, a news page, human resources and training updates, and COVID-19 related updates. In addition, there was information about 'employee assist' support services and competitions aimed at getting staff to provide feedback on specific areas of the business, in exchange for the chance of winning a prize.

A staff survey had been carried out in 2020 and 2021. Data comparison showed a slight reduction in agreement in all indicators although overall results were similar to those in 2020. An area identified for improvement was around recognising and rewarding staff. Survey results showed that 27% of respondents did not feel appreciated and 34% did not feel they were rewarded in ways that matched their motivation. As a result, the service re-launched their employee recognition scheme to expand the scheme from June 2022. The survey results were across the whole organisation and not broken down by region, so it was not possible to identify any specific areas for improvement or positive findings relating to ERS Medical North.

Managers held regular meetings with the local NHS ambulance services and commissioners to review service provision and performance.

Learning, continuous improvement and innovation

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.

There were clear processes for continual learning and how this was used to improve services. Information was collated and reviewed at every level of the service to ensure that learning was cascaded.

Quality assurance and improvement methodologies were apparent, with audits and reviews used to measure quality. There were comprehensive approaches to the management of incidents and complaints with subject specialists undertaking reviews of how these were managed to ensure actions and improvements were appropriate.

The service had launched an environmental and social impact report. This showed that in the last year vehicle emissions had been reduced by 110 tonnes of C02. Staff were encouraged to turn off vehicle engines when idle in order to achieve this.

In 2020 the organisation had achieved Investors in People accreditation, providing a framework for improvement for how the organisation engages and works with staff, improves culture and work practices.