BM Ambulance Service Ltd

BM Ambulance Service

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

We rated this service as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment and assessed patients' food and drink requirements. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Minutes of senior management and clinical team meetings were paper based. This limited staff to access the minutes from one location only and did not align with the service's objective of moving to a paper-less system.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	We rated this service as good. See the overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to BM Ambulance Service

BM Ambulance Service is operated by BM Ambulance Service Ltd. The service opened this location in 2017. It is an independent ambulance service in Ashford, Kent. The service primarily serves the communities of Kent and the surrounding counties. The service provides non-emergency patient transport and repatriations to and from Europe (self-funding and through insurance), and medical cover at events to private organisations. We inspected the non-emergency patient transport service that included self-funded repatriations using our comprehensive inspection methodology. We carried out a short notice announced inspection on 21 June 2021.

The service provides a patient transport service. This service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC regulates the patient transport service and treatment of disease, disorder and injury service provided by Primary Ambulance Services. The other services provided are not regulated by CQC as they do not fall into the CQC scope of regulation. The areas of Primary Ambulance service that we do not regulate are events cover and repatriations made on behalf of service users by their employer, a government department or an insurance provider with whom the service users hold an insurance policy.

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

The provider is registered to provide the following regulated activities:

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

The registered manager had been in post since registering with the Care Quality Commission in July 2016 which continued to this location in November 2017. Registered managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The provider employed 12 staff and worked with 70 staff on self-employed contracts. Staff included ambulance care assistants, emergency care assistants, paramedics, technicians, management and administrators. The fleet consisted of seven patient transport vehicles and between 1 May 2020 and 1 May 2021, the service provided 13,800 patient journeys. Of these, 13,200 were on behalf of their commissioning providers to NHS trusts and care facilities, 480 were high dependency transfers between local hospitals and 120 were for private clients.

Track record on safety:

- Zero never events
- 86 incidents; 48 clinical (no harm and zero deaths) and 38 non-clinical
- 11 complaints; 11 upheld

This is the first inspection of this location. The provider had 48 hours' notice of our visit to ensure staff would be available to give us access to the site, vehicles and observe routine activity.

Summary of this inspection

How we carried out this inspection

The team that inspected this location comprised of a CQC inspector and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

We reviewed information we had about the provider before the inspection. During the inspection, we spoke with all three members of the management team and five staff including the patient transport crew, vehicle management and administrative staff. We observed routine activity and reviewed documents, records, staff, patient and relative feedback kept by the provider. We inspected two vehicles. After the inspection, we reviewed further information the provider gave us.

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 trust 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 consider better access to their senior management and clinical team meetings minutes.

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

We rated safe as good.

Mandatory training

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

Staff received training when they started working with the service. All staff were up-to-date with their mandatory training. The training consisted of infection prevention and control, manual handing, mental health awareness, equality and diversity, safeguarding adults level 2, medical gases (O2 only), adult basic life support, information governance, mental capacity act and deprivation of liberty safeguards (DoLS) and clinical waste management. Mandatory training was delivered through a mixture of e-learning and face-to-face training have re-started since these were stopped during the peak of the pandemic.

The operations manager monitored mandatory training and alerted staff when they needed to update it. Staff found the training easy to access and were pro-active in ensuring their own training was up-to-date. Staff confirmed they received protected time to complete mandatory training. The operations manager recognised that some staff would have received training in many of the mandatory training topics from their main employer or from other providers. In these cases, the provider recognised and accepted evidence of this. The registered manager and operations managers worked alongside staff on a daily basis. This gave them the assurance that staff understood and followed the service's policies and procedures.

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.

The service had an up-to-date policy for safeguarding adults and children which complied with national legislation. The policy was clear with key contact details and had easy to follow charts showing staff how to report any concerns.

Good

Patient transport services

The service had arrangements to safeguard adults and children from abuse and neglect that reflected relevant legislation and local requirements. Eligible staff received training in adult safeguarding level 2 and children safeguarding level 1 even though the provider did not work directly with children. This was in line with the intercollegiate safeguarding guidelines. Records showed 100% of eligible staff had completed this training.

Staff had a clear understanding about what constituted abuse and the need to report this. They understood their responsibilities in line with the safeguarding policies and procedures, including working in partnership with other agencies. For example, staff would contact the police if they believed there was immediate danger. Staff also described examples of how they ensured the safety of adults at risk which constituted a safeguarding referral.

Staff said they would contact the local safeguarding team if they needed advice or support. This meant they had access to a level 3 trained professional.

The service promoted safe recruitment practices. All new recruits were subject to an enhanced disclosure and barring service check (DBS) and required two references before they could work operationally. The service also required the DBS to be updated every three years for staff in post.

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 premises visibly clean.

The provider had effective infection prevention and control systems and processes at the start and during the pandemic. We saw policies and procedures were reviewed and updated in line with national guidance. For example, social distancing in vehicles and the use and supply of personal protective equipment including donning and doffing and fit testing of masks. The provider made changes to the office layout and offered staff the option of working from home, to enable social distancing. Staff told us they had set heating ventilation and air condition in vehicles to extract and no recirculation to minimise the spread of infection.

During the pandemic, the service had the resources to obtain and reliable access to personal protective equipment and COVID-19 tests for staff and, where appropriate, for people who use the service. Managers told us staff would self-isolate if they showed any symptoms or tested positive. In the last 12 months, three staff had returned to work after a period of self-isolation.

Staff followed an up-to-date infection prevention and control policy and all staff were trained in infection control and prevention as part of their mandatory training.

Staff always kept vehicles and equipment clean. Staff completed a daily pre-work checklist prior to starting their shift. Cleaning records were up-to-date and demonstrated that the vehicles were cleaned daily. This included ensuring the vehicle interior was clean and disinfected as relevant and the exterior was clean including windows, mirrors and lights. Staff deep cleaned the vehicles on a 12-week cycle. There was clear guidance for what staff had to clean and how they could carry this out to ensure deep cleans happened as planned and when required.

We checked two ambulance vehicles and found they were both visibly clean and tidy. The vehicles were fitted with antibacterial hand gel dispensers and these were full and functional. They were well stocked with cleaning products and clean linen. Linen such as blankets, sheets and pillowcases were laundered after single use at the relevant hospital.

The cleaning station was visibly clean and tidy with the appropriate cleaning equipment. Mops were stored and colour coded in line with national guidance. This reduced the risk of cross infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff with PPE such as masks, gloves and aprons. These were stored on all vehicles and at the location. We observed staff wearing masks in the vehicles and in an open plan office.

We observed staff in uniforms complied with the Department of Health's guidance relating to arms "bare below the elbows". All staff were issued with a uniform. Staff were responsible for keeping these clean in line with the service's infection prevention and control policy.

Spill kits were available on all ambulances. This meant staff were able to manage any small spillages and reduce the infection risk to other patients.

There were systems to monitor compliance with infection control practices. The service carried out daily observational audits during work alongside staff members. Recent audit results showed a few staff did not wear masks in the vehicles. We saw the provider had one-to-one conversations with those staff and reminded all staff the importance of wearing masks in their private group communication. We also saw notices clearly displayed in all the vehicles to remind staff. This gave the provider assurance that staff had complied with infection prevention control policies and procedures.

Environment and equipment

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

The premises were secure, supported by a closed-circuit television system and coded entry locks. Administrative and staff files and other documents were stored securely in the office on the first floor. Only authorised staff had access to the office using a coded entry system. Ambulance keys were stored in locked cupboards. The master key to the cupboard was kept in a digitally locked safe.

Each ambulance had an allocated folder containing up-to-date information about the insurance, servicing and ministry of transport test (MOT). This was supported by an electronic fleet management system which was linked to satellite navigation devices fitted to each vehicle.

The storage areas in the premises were clean and tidy. The provider completed weekly stock checks. All equipment we checked had a sticker confirming it had been tested in the last 12 months and was safe to use.

Records showed the equipment in the ambulances was checked and tested daily and supplies topped up as needed. Stock was kept in the ambulance stations and staff collected items as needed to ensure the ambulance had the correct stock on board. All the ambulances we checked had the correct stock on board.

The provider promoted fire safety. Fire extinguishers were available in all vehicles. They had been safety checked in the last 12 months and were clearly marked with the next service test date. The premises had clearly marked fire exit routes to be used in the event of a fire. There was a break glass fire alarm system. Records showed the fire alarm system was tested twice yearly and had been tested in the month before inspection.

All sharps bins, that were in use, were correctly assembled and safely disposed. This was important to protect staff and patients from injury by sharp objects such as needles. This practice was in line with Health Technical Memorandum (HTM) 07-01: safe management of health care waste.

All clinical and non-clinical waste was correctly separated into different coloured bags. Clinical waste was securely stored in locked bins while awaiting collection for disposal.

Assessing and responding to patient risk

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

The service carried out basic risk assessments before confirming they would transport patients at the time of the booking. The criteria for accepting a booking was that the patient was for a non-emergency transfer and required no medical intervention. They also considered and completed individual risk assessments on all other needs such as patients with mental health concerns, infections, mobility and access to their homes.

The provider also transported high dependency patients for the local hospital within the locations they operate. These patients were accompanied by a qualified healthcare professional provided by their commissioning provider or the service's staff.

Staff described how they would respond to any patient feeling unwell. Vehicles carried oxygen administered by paramedics for high dependency transfers and monitoring equipment, and staff used these as part of their first aid skills. A crew would stop and call 999 for urgent medical attention if they believed that a patient in their care had deteriorated beyond first aid. All staff we spoke to were trained in basic life support. Records showed 100% of eligible staff had completed basic life support in the last 12 months.

Staff had a direct number to the duty manager on call for any emergencies out of hours. Staff knew how to escalate concerns when working out of hours.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave their staff including those who were self-employed a full induction.

The service employed 12 members of staff and 70 self-employed staff. These included senior management, base leaders, supervisors, practice educators, paramedics, emergency medical technicians, emergency care assistants and ambulance care assistants.

The provider used electronic systems to help with resourcing, rostering and billing. Managers and staff were positive about the systems. For example, staff could securely access the rostering system from any mobile phone or home computer.

The operations manager regularly reviewed and adjusted staffing levels and skill mix. There was enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care. Staff records showed all staff had received a full induction when they started work.

The service did not use agency or bank staff but used the self-employed staff and the existing internal team who worked additional shifts on overtime or flexibly where required. Staff could request to work additional shifts to cover situations such as staff sickness and annual leave. The service would not accept a short notice booking if they could not supply two members of staff.

Staff told us they were allocated time for rest and meal breaks.

Staff files contained up-to-date work histories and references. They were easy to navigate, reviewed and organised. There was a lone working policy to ensure staff safety even though staff always worked in a crew of two.

All eligible staff had valid enhanced disclosure and barring service (DBS) and healthcare professional register checks. This was in line with safe recruitment practices and the service's recruitment policy.

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.

Staff recorded key patient information when completing individual booking forms. They recorded details of multiple journeys on a daily job sheet. This gave crews all the relevant information to enable them to do their jobs safely. Crews received booking forms and daily job sheets at the base before they started their shifts. They included information such as collection and drop off times, addresses and information about a patient's needs. Information was securely stored in a locked compartment in the vehicle, keeping patient confidentiality.

The service stored patient records securely in a locked cupboard in the office. Completed booking forms and daily job sheets were returned to a different folder in the locked cupboard when the crew returned to base. The operations manager collected these for review, invoicing and filing.

Staff personnel files were stored in a locked cabinet in the office. Only authorised staff had access to the files to ensure staff confidentiality was kept.

The service ensured that up-to-date 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders and end of life care planning was appropriately recorded and communicated.

If a patient received treatment for high dependency transfers, staff completed patient report forms (PRFs). This is in line with the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines. Staff stored completed PRFs securely on an ambulance in the cab area, which they kept locked when the ambulance was unattended. We saw completed PRFs securely kept within locked cupboards in the office. The senior management team had access to the key which was kept in a separate locked cupboard bolted on the wall.

The service audited every PRF record informally and would discuss any learning with the staff. The director provided feedback to the staff on both the content of the PRF and the care they provided to patients.

Staff personnel files were stored in a locked cupboard in the office. Authorised access to these files were limited to the registered manager and human resource director, to ensure they kept staff confidentiality.

Medicines

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

The provider used their medicines management policy for the ordering, receipt, storage, administration and disposal of medicines.

The service stored medical gases safely.

A medicine bag was available on the high dependency ambulance, which was staffed by a paramedic and an emergency care assistant. The high dependency ambulance transported patients with more complex needs, who may require support from trained staff during their journey.

There was a tagging system in use for ambulance medicines bags. We checked the medicine bags and all medicines were in date. Medicine bag tags were kept securely to ensure the bags could not be tampered with and only authorised staff could access the tags. Staff completed daily checks to ensure they had the correct medicines on their vehicle. Paramedics and ambulance technicians recorded medicines administrations on a log kept within the medicine bag and the patient report forms. The administration record contained the name of the paramedic or technician accountable for the administration and the medicine name.

Medicines were stored safely and securely. Records showed medicines were stored within their recommended temperature ranges and staff took appropriate action when the temperature was outside the recommended range.

The local medicines management policy contained guidance about which medicines different staff grades could administer dependent on their role and scope of practice. Patient group directions (PGDs) allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This ensured that patients had safe and quick access to the medicines they needed. However, some of the PGDs were not in line with the legislation. We raised this concern with the provider who took immediate action to address it. They changed the entry codes to the two medicine safes and re-issued the new codes when they had obtained signatures from the named healthcare professionals for the PGDs.

The service did not use controlled drugs (CDs). CDs are a group of medicines that require special storage and recording arrangements due to their potential for misuse.

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, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support.

There was an up-to-date incident reporting policy for staff to report accidents, incidents and near misses. The service reported 86 no harm incidents from 1 May 2020 to 1 May 2021. Of these, 48 incidents were clinical incidents and 38 were non-clinical. There were no serious incidents reported within this period.

Staff reported any incidents to the senior management team. We saw evidence of learning from incidents and staff could give examples of change happening as the result of an incident. Staff who were not directly involved in the incident could describe the nature and learning from the incident. This demonstrated a good incident reporting and learning culture within the service.

Good

Patient transport services

We reviewed the service's incident log and found there was differentiation made between serious incidents, incidents, near misses, complaints and safeguarding related concerns. This meant the service could assess and analyse incidents or identify themes and trends, or areas for improvement.

The service had a duty of candour policy that clearly described the purpose and process. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff clearly described the process of being open and transparent. Staff understood their responsibilities to be open and honest with people if things went wrong and to immediately seek support from their manager if a patient experienced avoidable harm.

Are Patient transport services effective?

Good

We rated effective 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.

The service followed evidence-based practice, regulatory requirements and up to date guidelines such as the National Institute for Health and Care Excellence (NICE). These were embedded in the provider's policies and procedures.

Staff could access all policies and procedures on an electronic format. This was issued to each employee at the start of their employment. We saw staff followed the service's policies to carry out their roles. For example, staff would not transport a medically unwell patient, or they knew the process to report any safeguarding concerns.

Nutrition and hydration

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

The service made sure a patient's food and drink requirements are met during longer journeys and in repatriations. They assessed each patient's needs at the time of booking, and staff ensured vehicles were stocked with a choice of water or soft drinks and sandwiches or snacks. They also considered a patient's specific request if required.

Response times

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

Good

Patient transport services

The service had systems to monitor response times even though they did not have contracts with their commissioning providers. Managers told us they met their response times. Staff recorded the time they left base, the time they arrived at the destination to pick up the patient, the time they left to transport the patient to their destination and the time of arrival at the destination. Staff also recorded subsequent timings in relation to waiting and returning as appropriate, to the next job, or back to base.

Staff contacted the commissioning provider immediately in the event of any delays which might make them late in picking up patients for their journey, such as heavy traffic or road closures.

The operations manager had oversight of response times and regularly reviewed the information to make improvements. They used the information to help with planning bookings. For example, they left enough time in between all patient transport journeys to allow for unexpected delays. This ensured any delays did not impact on bookings later the same day. The operations manager had not found any concerns in relation to response times.

The service received no complaints about response times in the last 12 months.

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.

The service ensured all staff could perform their roles safely and competently. All staff received information on the company structures and processes of their working environment. All new staff received a comprehensive induction in line with the service's recruitment policy. The induction programme covered knowledge of company procedures and policies, infection prevention and control, manual handling, clinical skills, equipment use and documentation. Records showed all staff had completed their induction. Staff we interviewed told us they received a detailed induction which gave them the knowledge, skills and confidence to carry out their roles.

The service completed driver and vehicle licensing agency checks for eligible staff before the commencement of their employment. All staff who were drivers completed a driving assessment on commencement of employment. Staff knew the need to notify managers of any changes to their license in line with the driving standards policy. There were arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. Any risks identified during the assessment could be addressed immediately. Staff would inform managers if they had a concern about the standard of a driver they worked alongside.

All staff received a formal assessment of their strengths and weaknesses as part of their yearly appraisal. Records showed 100% of staff had completed appraisals. The service ensured staff only worked within the scope of their qualifications, competence, skills and experience, ensuring this was within the service's policies and procedures. Managers worked shifts alongside staff to assess their adherence to safe practice.

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.

Good

Patient transport services

The service coordinated all transport services and repatriations with the commissioning providers. For hospital discharges and transfers, staff described how they worked closely with the hospitals on every shift, for example, by contacting the clinical support desk. Staff had positive relationships with the clinical advisors and hospital managers. This enabled effective handovers when they transported patients to and from hospitals. Managers explained they had regular informal discussions with liaison managers from each commissioning provider.

Staff reported handovers between themselves and hospital staff were effective.

Staff telephoned care providers if there was a delay with the transfer of a patient or an issue that needed to be resolved, such as confirmation of a care plan.

The service worked with different agencies such as local care providers and repatriation companies when they repatriated patients from another country.

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.

All staff had received training about the Mental Capacity Act 2005. Staff we spoke with showed awareness and understanding of the Mental Capacity Act 2005 code of practice and consent processes. They described how they would support and talk with patients who initially refused care or transport. For example, they would seek verbal consent from patients before transporting them, before any observations and before they fastened their seatbelts. Staff would also involve a patient's family and/or carers if they had concerns.

Staff checked all patient information, including if there was a DNACPR (Do not attempt cardio-pulmonary resuscitation) decision/document. Patient report forms showed crews used best interests' decision forms to document the best interests decision-making process when required. This complied with national guidance and the Mental Capacity Act 2005.

Are Patient transport services caring?

Good

We rated caring as good.

Compassionate care

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

We reviewed feedback the service received from patients and their relatives. They were all positive with appreciative comments about the service patients and relatives had received and the caring attitude of staff. The feedback we saw demonstrated kind and compassionate staff.

Some examples of comments were; “Thank you for treating my son with great compassion and loving kindness, want to thank you from the bottom of our hearts”, “ Ambulance crew were excellent, very understanding to my needs and wonderful bedside manner” and “I am a nurse and I was transferring a patient to another hospital. Two great guys! They went out of their way to ensure our safe arrival and they also gave me a lift back to the hospital I work in. Cannot thank these guys enough. Massive thanks”, “Super nice, great service” and “caring and friendly, journey was most enjoyable”. Staff showed they took the required time to engage with patients, were warm and empathetic. They communicated in a respectful and caring way. They also always considered the patients’ individual wishes; an example comment about a European repatriation was; “we were absolutely beside ourselves with worry and grief. Staff were absolutely wonderful from start to finish keeping us informed all the way. They showed my sister videos and photos from us and played her favourite music all the way home”.

Staff maintained patients’ privacy and dignity. Patients conveyed were covered in a blanket to maintain their modesty and to keep them warm while on a stretcher or in a wheelchair. Staff described how they would maintain patient privacy and dignity, especially when moving patients through public areas.

Patients living with dementia or a disability could have a relative or carer with them while being transported whenever possible. All staff we spoke with were passionate about their roles and were dedicated in providing excellent care to patients.

We saw posters displayed in staff areas reminding staff on the service’s expectations about delivering excellence and committed care. Staff demonstrated a good understanding of these principles and gave examples where they provided good care.

Emotional support

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

We reviewed patient feedback the service received in the last 12 months and records showed all patients were overwhelmingly positive about the emotional support staff had provided. Comments included, “Great crew, many thanks. I was very scared, but the crew were so calming and caring I was able to relax, couldn’t have been more helpful!”.

Staff knew about the need to support family or other patients should a patient become distressed during a journey. Patient report forms showed staff checked on patients’ wellbeing such as physical pain and discomfort, and emotional wellbeing during their journey. Staff described a time when they dealt with a care home patient who refused to leave. Staff gently and appropriately encouraged them to leave, explained the reasons but respected their decision and agreed to come back the next day to try again.

Staff showed an understanding of how to care for patients with different needs such as religious, language and cultural needs. For example, they had access to communication cards and language translation applications.

Understanding and involvement of patients and those close to them

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

Good

Patient transport services

We saw from the patient report forms staff involved patients and relatives in decisions about their care and transport. Crews gave clear explanation of what they were going to do with patients and the reasons for it. Staff checked with patients to ensure they understood and agreed. They explained they encouraged family members and carers to accompany patients during the journey, if required. Feedback from patients showed they were fully informed of any delays and always had their questions answered.

Staff told us they provided clear information to patients about their journey and informed them of any delays. Patients commented having confidence in the staff providing their care, and patients were involved as much as possible when planning their journey to and from the hospital.

Staff said they asked permission to enter the patients' home, when they collected patients from their homes to take them to hospitals.

Staff told us they showed respect towards relatives and carers of patients and knew about their needs; explaining in a way they could understand to allow them to support their relative. Relatives commented they appreciated how caring and attentive staff were when they delivered patients home safely.

Are Patient transport services responsive?

Good

We rated responsive 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.

The service undertook 13,800 transport journeys from 1 May 2020 to 1 May 2021. The operations manager ensured there were enough vehicles and crew numbers that met the needs of local people. They offered a variety of patient transport services such as transfers to or discharges from hospital including high dependency transfers between hospitals, outpatient appointments, transport between care homes and self-funded repatriations.

The service had two core elements; pre-planned patient transport services and unplanned services to meet the needs of patients. The service's core operational hours ran from 8am to 8pm, seven days a week. Staff could work outside these hours.

The service responded quickly to on the day telephone bookings. The operations manager identified which drivers were free or had finished jobs and were nearest for the next job. We observed effective communication between the operations manager, individuals and providers who made bookings. The feedback from patients and their relatives demonstrated the service was good at responding to planned and short notice bookings.

All the ambulances were equipped with tracking devices. The service had the ability to monitor the locations of its vehicles and to identify where they were. They also had the ability to monitor the hours crews had driven to ensure they took appropriate breaks. Staff felt satisfied they often managed to take breaks and managers encouraged them to do so.

Good

Patient transport services

Meeting people's individual needs

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

The operations manager pre-assessed all patients for eligibility of patient transport service. Staff received all relevant information at the start of their shifts to enable them to meet a patient's individual needs. The pre-assessment took account of all aspects of the patient, the journey and the environment. This included the level of support required, the person's destination set-up, communication needs and family circumstances.

Staff had access to communication aids such as electronic applications containing pictorial aids and a translation tool to help them communicate with patients whose first language was not English, people with a disability or had sensory loss. This was in line with the Accessible Information Standard which the government introduced in 2016 to make sure people with a disability or sensory loss were given information in a way they could understand. The service encouraged a relative or carer to accompany patients who were unable to speak due to their medical condition or who had complex needs. This helped communications with patients who were not able to understand or explain their needs.

The service had one ambulance equipped with a bariatric stretcher and other specialist equipment to support bariatric patients. Bariatrics is a branch of medicine that deals with the treatment, prevention and causes of excessive body weight.

For patients living with dementia and those with reduced mental capacity their support needs were assessed at the point of booking. There was seating in the ambulances to allow an additional person to travel with the patient.

The service met patients' individual needs, including cultural and religious. For example, they provided time for patients to pray if needed on long distance journeys and factored in time if patients required to use multi faith rooms at airports when repatriating patients. Staff told us that they made toilet stops for patients when required. The service also had equipment available on board the vehicles to meet toileting needs.

Ambulances had different points of entry, including sliding doors, steps and tailgates so that people who were ambulant or in wheelchairs could enter safely. Staff told us they would transport a patient in their own wheelchair if possible, rather than transferring them to a trolley, so they were more comfortable.

We saw food and drink were available on board the vehicle for patients transported on longer journeys.

Access and flow

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

The service operated within the core hours of 8am to 8pm every day. They also provided out of hours service when required. Staff carried job sheets which provided them with journey information including the patients' name, date of birth, allergies, pick up point, destination, mobility requirements and any specific requirements based on individual needs.

Good

Patient transport services

Patients had access to timely care and transport. The operations manager calculated all journey times at the time of booking to allocate enough time in between all patient transport journeys to allow for unexpected delays. This ensured any delays did not impact on bookings later the same day.

If a journey was running late the driver would ring ahead to the destination with an estimated time of arrival and keep the patient and the hospital informed. Crews always communicated any potential delays with patients, carers and hospital staff by telephone.

The vehicles and ambulances had direct access to a key motorway which had the potential of delays caused by external factors. This improved access and flow as it helped cut down time required for vehicles to join the motorway.

Managers confirmed that patient transport services although they did high dependency transfers, they did not do emergency transfers or provide critical care, and patients transported were usually clinically stable.

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 had a system for handling, managing and monitoring complaints and concerns. Each ambulance had patient feedback forms available for patients to complete. They had details of how to contact the office and how to complain. Staff knew how to advise a patient if they wished to complain. The service's website had an electronic process for anyone wishing to feedback about their service.

The service's complaint policy outlined the process for dealing with complaints initially by local resolution informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement within three days of receipt followed up by a further letter, once an investigation into the complaint had been made.

The service had received 11 complaints out of 13,800 journeys from 1 May 2020 to 1 May 2021. Ten of the 11 complaints were about poor communication and one complaint was about a crew's driving behaviour. The senior management team had investigated these complaints, took actions to make improvements and shared learning with all staff. For example, they shared learning with staff through regular team messages and provided staff regular training that covered communication.

Are Patient transport services well-led?

Good

We rated well-led as good.

Leadership

Good

Patient transport services

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

The leadership at BM Ambulance consisted of a managing director, human resources director and the operations manager who all worked full time and were also part of the operational team. The registered manager who was the owner and director of the business was responsible for the strategic and operational management of the overall service. They had been in post since 2016 and was fully aware of the Care Quality Commission registration requirements and the essential standards Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operations manager was responsible for all patient transport related activity. They ensured full delivery on agreed bookings while taking ownership of maintaining clinical standards and management of the team. There was a human resource director who led on staff welfare and governance. The clinical director jointly worked with the operations manager and was responsible for implementing and maintaining the clinical standards including medicine management.

All staff spoke highly of the leadership and culture at the service. Staff felt comfortable to raise any concerns they had with the senior management team. We observed senior managers were calm, supportive and provided clear direction when staff had telephoned to raise concerns. Staff said senior managers were always visible at base and through telephone when needed.

Senior managers showed an understanding of the risks to the service. The senior management team meeting minutes, although paper-based, demonstrated an ongoing oversite of quality and governance issues such as policies, risk management and human resources.

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 provider had a written statement of vision which was “delivery excellence, committed to care”. The service aimed to provide the highest quality patient transport service to each of their customers, without favour, while paying attention to patients’ comfort, their dignity and their (or our) individual safety. The provider’s vision was printed on their website. Staff clearly demonstrated the service’s values which were to provide an excellent and caring service.

The senior management team had a good understanding of the commercial aspect of the patient transport service, ensuring they remained sustainable and competitive. The leadership team regularly worked alongside staff. This gave them the opportunity to ensure staff displayed the provider’s vision and values in practice. Staff appraisals incorporated the service’s values as a key performance area which provided staff the focus on achieving the service’s vision.

The service strategy was to develop and improve the quality of service. The registered manager was actively looking for opportunities to expand into other geographical areas and diversify the range of commissioning providers to improve sustainability. The human resources director informed us they had plans for service expansion in repatriations outside the United Kingdom.

Good

Patient transport services

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.

Staff described an open and supportive culture where learning and progression was encouraged. Managers anticipated stressful situations and provided support for staff. They provided staff with informal debriefing following stressful shifts.

The senior management team were visible and approachable. They met with staff to discuss any concerns and provided emotional support when required. Staff felt confident to discuss issues knowing senior managers took them seriously and dealt with issues. Staff felt everyone's contribution was valued. The culture was one centred on people's needs and experience, patients or staff.

The service had a system to safeguard the public interest and to promote a culture of accountability and integrity. The service had a freedom to speak up champion. These practices were in line with the service's whistleblowing policy.

Managers provided clear communications to staff about the expected work standards. Staff turnover rate was low, and managers attributed this to the service's supportive and inclusive culture. Staff said they were proud to work for the provider. We observed staff wanted to make a difference to patients and were passionate about performing their roles to a high standard. The feedback from patients was overwhelmingly positive about how staff were caring and committed to doing their best and beyond.

Governance

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

The provider had governance systems that were appropriate and proportionate to the size of the service. The service had a system to identify and manage risks, and they took actions to address the risks. For example, there was an incident reporting process and a comprehensive risk register.

The senior managers had a daily briefing and worked closely alongside all staff. Sharing of information occurred at the briefings. Operational issues were communicated to staff and staff could easily access policies and procedures online. Managers and staff knew and understood the issues as they described them well when they provided examples.

The service used a private group on social media dedicated for all staff to enable easier communication. Ideas and issues about governance were often effectively exchanged through that channel.

The service had embedded processes to assure the registered manager that staff had the appropriate competencies and skills to provide safe care and treatment. They had systems to ensure staff had completed their required mandatory training and to ensure they had up-to-date enhanced disclosure and barring service checks. Staff were clear about their roles and understood what they were accountable for, and to whom. The provider had systems to ensure staff worked within their competence. For example, they carried out risk assessments of patients before accepting bookings and worked alongside staff on a regular basis.

The senior management team held governance meetings covering policies, incidents, safeguarding, risks and issues, audits, logistics, driving standards, education and clinical updates. Although the recording of the meetings was paper based, the leadership team had oversight of governance issues and challenges. Paper recordings of meetings meant access to this was limited to one location and did not align with the service's aim of going paper-less.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service used an electronic reporting system to help managers identify, classify and manage risk. We reviewed the current risk register which contained strategic, organisational and business risks. Each risk had a named lead, details of actions, completion timeline and a risk score. The senior management team regularly reviewed these to identify themes and trends to enable them to manage or minimise the identified risks.

The service carried out audits in areas such as documentation and patient report forms, driving assessments, hand hygiene, personal protective equipment and medicines. The service used information from the audits to improve performance. They also used the information to monitor any potential risks and took actions to address the risks.

The operations manager monitored response times. This provided them with assurance that patients were picked up within the agreed timeframe and providing a timely service. They undertook health and safety risk assessments, documented and stored these appropriately.

Staff would escalate any risks to a senior manager directly by phone or in person. They said a manager was always available to contact when they were operational.

The service had a business continuity plan that provided guidance on what to do in case of emergencies such as severe weather, shortage of staff and severe weather. For example, staff had access to accommodation next to the location if there was severe weather.

Managing information

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

The service demonstrated a holistic view and understanding of performance. The leadership team had oversight of all areas of the service. There were clear service performance measures such as monitoring training compliance which the senior managers monitored and reviewed.

The senior leadership team made sure the information they used to monitor, manage and report quality and performance was accurate, valid, reliable, timely and relevant. All the information we reviewed supported this, such as staff files, patient report forms and mandatory training compliance.

Records showed information governance training formed part of the mandatory training programme and 100% of staff had received this training. Staff showed us how they accessed information on the electronic tablet. Each staff had a unique pass code to use the system ensuring information was kept secure.

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.

The service encouraged patient feedback through paper forms easily accessible on the ambulances or through online reviews. The service's website had the ability for people to give feedback about the service. The reviews we looked at were complimentary about the care and treatment people had received.

Staff received feedback from the senior managers, and managers requested staff feedback at appraisals. The service regularly communicated with staff and encouraged feedback from them. They used technology such as private messaging groups and mobile phone applications to keep in touch with their colleagues.

The service also received feedback through the commissioning providers. The operations manager collated the feedback and shared these with staff.

Senior managers said they had an open-door policy and that staff could approach them at any time. There was a 24 hour on call system that staff could use if they had concerns or issues that needed urgent resolution.

There was a staff notice board in the location's corridor. It had various forms and key information including key contact details for the commissioning providers, blank incident forms, and information regarding safeguarding and duty of candour.

The service used technology such as different social media channels to enable easier engagement with patients and the public.

Learning, continuous improvement and innovation

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

The service had invested in a device to measure the levels of microorganisms such as bacteria in all their ambulances. This device rapidly tests the cleanliness of surfaces in the vehicles and provides the service assurance in addition to their daily cleaning routine. The service carried out monthly tests to minimise and prevent the spread of infection. In the past 12 months, 73 test results showed 38 of these passed, 29 failed and three with caution. The service had carried out deep cleaning of all the vehicles that showed failed and with caution.

The provider was responsive to change and wanted to maintain the company's positive reputation and continue to offer enough work to the staff.

The service took prompt action where issues were found at this inspection. This was supported by our findings at the end of the inspection on the same day and information provided to us after the inspection.