

Manone Medical Ltd

Ambulance Station

Quality Report

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

Ratings

Overall rating for this
ambulance location

Good



Patient transport services (PTS)

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

The Ambulance Station was operated by Manone Medical Limited; it was a patient transport service.

We carried out an unannounced inspection on 11 and 12 September 2018.

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

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

We found the following areas of good practice:

- The culture of the service was positive. Management were visible, open and transparent and created an ethos of inclusiveness with staff.
- The service had developed a clear risk assessment for ambulance staff to safely assess risk of patients referred for transfer.
- All staff were up to date with mandatory training including safeguarding training for children and adults.
- The service managed cleanliness, infection control and hygiene well.
- The service made use of electronic systems to ensure flow of information and communication.
- The service had a thorough induction package for new staff and staff were encouraged to complete refresher training.
- There were effective support systems in place for ambulance staff.
- The service had developed useful auditing systems to identify areas for development and monitoring. The service made improvements following analysis of audits.
- Staff were engaged with the overall vision of the service and were motivated to provide a good service to patients.

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

- The service did not assure us that where lessons were learned following incidents, that this was communicated to all staff.
- There were no lockable cupboards within the ambulances to store confidential information.
- Consideration of adjustments made for patients with special requirements.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region), on behalf of the Chief Inspector of Hospitals.

Summary of findings

Our judgements about each of the main services

Service

Patient transport services (PTS)

Rating

Good



Why have we given this rating?

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Ambulance Station

Detailed findings

Services we looked at

Patient transport services (PTS);

Detailed findings

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Background to Ambulance Station

The Ambulance Station was operated by Manone Medical Limited. The service opened in January 2015. It was an independent ambulance service in Wallasey, Merseyside. The service primarily served the communities of North West England and Wales.

The service has had a registered manager in post since January 2015.

A significant proportion of the business was the transfer of mental health patients from accident and emergency departments to wards on mental health units or transfers between wards. The majority of such transfers were delivered via a contract with the local mental health foundation trust. The service received spot requests from other mental health hospitals.

The service rarely transferred patients into the community with police escort.

The service also undertook other patient transfers, for example, the discharge of elderly patients to their home or hospital transfers.

The service received bookings for private events and medical repatriations, however as these services were not required to be registered with CQC they were not looked at during the inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, three CQC inspectors, and a specialist advisor with expertise in ambulance services and mental health. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the ambulance station base and the head office. We spoke with three ambulance care staff, the registered manager, director of operations, the clinical performance manager and the human resources director. There were no patient transfer

journeys on the day of inspection however we spoke to one patient on the telephone. We spoke with the mental health foundation trust with whom the service holds a

Detailed findings

contract. We observed several 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 30 sets of patient records.

Facts and data about Ambulance Station

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once in 2017 at which time CQC did not rate ambulance services. At the last inspection we found areas that required improvement.

Activity (September 2017 to August 2018)

- There were 1396 patient transport journeys undertaken and a further 973 mental health transfers.

The service employed eight members of staff three of which were bank staff.

Track record on safety

- No never events
- No clinical incidents
- No serious injuries

The service received no complaints in the past 12 months.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Not rated	Good	Good	Good
Overall	Good	Good	Not rated	Good	Good	Good

Patient transport services (PTS)

Safe	Good	
Effective	Good	
Caring	Not sufficient evidence to rate	
Responsive	Good	
Well-led	Good	
Overall	Good	

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Are patient transport services safe?

Good



Incidents

During the inspection we checked all incidents recorded between October 2017 and September 2018. We saw that staff knew how to raise incidents and were aware of their duty of candour. Duty of candour is a regulation set on providers to ensure they are open and transparent when things go wrong regarding care and treatment.

Staff completed electronic incident forms and sent them to the duty manager for analysis. The duty manager transferred incidents on to the service dashboard to monitor the number of incidents and investigate further.

We saw evidence of the investigations being undertaken using root cause analysis methodology to a good standard.

The safety dashboard recorded actions put in place following investigations to help track completion of actions. For example, following an incident where a patient became unwell during transfer, management reminded staff about the deteriorating patient policy.

Managers informed us that changes to processes following investigation were communicated to staff via their messaging application or face to face. The application required staff to acknowledge receipt of and understanding of the information by clicking on the 'thumbs up' icon.

For two incidents we looked at, investigations, lessons learned and action plans for future safe practices were evident. However, we could not see that the lessons learned had been communicated to staff through the electronic system.

Mandatory training

The service provided a comprehensive induction for ambulance care assistants, managers and directors. The aims of the induction period were clear and staff we spoke to confirmed they had received and were able to describe what was covered. All training was delivered internally by the service. The induction included the following mandatory training:

- infection prevention control

Patient transport services (PTS)

- adult basic life support
- manual handling
- mental capacity
- reducing restraint
- safeguarding children level one and two
- safeguarding adults level one to three.

The induction period also covered completing risk assessments, deep cleaning of vehicles and duty of candour.

The service used a clear tool to record when staff had completed their training and the system highlighted to staff and management when refresher training was due. Staff were required to complete refresher training in the mandatory areas on an annual basis. Staff could easily log into the database to update their training and were able to complete during working hours. We saw that all staff were up to date with their mandatory training.

Safeguarding

The service had a clear safeguarding policy. We saw that all staff including managers were aware of their safeguarding responsibilities and all staff had completed safeguarding training. Safeguarding referral forms and the safeguarding policy was available via staff handheld devices.

The director of operations was the safeguarding lead for the service and we saw evidence of three safeguarding referrals made to the local authority where staff had filled in the correct form. The service did not receive feedback on the outcome of any safeguarding referrals.

The service had downloaded the NHS safeguarding application on to all handheld devices. This gave contact details for local authority safeguarding departments across the country and contained useful information regarding safeguarding issues.

Staff were up to date with safeguarding training.

Cleanliness, infection control and hygiene

The service had good systems in place to maintain cleanliness, infection control and hygiene:

Staff were shown how to maintain vehicles during their induction. We inspected four ambulances at the ambulance station; all vehicles were visibly clean and tidy inside.

We observed the safety and quality performance dashboard which contained a six-week deep clean cycle. The service told us that they did not accept emergency work that required decontamination; therefore, the deep clean was completed by the service rather than contracted out. The service would re-consider should they undertake emergency work in the future.

We saw there was personal protective equipment available to staff in the form of alcohol gel on the vehicles and gloves. Decontamination wipes were available on all vehicles checked.

Weekly audits of the ambulance station were completed by two members of staff on station duty to ensure cleanliness and we saw evidence of infection prevention control audits undertaken reflecting 100% compliance.

Staff completed vehicle cleaning forms which were sent to the dashboard to be monitored by the clinical governance manager. These were audited to ensure vehicle cleaning compliance.

Environment and equipment

During the inspection of the four ambulances we saw that the condition of the vehicles was good, for example lights and doors in good working order.

- All ambulances had one electronic handheld device and one mobile telephone which were working and the batteries charged. These items were charged in the ambulance station office prior to patient transfers.
- Vehicle harnesses and chairs were available for patients including children.
- Sterile supplies were stored appropriately with packages intact and in date.

The weekly ambulance station audit included a stock check followed by a monthly stock check which we observed. All stock was logged including the batch number and expiry date for all items including oxygen masks and cannulas.

Vehicles were sold and replaced before they were seven years old.

Patient transport services (PTS)

During the inspection we observed that all vehicle details were listed on the service tracker and dashboard. The data recorded when MOT, tax, insurance and service were due and the clinical governance manager had good awareness and knowledge of these details. We checked that they were all in date. Two ambulances were decommissioned which the service wanted to sell.

Ambulance staff had access to up to date satellite navigation systems and the duty manager could track the location of ambulances from head office.

Assessing and responding to patient risk

It was evident during the inspection that the service possessed an escalation policy for deteriorating patients which included both clinical and behavioural deterioration. Staff received training during the second day of induction. Management told us the policy was re-sent to all staff following a recent incident.

We saw that at the time of patient booking ward staff or an adult mental health practitioner sent a risk assessment to the service. On the day of transfer the risk assessment was repeated by ambulance staff. If staff felt the original risk assessment had changed they contacted their duty manager for guidance.

At the time of the inspection, the service was piloting a risk assessment which staff could input electronically using mobile devices. The risk assessment was clear and included automated drop-down boxes. The areas of risk covered included:

- knowledge of transfer
- risk of violence
- risk of self-harm
- current presentation
- risk of absconding

The overall risk score was rated according to the above framework and the score indicated whether staff should use the secure 'celled' vehicle or not for the patient transfer.

It was evident that the service had learned from a previous incident where the risk assessment under scored the level of risk, contributing to a patient absconding and assaulting a staff member. The service amended the risk assessment to improve the risk rating procedure and produced a recognition and management of risk policy.

The patient record form had the mental health risk screening record embedded and the policy stipulated this should be repeated every hour. Through discussion with the duty manager the time frame could be reduced.

During the inspection we found that the service accepted high risk patients and a total of 96% of patients transferred were detained under the Mental Health Act, 1983. The average length of journey was 122 minutes. The service developed a policy for the transportation of patients sectioned under the act which stated that for long journeys, staff must make suitable plans for welfare breaks. Staff ensured any stoppages were made at safe places defined as hospitals or police stations, and to record such stoppages on the patient record form. During the inspection we saw that staff knew welfare breaks should be made at the safe places.

Staffing

The service could maintain the correct staffing levels; there were always two ambulance care staff present on the ambulances. At times one of the managers would act as the second member of staff in the ambulance.

The service could adequately staff each shift and employed eight ambulance care staff. Two were full time, two were part time and three bank staff. The bank staff were encouraged to become substantive. The service was inducting two further full-time staff during the inspection. The recent quarterly audit showed that all journeys had the correct ambulance crew mix and correct ambulance crew numbers.

New staff were supported by the duty manager and were assigned to work with experienced members of staff for the first part of their induction. Managers assured themselves that staff were competent from the on-line training system and staff work book. All ambulance care staff undertook the same level of training to equip them with the skills to undertake their roles.

Records

Records checked were clear and legible. We checked 10 patient record forms and found that all information was included. We also checked 15 mental health records and observed that details were legible and signatures were clear.

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The patient record form included a prompt for staff to check all documents before transfer. The patient record form had a section for previous medical history, and a section for red flags including psychiatric and social issues.

The patient record form included a section for risk assessment with several rows for reassessment throughout the journey. On the records we checked we saw evidence of risk assessment and re-assessments completed.

Ambulance care staff completed weekly audits for the patient record form followed by a monthly audit undertaken by the clinical performance manager to monitor completion rate and quality, enabling the service to make improvements.

Up to date do not attempt cardiopulmonary resuscitation orders were included on the patient booking forms and the service did not accept end of life patients. Information regarding do not attempt cardiopulmonary resuscitation included in the job details were conveyed to staff in line with the service's policy.

We saw limited space for staff to document events on the patient record forms on each journey although this will be alleviated using recently established electronic forms.

There was no locked cupboard within the ambulances to store patient record forms securely. However, staff told us that documents would be stored in the glove box and the vehicle was always kept locked.

Medicines

The service informed us they do not have a medical director and vehicles or staff do not carry any medicines for the patient transport service.

The service developed a standard operating procedure for the use of oxygen during patient transfer journeys. Oxygen would be administered if directed to do so by the health care professional handing over the patient. The health care professional advised ambulance care staff of the correct volume to administer. Oxygen was stored securely in the cylinder storage point which we observed. The use of oxygen was included in the end of shift audit to ensure it was replaced if needed. The service had no instances where patients brought their own oxygen.

The service had a medications management policy for private work and repatriations; this work was not covered

by the regulation and therefore not included in the inspection. The ambulance station had a locked cupboard of medications for private work which ambulance care staff could not access.

Staff told us that patients often brought their own medication with them on patient transport journeys. The service policy directed staff to transfer any medicines within the provided pharmacy transfer wallet and kept under direct supervision at all time. Details of the medicine and amount was recorded on the patient record form within the patients belongings section of the form. The policy indicated that medicine should be handed to a designated practitioner. The patient record form has a box for ambulance care staff to tick to indicate that medicines were transferred securely.

Are patient transport services effective?

Good



Evidence-based care and treatment

The service delivered care that was based on national guidance and best practice and had developed a thorough audit programme since the last inspection.

During the inspection we found that the service did not have a formal eligibility policy. However, the duty manager discussed potential patient transfers with the referrer and a decision made whether to accept based on the referring information. For example, the service did not accept end of life patients.

The service accepted mental health patients and held one contract with a mental health foundation trust. The contract included the transportation of patients detained under the Mental Health Act, 1983.

On the last inspection, we found ambulance staff did not always record they had proper lawful authority to convey or transfer patients under the Mental Health Act, 1983. We told the provider they should ensure that systems were in place for ambulance staff to assure themselves properly.

On this inspection, we found that managers had improved their systems and journey recording from. Staff ensured they received written assurances and authority to transport detained patients from the referring agency, and that this was within the legal framework.

Patient transport services (PTS)

Records reflected written authorisation including:

- authorisation from the approved mental health professionals to convey the patient from the community to hospital under compulsion,
- the statutory Mental Health Act, 1983 form H3 applying for detention to the hospital managers,
- authorisation from the police to convey the patient from the community to a health based place of safety under section 136 of the Mental Health Act, 1983 and
- authorisation through the statutory form (Mental Health Act, 1983 form H4) if the patient was transferred to a different NHS Trust or independent hospital.
- Staff received a signature from mental health hospital or community staff authorising the transfer of detained patients.

The records showed that ambulance staff had a checklist and carried out a basic check of the Mental Health Act 1983 paperwork to identify common errors that might cause difficulties at the receiving hospital.

The service possessed one bariatric ambulance to provide care and support for bariatric patients.

Nutrition and hydration

We saw that water was available for patients. Prior to the journey, staff asked whether patients had eaten and had a drink. If patients had not eaten prior to a short journey, ambulance staff would inform the receiving hospital. Where patients were on longer journeys, staff recorded that patients were offered a drink and/or food.

On the patient transfer report form, a refreshment break was indicated for journeys over four hours. Records showed that patients were offered or given a comfort break stop for journeys longer than four hours. For example, we saw records of patients being transferred from Lancashire to London due to the lack of an available local mental health bed and, on these occasions, patients were given or offered a comfort break.

The service informed us that urine bottles were provided and staff knew that sectioned patients may need to have rest breaks at a safe place (emergency department or police station), as per the service policy.

Response times / Patient outcomes

The service did not undertake emergency work so response times were not recorded.

The service provided the celled ambulance to deliver the block contract between the hours of 1200 and 2200, Monday to Friday. The service reported there were no cancellations.

The service was demand led and able to meet all the contractual requirements.

The most recent quarterly audit for the period April to June 2018 reflected that:

- 91% of ambulance crews arrived either early or on-time for planned and responsive journeys,
- 84% of handovers were completed within 15 minutes,
- 100% patients were taken to the correct drop off location.

Competent staff

All staff received a thorough induction period and were reviewed again at six and 12-month intervals. Staff were required to receive an annual appraisal at which point themes were revisited; for example, duty of candour and safeguarding referrals. This was also an opportunity for the service to consider development needs. The service had 100% compliance rates for appraisals. New staff were put on the rota with experienced staff to support the induction period and had access to a mentor.

During the appraisal themes such as completion of patient record forms were considered looking at training and development needs for staff. Managers told us that assurance was gained about staff competencies by the completion of an online test, workbook and observational shifts.

Staff were required to complete refresher training following their first year of employment, including supporting patients with mental health needs.

The service did not undertake emergency work so therefore staff did not receive training for high risk events. The service would reconsider this should the nature of their work change as planned.

The service ensured that staff received their meal breaks in line with the working time arrangements guidance which staff we spoke to confirmed.

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The service ensured that staff received a de-brief following any serious incidents.

Although staff received regular informal supervision and felt well supported by their duty managers, the service did not utilise formal supervision following the first year of employment. The service did not employ an external occupational health service.

Multidisciplinary working

The service worked well with the mental health foundation trust and planned to commence engagement meetings to further benefit the work. Communication was effective specifically at the point of referral where account was taken of special notes, do not attempt cardiopulmonary resuscitation and mental health transfer documents.

Management told us that staff engage well with staff on the wards and have built up good working relationships.

We observed good rapport between managers and ambulance staff during the inspection.

Health promotion

The service did not describe any actions they took regarding health promotion of patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy regarding the Mental Health Act, 1983, The Mental Capacity Act, 2005, and Deprivation of Liberty Safeguards which was available for all staff. Training in these areas was undertaken during the induction period.

We saw that staff were aware of the need to gain consent from patients before commencing a journey. Staff introduced themselves to patients and checked whether the patient was consenting; this was documented on the patient records.

Of the 15 patient records checked all reflected that at the beginning of each journey, staff recorded the legal status of each patient. Staff also recorded whether patients who were not detained were aware of the purpose of the journey and agreed to the transfer.

The 15 mental health patient records that we checked did not indicate that physical interventions to restrain patients had been used at any time and the service confirmed they do not use mechanical restraint such as handcuffs.

Are patient transport services caring?

Not sufficient evidence to rate



We have not rated 'caring' due to limited evidence available.

Compassionate care

We spoke to one patient during the inspection who told us that the care received was 'excellent and second to none'. The patient described being made to feel at ease and staff were very caring. The patient felt that their individual needs were met and felt comfortable asking questions of staff.

The comment cards that we reviewed all indicated positive responses to questions such as did staff introduce themselves.

Emotional support

The mental health records we reviewed indicated that staff provided emotional support to patients and aimed to reduce any anxiety and distress by reassuring patients and talking to them calmly.

Understanding and involvement of patients and those close to them

The service had a policy of saying to patients 'hello my name is'. The patient we spoke to and the feedback cards confirmed that staff always introduced themselves.

Staff told us that they would liaise with patient's family members and the ward staff to find out how best to communicate with a patient and check their level of understanding.

The patient we spoke to told us that staff talked to theme throughout the journey and they were aware of his condition.

Are patient transport services responsive to people's needs?

Good



Service delivery to meet the needs of local people

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The service had equipped itself with a dedicated ambulance within the last year to meet the needs of patients with mental health needs. The ambulance had a secure 'cell' within the vehicle.

The service had successfully secured a contract with the local mental health foundation trusts from July 2018. The contract operated between midday and 10pm, Monday to Friday. We spoke to the team manager for the trust who confirmed that the service was open and transparent with good communication. The trust said that patients were happy with the service provided and staff interacted very well with ward staff and patients.

The service was developing a 'complex needs policy' which was awaiting sign off.

Meeting people's individual needs

The service employed a small team of regular staff which allowed continuity of staff for patients being transferred.

The service did not access translation services; staff used google translate to communicate with patients for whom English was not their first language.

Ambulance staff provided personalised care to people with mental distress. Records showed that where patients were distressed due to their mental health, accompanying ambulance staff spoke with patients and provided reassurance along the journey.

Most records showed that staff providing assurance in this way helped to calm patients and most journeys were incident free. In some cases, where staff interventions did not assist calming the patient, staff made records of observations, continued with their attempts to reassure and calm the patient and tried different approaches. Staff received training regarding de-escalation techniques for violent or aggressive patients.

The service took account of patients' individual needs at the point of booking and any special requirements documented. There was a section to highlight where patients had extra needs such as communication difficulties, learning disability or sensory impairment.

However, staff were unable to provide any examples of where they had made reasonable adjustments to take account of special requirements.

Learning from complaints and concerns

The service had not received any complaints in the last 12 months (October 2017 – September 2018).

The service gave patients a complaints/compliments feedback card that was easy to understand with clear details on how to contact the service. The feedback cards included questions such as whether staff were on time, and whether they introduced themselves. We saw that all the feedback received was positive and this was shared on the messaging application so that all staff were aware of positive feedback received about the service.

However, the service recognised the need to improve its system for collecting feedback and were establishing a new process to send out feedback letters to all patients.

Are patient transport services well-led?

Good



Leadership of service

The service employed a managing director and a director of operations, resource manager, clinical performance manager and fleet manager. However, the director of operations left shortly after the inspection. The service was supported by an external human resources director who acted as a consultant, providing advice to the managing director.

The clinical performance manager had been in post for one year and this role assisted the service to improve leadership and quality following the last inspection. The role encompassed direct line management of care ambulance staff and delivery of training.

Managers were encouraged to undertake external training to assist their roles. The registered manager was being funded to undertake further education which included modules in leadership and management.

Managers told us their leadership strategy was to ensure that managers and staff were suitably qualified to deliver a safe service. Managers told us that staff were provided with the relevant training and supported to do their jobs well.

Vision and strategy for this service

The service had a clear strategy for 2018 which reflected their three high level priorities. The priorities were to secure the mental health contract, to launch the emergency care

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traineeship and to work towards becoming a sub-contractor for a different ambulance service. Two of the three priorities had been achieved with active work on-going for the third.

The service was focussed on being able to bid for more work covering the winter pressures and had put plans in place to achieve this.

In line with the strategy the service concentrated on organisational and commercial continuity planning. The service aimed to stabilise the company for example by securing further contracts. This would allow increases in staffing establishment and to offer staff permanent contracts and security. Staff were aware and engaged in the strategy and were motivated to work towards achieving the priorities.

Culture within the service

During the inspection it was clear the service operated an inclusive culture. Staff told us they enjoyed working for the service and that managers were present and visible. Both the director of operations and the clinical performance manager were paramedics and regularly accompanied staff on patient transfers. This allowed staff to observe management adhering to policies and procedures and leading by example.

The service had clear organisational values which included:

- providing a safe, patient centred service
- embrace integrity and diversity
- show patients courtesy and respect
- promote informed good practice
- to provide a responsive service
- to provide a learning environment for staff.

These values were evident during the inspection for example, staff were actively engaged in the learning programme delivered by the service.

Staff reported that morale was high within the service and felt happy in their roles. Issues relating to individual staff and impact on culture was acknowledged and addressed by management satisfactorily.

Staff felt that the care provided by the organisation was excellent with staff putting their 'heart and soul' into the business.

We saw that positive feedback was communicated via an application on smart phones and hand held electronic devices. Staff reported this improved moral and a way for the whole team to be made aware of good practice.

Duty of candour was a regulation requiring providers to ensure they are open and transparent when things go wrong regarding care and treatment. All staff were aware of duty of candour and this was covered in the staff induction programme.

Governance

The service operated a rigorous recruitment process at both management and ambulance care assistant level and there was a policy and procedure in place. The service employed three bank staff and confirmed that the governance remained the same as for substantive staff. For private events which were not covered by the regulations, the service used paramedics employed by external companies. The human resources management ensured that such staff were registered with the health care professional's council.

The service held a monthly clinical governance meeting where performance targets and clinical quality standards were discussed and actions agreed.

The service developed a live dashboard to record incidents, investigations and lessons learned which were discussed at the monthly management meeting. We observed the dashboard and could see clearly that this ensured managers had an overview of the service.

'Fit and proper persons' was a regulation that placed a duty on providers to ensure directors meet several requirements to undertake the role. During the inspection we saw that the service had a fit and proper persons policy and that the requirement was met.

Management of risk, issues and performance

The service held a risk management policy and risk register; risks were discussed at the monthly governance meeting. Each risk had a person responsible with target dates and actions attached. There were no risks on the register longer than 12 months. Management told us that the top current risks were winter pressures; specifically, resource and capacity within the service. This was managed in several ways including 'winterising' the vehicles and employing a fleet manager. The service had captured three years of information to gain an

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understanding of fluctuating demand. For example, the information showed that April and May tend to be quieter months so the service could focus on staff training and development.

A further key pressure was the difficulty in balancing staff levels against demand. To manage this the service developed a monthly recruitment schedule and cycle of assessment days.

An area of risk that had previously been acknowledged by management included job safety analysis and risk assessments for patient transfers. The service had already put in place actions to address these risks such as improved risk assessments and audits of the patient transfer records.

The service secured a contract with a mental health foundation trust from June 2018 and sent them weekly performance figures to benchmark against the contract. Managers told us they were in continuous communication with the trust and reported positive feedback about the service provided by Manone.

However, we found that management did not acknowledge that the lack of a clear policy around their use of control and restraint was a potential risk.

Information Management

The service used a live dashboard system to capture data around performance and the information was used to improve quality. For example, the service improved the quality of the patient record forms following analysis of audits. The dashboard also included a flag to ensure that notifications were sent to the relevant external body such as the local authority or the Care Quality Commission.

The service had several key performance indicators including welfare breaks recorded. The most recent results showed that all patients were offered a comfort break for journeys over three hours long.

The service disposed of confidential waste using a shredder at the head office. The paper copy patient record forms were stored according to job type for example mental health in a locked cabinet at the head office. The service aimed to move to fully electronic record keeping following the current pilot.

The ambulances did not have a locked cupboard for records or handheld electronic devices. Staff told us that items would be placed in the glove box and the vehicle locked.

Public and staff engagement

The company was a small service and therefore did not undertake any public engagement.

Managers told us they engaged with staff regarding the organisation and any changes. Managers told staff they were committed to procuring work to provide stability and job security. Managers talked to staff daily through the use of telephone calls, the messaging application and accompanied them on patient transfers.

We saw that managers were transparent with staff and we observed positive communication between management and staff on the telephone. Staff could describe changes within the organisation and the rationale. Staff were enthusiastic about the changes ahead regarding undertaking urgent and emergency work.

Managers responded to staff feedback and took actions to address, for example ensuring the correct equipment for repatriation work was always available in the vehicle.

The service offered an informal workplace listening service and did make use of external occupational health services when required.

Innovation, improvement and sustainability

It was evident that the service was focussed on continually evolving to meet the requirements of securing extra services and contracts. The service looked at how they could procure further block contracts to ensure sustainability. To develop the business, investment was focussed on the fleet, information technology and staff development.

The service aimed to increase its staffing establishment to 20 full time employees and had set up a training pathway to enable the service to deliver urgent and emergency care within the next year.

The inspection found that the service was innovative regarding their use of information technology. Managers ensured that staff had access to handheld electronic devices to remain in contact with colleagues and duty manager; and messaging applications were downloaded

Patient transport services (PTS)

onto personal mobile telephones to effectively keep in touch. The service used an interactive satellite navigation system to monitor location of the vehicles and local traffic and weather.

The service aimed to go fully electronic. This included all policies and procedures and electronic patient record forms being accessed instantly. The portal also included all forms such as incident reporting forms and risk assessments.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

We found the following areas for improvement during the inspection:

Action the provider SHOULD take to improve

- The provider should ensure lessons learned and actions plans to improve standards following incidents are communicated effectively to all staff at all times.
- The provider should consider obtaining locked cupboards in the ambulances for secure storage of records.
- The service should consider ways to meet individual needs of patients, for example regarding culture and faith, people with dementia, people with mobility needs.