ERS Medical North

Quality Report

Unit 5, Severnside Trading Estate,
Textilose Road, Trafford Park,
Manchester,
Lancashire,
M17 1WA
Tel: 07985 333303
Website: www.ersmedical.co.uk

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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?	Good
Are services well-led?	Good

Overall summary

ERS Medical North is operated by ERS Medical, which in turn is owned by ERS Transition Ltd. The service provides a patient transport service throughout the north of England from five bases: Manchester, Mansfield, Leeds, Crewe and Speke (the crew and vehicles are based within a hospital in Merseyside). There are 38 patient transport vehicles split (by demand) across all five sites. The registered location address is in Trafford, Manchester.

ERS Medical was previously owned by another company which sold the business towards the end of 2017. The new company, ERS Transition Ltd has been registered with the CQC since October 2017.

ERS Medical North provides support to the North West Ambulance Service as required. It also supports several acute hospital trusts across the north of England and provides support for a GP urgent care contract to a GP federation in Leeds.

Summary of findings

ERS Medical North can transport patients detained under the Mental Health Act 2007 in a formal and informal context.

ERS Medical North is registered to provide treatment of disease, disorder or injury, and transport services, triage and medical advice provided remotely. We carried out our inspection between the 18 and 20 September 2018, and 12 February 2019.

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?

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 service protected patients from abuse and harm.
- The service used suitable vehicles and ensured equipment was stored on these safely and securely.
- The service had updated its running sheets to allow clinical handover information to be recorded.
- Patient records were securely stored.
- Disclosure and barring service checks were completed for all staff.
- Staff ensured appropriate paperwork was available when transporting patients detained under the Mental Health Act.
- The service had introduced an updated national training programme for road crews, as well as an updated observational audit to assess the competency of staff.
- The service's policies were up to date.
- The service had introduced systems to monitor the quality and safety of the services provided.
- All staff had completed training that was required to undertake their roles safely. In addition, records indicated that most staff were up to date with mandatory training.
- The service had a clear policy for staff to follow in the event of an emergency. Staff were aware of this and knew what actions to take if needed.
- Staff delivered patient care in a caring and compassionate way. Staff demonstrated an awareness of the need to protect the privacy and dignity of patients.
- Sites had specific business continuity plans.
- Patient feedback was very positive.
- There was a good culture in the organisation, staff felt engaged, and they praised the regional manager.

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

- Patient review forms were inconsistently completed.
- Not all the running sheets we reviewed contained clinical handover information.
- The service did not always record that staff returned uniforms or badges when they left the service.
- The Leeds site did not hold regular staff meetings (albeit that new manager had plans to reintroduce meetings and to increase attendance).

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.

Ann Ford

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good	ERS Medical North provided patient transport service from five bases throughout the north of England. We found the following areas of good practice: • The service protected patients from abuse and harm. • The service had appropriate vehicles for transporting patients and these were well equipped. • The service had updated its running sheets to include a section for staff to record clinical handover information, albeit that this information was not consistently completed • Patient records were securely stored. • Staff ensured appropriate paperwork was available when transporting patients detained under the Mental Health Act. • The service had introduced an updated national training programme for road crews. • The service's policies were up to date. • The service had introduced an updated observational audit to assess the competency of staff. • The service had introduced systems to monitor the risk, quality and safety of the services provided. However, we found the following issues the service provider needs to improve: • Patient review forms were inconsistently completed. • The service did not always record that staff returned uniforms or badges when they left the service. • There were no regular staff meetings at the Leeds site (albeit that new manager had plans to reintroduce meetings and to increase attendance).

Summary of findings

Contents

Good

ERS Medical North

Services we looked at:
Patient transport services

Summary of this inspection

Background to ERS Medical North

ERS Medical North is operated by ERS Medical. The business was sold to ERS Transition Ltd in the autumn of 2017. It is an independent ambulance service with five ambulance bases throughout the north of England. The service has 38 patient transport vehicles, one of which serviced the GP urgent care contract, and approximately 111 operational staff.

The service has had a registered manager in post since October 2017. The current registered manager was in post from August 2018.

Our inspection team

Across the two visits, the teams that inspected the service comprised a CQC lead inspector, four other inspectors including two mental health inspectors, and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about ERS Medical North

The service is registered to provide the following regulated activities:

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

During the inspection, we visited three stations; Mansfield, Leeds and Manchester. Manchester was the registered location address; it contained a crew room, office, welfare facilities and an internal storage area for the vehicles. Leeds was the head office address for ERS Medical and contained the control room staff as well as being a base for the crews. This was a three storey building with staff operating out of the top floor. Mansfield operated from a leased unit in a business park with welfare facilities available in a council run building near to the unit. All sites had secure access to the units, but some vehicles, including those at Mansfield, were parked in an open car park. Vehicles could be driven into an internal bay to be loaded and checked.

The Crewe and Speke sites are located on industrial units and have secure vehicle parking, training rooms and staff welfare facilities.

In total we spoke with 23 staff including; the regional manager, care quality manager, team leaders, human resource manager, ambulance crews, control centre staff and hospital staff. We also spoke with four patients. We received 42 'tell us about your care' comment cards which patients had completed before and during our inspection. We reviewed over 310 sets of patient records including running logs and patient review forms. We also accompanied a crew on one patient journey for the GP urgent care contract.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since it registered with the CQC.

Activity (January 2018 to September 2018)

- There were approximately 40,000 patient transport journeys undertaken, including 180 paediatric transfers.
- The service did not use controlled drugs.

Track record on safety

- Zero Never events.

Summary of this inspection

- Clinical incidents: two no harm, four low harm, seven moderate harm, two severe harm, one death.
- Zero serious incidents.
- 50 complaints reported from February to June 2018.

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

- Staff who worked as mental health crew received training in de-escalation and management of violence and aggression. Staff had received training in the application of handcuffs, but training had not been provided in the use of spit hoods which were in use.
- ERS Medical North had a training prospectus that set out the statutory and mandatory training that all staff had to complete. This included modules in safeguarding adults and children (to level two), "PREVENT" (a government strategy to identify and prevent terrorism), health and safety, infection prevention and control, moving and handling and equality and diversity. All staff that had patient contact also had to undergo mental capacity and consent training.
- At the time of the inspection most staff (80%) were up to date with their mandatory training. The service had introduced mandatory training cards which staff were required to keep so that they were able to evidence that they were up to date with relevant mandatory training modules.
- Staff who worked on the urgent care contract were required to complete modules such as basic life support for adults and children as well as other modules such as information security and moving and handling. Records indicated that both members of staff employed directly by the service were up to date with these.

Safeguarding

- The service had a safeguarding adults and children policy which was available for all staff to access. Staff we spoke with were aware of this policy and knew how to locate it. Staff we spoke with could articulate what a safeguarding incident was and how to report it (via a dedicated incident reporting number).Staff would also call the incident line for advice including what action to take.
- Over 85% of eligible staff had received appropriate safeguarding children training.
- There was a named safeguarding lead for the service (the medical director) who was trained to level four.
- We reviewed how the service dealt with safeguarding incidents. Most of these were dealt with appropriately and a safeguarding referral made to the local authority the same day.
- We saw evidence that one incident had not been recorded as a safeguarding incident when it should have been (albeit that the patient was "safety netted" at the time and returned to a place of safety).This was investigated, and action taken including speaking to the relevant staff member and a making the safeguarding referral. ERS Medical North told us that it had identified a system issue at the time (December 2017) which meant that the operations manager had not been alerted to the incident. We saw evidence that the system had been changed to allow easier recognition of safeguarding alerts.
- Handcuffs and spit hoods were stored in the glove boxes of locked vehicles when not in use. Vehicle keys were also stored securely.

- The provider's policy detailed the need for prior authorisation for use of handcuffs and situations where these may be applied during transport in an emergency. Staff should have completed an authorisation form for this, but we were told these were not being used and use of handcuffs was documented on an incident form post transfer instead.
- The service transported patients sectioned under the Mental Health Act. There had been 181 journeys carried under the Act from April to September 2018.Of these journeys, 14patients were transported whilst restrained. National Institute for Health and Care Excellence guidance 10 stated that ambulance staff should "ensure that the techniques and methods used to restrict a service user: are proportionate to the risk and potential seriousness of harm; are the least restrictive option to meet the need; are used for no longer than necessary".
- ERS Medical North provided training to staff that included reference to considering the least restrictive option. However, during out initial inspection, its policies and procedures were not consistent with this training as they did not refer to the conditions of the National Institute for Health and Care Excellence guidance. However, during a follow up visit, we found that the service had updated its Mental Health Services policy (in November 2018) to include additional details about mechanical restraint. This highlighted that handcuffs should only be used as a last resort and for the minimum time necessary for patients' protection and those around them. This was in accordance with National Institute for Health and Care Excellence guidance 10 which stated that ambulance staff should "ensure that the techniques and methods used to restrict a service user: are proportionate to the risk and potential seriousness of harm; are the least restrictive option to meet the need; are used for no longer than necessary". The policy did not previously reference this national guidance.

Cleanliness, infection control and hygiene

- The service monitored compliance with hand hygiene audits across its sites. Monthly head office infection audits showed a lack compliance across ERS Medical North. In February and March 2018, some sites had poor compliance with infection prevention and control audits at between 45% and 50%.However, these issues were discussed in the monthly Governance and Patient Safety meeting and compliance had improved to over 80%.Most sites were complying with the audit at the time of the inspection.
- Infection and prevention control training was delivered to all staff. Staff who we spoke with were aware of their roles and responsibilities for infection and prevention control. We found that staff had an awareness of 'bare below the elbow' when delivering care to patients.
- All sites we visited were visibly clean and tidy.
- Sites used colour coded mops for use in specific areas: toilets; general areas; kitchen and vehicles.
- The vehicles we inspected were visibly clean.
- ERS Medical North had a comprehensive Infection Prevention and Control policy, which included details of how staff should decontaminate uniforms, when to wear personal protective equipment, and the use of aseptic non-touch techniques.
- The service had an Infection Prevention and Control – Environmental Management policy. This stated that "the clinical waste bin in one of the stations was located outside in a carpark used by other businesses. Whilst it was behind a locked gate, the bag itself was open. Staff told us that they added to the waste bag when necessary and it was only cost effective to seal it at the end. Another site tied clinical waste bags closed because staff did not always have access to tags to seal them.
- For the GP urgent care contract, patient information was passed to the crew verbally by the provider whom work was being undertaken for, rather than booking forms being completed in the control room. Ambulance staff we spoke with informed us that information about infectious patients, for example, those with Clostridium difficile or meticillin-resistant Staphylococcus aureus, was not routinely provided as part of this process. This meant that there was an increased risk that infection would be spread if the appropriate personal protective equipment was not worn.
- Most vehicles carried appropriate infection, prevention and control equipment including clinical waste bags, vomit bowls and gloves. During our first visit we saw that there were no spill kits available on the vehicles at Mansfield, or the vehicle used for the GP urgent care

contract at Leeds. However, during the follow up visit we checked three further vehicles and found that they all contained spill kits, gloves and wipes. They were also clean and tidy.

- Following our last inspection, the service updated its Quality Audit – Observation Shift form. This form included questions about whether staff followed correct infection control procedures including hand hygiene and vehicle cleaning.

Environment and equipment

- The service had one ambulance equipped with blue lights which was routinely used for the GP urgent care contract. This vehicle had been off the road since the 7 September due to a mechanical failure, therefore we were unable to inspect this vehicle during the inspection. However, we reviewed records between August and September 2018, finding that daily vehicle and equipment checks had been completed for the vehicle on all occasions. In addition, we found that the vehicle had been serviced on a regular basis as well as having an up to date MOT.
- Prior to our follow up visit, the service had implemented a revised contract with the GP federation in November 2018 (for the GP urgent care service) which stated that ERS Medical North must use stretcher equipped vehicles for patient journeys. Staff told us that this happened.
- Each vehicle had a file in the crew room that would then be taken to each vehicle when it was used.This file contained, amongst other details, a driver's handbook, certificate of motor insurance, incident reporting form, end of life care information and capacity to consent forms.
- ERS Medical North used a third party provider to monitor vehicles including servicing, tax, MOT, or whether vehicles were off road. The reports produced by the provider showed that vehicles were up to date with these requirements. We checked 12 of these vehicles against the Government's tax and MOT database which supported the data supplied by ERS Medical North. ERS Medical North used another provider to manage the deep clean of vehicles.
- A traffic light system was used to alert operations managers about upcoming vehicle servicing requirements and MOTs. We saw evidence that vehicles were being monitored appropriately, and those not up to date with servicing were placed off road.
- Vehicle Off Road reports were generated every night which helped operations managers to plan and schedule resources.
- We saw that bases displayed their group vehicle insurance policy and medical malpractice policy and had clear details of the fire assembly points.
- We saw evidence that vehicles keys were stored securely.
- Sites had access to a system that allowed children to be transported on adult stretchers. We saw evidence that staff had received training on the use of the equipment and had signed to say this had been completed. This equipment was not available at all sites (for example, Mansfield) but staff told us that they could contact a neighbouring site to use their equipment. The Mansfield site had not completed any paediatric transfers since it opened in April 2018. There had been a total of 180 paediatric transfers across ERS Medical North in the nine months prior to the inspection.
- Each site had secure oxygen storage. ERS Medical North's storage policy was in accordance with the manufacturers Medical Gases Data Sheet – oxygen cylinders were clearly segregated between full and empty. Oxygen cylinders were regularly checked and those nearing empty (approaching the red line) were moved to the empty side of the container with clear separation (crews could not mistakenly pick up an empty cylinder).
- During our first visit we observed the ambulance crew transferring a response bag (which included equipment such as a defibrillator) and monitoring equipment to an ambulance. However, we found that there was no facility on the patient transport vehicle to store the monitoring equipment safely. This meant that in the event of a road traffic accident, there was an increased risk that it could cause staff or patient injury. However, during our follow up visit, staff showed us how the equipment could be safely stored on the vehicle.

- There was a daily vehicle checklist which crews should complete to ensure vehicles were appropriately stocked and safe for use. Checks included medical equipment, restraint (where appropriate) and fuel cards. However, the checklists were not always used consistently. One vehicle at the Mansfield site had not had a daily checklist completed on four out of the previous 11 occasions the vehicle was used. There was also one occasion were a defect was reported but there was no log of what action was taken to remedy it. Vehicles at the Leeds site had been checked daily. Staff recorded, on four occasions, that equipment was missing, but there was no record of what action they took to remedy this.
- However, during our follow up visit we found that the service had used daily vehicle checklists. We saw evidence that where a vehicle had not been used, the daily checklist either stated that the vehicle was "not in use" or was "off road". The Leeds base also contained a whiteboard detailing which vehicles were off road. The service also had an electronic system that monitored this. We also saw evidence that the team leader conducted local checks of vehicles. They told us that they tried to do this once a week and would check the condition of the vehicle, including whether it had been appropriately cleaned, and the state of the equipment.
- We observed that one secure patient transfer vehicle in Leeds contained no decontamination wipes. In addition, we found a box of paracetamol in an unlocked glove compartment, and cleaning granules used for spillages were out of date. Another vehicle did not have any clean linen available.

  ERS Medical North had several older vehicles that required increasing maintenance – this was recorded on the corporate risk register.

Assessing and responding to patient risk

- Although the service did not routinely record patient review forms, staff were required to complete them for all patients who required clinical assessment or monitoring. We reviewed five patient review forms that had been completed, finding that patient observations such as blood pressure and pulse rate had been documented on all occasions.
- The service used a numerical pain scoring system (between one and 10) to document how much pain a patient was in. Also, following the inspection we were informed that there was a pain scoring tool available for staff to use when assessing pain for children. However, during the inspection this was not available to staff and staff were unaware of it.
- Bookings were taken by control room staff who completed a patient transfer request form. Information recorded included patient requirements (for example - wheelchair, stretcher, medical escort – for those patients requiring medicines to be administered during the journey) and would indicate if a patient was not for resuscitation (the booking form clearly highlighted that this documentation would be required by the collecting crew).The computerised booking system asked control room staff to record infection, oxygen and mobility status, and whether the patient had any disabilities.
- A 24 hour bookings team took telephone bookings for mental health transfers. They worked through a comprehensive assessment of the patient's needs during transfer, including the patient's diagnoses, whether they were detained under the Mental Health Act, current presentation, behavioural triggers, absconsion risk and whether restrictive interventions were needed. The information generated a risk summary and level of staffing needed.
- Crews knew to call 999 should a patient deteriorate and there was a policy in place for this. Staff could give examples of when they had followed it.
- Staff had access to an automated external defibrillator (equipment that is used to diagnose and treat life threatening irregular heartbeats). We found that defibrillator pads were present, sealed and in date.
- The patient risk summary generated by control room staff was available to mental health crew undertaking the transfer. This information was sent electronically as a read only file to the hand held mobile devices used by the crews. Whilst some crew told us that they did not complete a further risk assessment at the time of transfer, others confirmed that they did and would contact the management team for advice if required.
- ERS Medical North transported renal patients requiring dialysis. Its policy relating to these transfers was in line with relevant guidance issued by the national Institute for Health and Care Excellence. Job bookings went

directly to road crews' electronic device and clearly identified that the booking was for a renal patient. Transfer times were in accordance with guidance issued by National Institute for Health and Care Excellence.

- During our initial inspection, we found the provider had not acted in accordance with an alert issued by the National Institute for Health and Care Excellence in 2015, The importance of checking vital signs during and after restrictive interventions/manual restraint (which applied to all organisations providing NHS-funded care). There was no evidence that of the 14 journeys involving restrained patients, crews took observations during and after restraint. In addition, in accordance with National Institute for Health and Care Excellence guidance 10 - Violence and aggression: short-term management in mental health, health and community settings, there was no evidence that staff were completing an immediate post-incident debrief. Therefore, there was a risk that staff might not identify a deteriorating patient.
- The policies for restrictive interventions, including the restraint policy and a policy outlining the use of spit hoods, included reference to dynamic risk assessments being undertaken. These risk assessments were not documented for any of the 14 journeys involving restrained patients as there were no journey records.
- However, the service's restrictive interventions policies had been updated during our last visit to reference the National Institute for Health and Care Excellence 2015 alert: The importance of checking vital signs during and after restrictive interventions/manual restraint (which applied to all organisations providing NHS-funded care). They set out that any patient under mechanical restraint required continued observation in line with the national guidance, and that these observations should be recorded on a patient review form. No patients had been transferred using mechanical restraint in the five months prior to the follow-up visit.
- The restrictive intervention policies also referenced National Institute for Health and Care Excellence guidance 10 - Violence and aggression: short-term management in mental health, health and community settings. The national guidance highlighted that staff should use the least restrictive option and for no longer than necessary. The service's application of spit hoods guidance stated that they should only be used as a last resort.
- The policies included reference to dynamic risk assessments being undertaken, and the use of a risk matrix. Risk areas included patient behaviour, triggers, self-harm history, physical or medical restraint. Each transfer would be given a risk rating and the score identified the number of road crew required. If the risk rating was three or more than a registered mental health nurse was required to accompany the patient. The risk assessment included a question about whether patients' "behaviour was consistent with presentation of dementia".
- During our follow-up visit we saw that risk assessments were appropriately completed for two mental health transfers completed in the three months prior to visit. They detailed the number of staff required and what to do if the road crew experienced difficulties. The relevant section paperwork had been completed by a health practitioner from the NHS who accompanied the patients. In one incident, which was recorded, consideration was given for use of mechanical restraint, but this was not needed.
- The service had a Conflict Resolution and Physical Restraint policy that had been updated in November 2018 to reflect national guidance. The policy included amongst other things, guidance for staff about what to do if a patient became unmanageable (call 999).It also highlighted what staff should do regarding positional asphyxia; it gave an overview of warning signs, and if there were concerns, to immediately release or change the method of restraint. Conflict resolution and de-escalation training was provided to staff on induction.
- Road crew told us that for those patients being transferred to the emergency department under the GP urgent care contract, hospital staff required up to date observations on a patient review form prior to handover (blood pressure, blood oxygen levels, temperature and blood monitoring results).However, this was not consistently done. Of the 142 running sheets we reviewed between October 2018 and December 2019, there were four transfers to the emergency department where patient review forms had not been completed (one each in October and November, and two in December 2018).

- In addition, the service completed running sheets for all booked patients under the GP urgent care contract, and these had been recently updated to include details of the clinical handover from the GP service.

Staffing

- One operations manager told us that staff rotas had changed to better meet the demands of the organisations they provided services for.
- The Leeds base managed staff rotas using a software application which all relevant staff had access to. The software enabled the operations manager to easily view weekly timesheets, and managed financial reports and budgets. The system had a noticeboard function which allowed the manager to relay information to staff. This system was not universal across all ERS Medical North sites and other bases managed rotas on a shared drive. We saw staff rotas in the crew rooms.
- Most shifts were fully crewed. There had been some issues with short term staff sickness that had impacted on one of the contracts operated from the Leeds base. However, additional staff had been recruited and minutes from the contract meeting suggested that performance had improved – albeit that we could not see the level of improvement.
- Whilst most staff had had disclosure and barring service checks completed, a minority were waiting for their applications to be processed. Operations managers had completed risks assessments and restricted these staff members to driving duties only until their application had been processed. They could also not work alone.
- ERS Medical North's human resource function was outsourced to a third party. Operations managers could manage staff via an online computer system. Staff we spoke to told us that the system was easy to use.
- Driving licence checks were carried out on all employees. The computer system would generate an alert when these were due to be renewed.
- We reviewed correspondence from the NHS Trust who had commissioned the GP urgent care contract, which determined that a minimum of one emergency care assistant should be available on every shift to deliver the urgent care service safely. Emergency care assistants had received training in assessing patients through examination and undertaking diagnostics such as blood pressure, oxygen saturations or an electrocardiogram (a picture taken to assess the electrical activity of the heart).

Records

- The service's record management policy stated that staff were required to complete a patient review form for all patients who required clinical assessment or monitoring during the journey (a patient review form documented important information such as a patient's vital signs, mental capacity and pain score, as well as having space to document a patient's main complaint and any medicines that the patient had).Crews did not complete patient review forms unless there had been a problem during patient transfer. This include mental health transfers.
- During our initial inspection, we reviewed five patient review forms completed for journeys between July and September2018.There were inconsistencies in how these were completed. Two patient review forms were completed fully apart from recording whether staff needed to take any action during the journey. One patient report form included details of a safeguarding concern. Whilst the patient report form recorded that an appropriate safeguarding referral had been made, it did not document what immediate action staff had taken to keep the patient safe. That said, ERS Medical's own incident tracking system contained this information. One patient report form was incomplete - it contained no patient information and did not document what happened during the journey. We raised this with management at the time who acknowledged that this was not good practice and that staff would be spoken with. One patient report form showed that a patient had collapsed at home and was unconscious for three minutes. Staff eventually completed the patient journey but there was no evidence that they escalated the patient (sought clinical advice), considered calling 999 or took any other action to stabilise or monitor them.
- Managers told us that crews checked the Mental Health Act documentation at the start of transfer. One crew member told us that a "focus for all [ambulance care assistants] … is to ensure paperwork is fully completed. If paperwork [had] any mistakes it can be disastrous". However, at the time of our initial inspection, there had been two recent incidents where patients had needed

to return to their original hospital as detention papers were incorrect. In one case there was no Mental Health Act H4 form (which authorises the transfer of a patient detained under the Mental Health Act to move from one hospital to another). In the other case, the crew were given copied papers rather than the original detention papers.Failing to ensure the correct documentation was in order meant that staff could not say that the correct legal processes had been followed, exposing them to risk.

- However, during the follow up visit we saw that relevant road crews carried a Mental Health Act section papers checklist.This set out the forms that were required for the transfer of a patient detained under the Mental Health Act; confirmation that the papers were lawful; and what to do if the papers were not completed correctly. The correct paperwork was in place for two mental health journeys that had taken place in the three months prior to this visit.
- We reviewed five patient review forms for the GP urgent care contract that had been completed by staff between July and September 2018. Although patient observations and presenting complaints had been clearly documented on all occasions, the job reference number and ambulance call sign had not been documented on any.
- During our initial inspection, we reviewed 160 running logs (from April to September 2018) relating to the informal contract between the Leeds site and a local hospital. The sheets were not designed to make a contemporaneous record of the journeys undertaken. On three occasions we noted comments on the running logs such as “TTO missing”, or “could not find patient”. There was no record of what action staff had taken to resolve these issues. We also saw evidence of one journey when a mental health patient was transferred in a patient transport bus. There was no evidence that a risk assessment had been carried before transporting the patient in this vehicle.
- During our follow-up visit we reviewed a further 142 sets of patient records including running sheets and patient review forms. Most of these had been appropriately completed.
- Staff did not complete patient review forms for routine patient transfers. They told us that forms would only be completed if a patient deteriorated, there was any incident or accident, concerns about safeguarding, or a capacity assessment required. We saw that these forms were stored on the vehicles we checked. We saw one patient review form completed for a patient transferred to an acute medical unit; there was no indication on patient review form that they had deteriorated
- We noted one incident where a patient review form should have been completed but was not. This was identified following a technical review of the incident (incidents were automatically sent to and reviewed by the care quality manager).Learning was shared with the crew who were reminded of their responsibility to complete the forms in these circumstances.
- The operations manager told us that due to a shortage of staff trained in undertaking the transfer of mental health patients, these transfers were not currently taking place in ERS Medical North locations.
- The running sheets for each day were posted to a locked box in the office (within a locked room).The sheets contained sections to record the patient’s name, address, pick up time and clinical handover information. There was nowhere on the running sheet to indicate whether a patient review form had been completed.
- There was no standardised approach to documenting the administration of oxygen. The running sheets were not designed to capture such information.
- Staff we spoke with were aware of do not attempt cardiopulmonary resuscitation orders and the requirement to carry relevant paperwork with patients at all times.
- Crews told us that do not attempt cardio-pulmonary resuscitation orders were recorded in the special notes section on the patient booking form and that they would review the validity of these forms prior to collecting the patient.
- Staff reduced the risk of patient identifiable information being lost by keeping completed records with them at all times. We reviewed all incidents reported between January and September 2018, finding that there had been no reported breaches of patient confidentiality. In addition, all paper records were stored securely at the ambulance station.

Good

Patient transport services

Medicines

- Patient transport vehicles did not carry any medicines. If a patient required sedation during a secure transfer, ERS Medical North would request a medical escort (a registered mental health nurse).Nurses were provided via an agency.
- Oxygen cylinders were stored securely on vehicles.
- ERS Medical North had produced several standard operating procedures including the Administration of oxygen by PTS crews.This guidance supplemented the training given to all patient transport service crews and was developed in line with UK Ambulance Service Clinical Practice Guidelines 2016.The guidance set out how much oxygen therapy an ambulance care assistant could provide (up to four litres per minute) and stated that its use must be documented in the patient review form. The guidance also stated that if there was to be a continuation of oxygen therapy (from a unit and during transfer) staff must record details of the healthcare professional that had made that assessment.
- Staff had access to guidance that set out what to do in emergency situations and the types of oxygen masks that could be used. Staff had access to an on-call care quality member of staff via the control centre if they had concerns about administering oxygen therapy.
- The service had a medicines management policy, but this did not include details about the reconciliation of patients' own medicines.
- The service had a controlled drugs policy that included a form for the reconciliation of those drugs, but this form was not being used at the sites. We informed senior management of this point and they immediately put the appropriate paperwork on the vehicles at the site we were inspecting at that time. During our inspection we saw evidence that this new process had been rolled out to other sites.
- Staff were required to complete a controlled drugs reconciliation form on occasions when patient's own controlled drugs were transported as part of a journey. However, staff who we spoke with informed us that they had not been aware of this requirement prior to the inspection and that this form had not been routinely used. This was important as there would be a clear record of controlled drugs being transported and being safely handed over to other healthcare providers.

Incidents

- Staff we spoke with knew how to report incidents. There was a dedicated incident reporting telephone line which staff called and the incidents details would be logged onto a dedicated computer system. An email alert would be sent to relevant team leaders and operations manager to review the incident and complete any actions. The alert would also be sent to the regional manager. The incident would also be sent to the clinical manager or health and safety manager for technical review. Any actions developed from the technical review would be assigned to a specific person.
- The regional manager was alerted to every incident and copied into any technical feedback (which also went to the operations manager).
- Staff told us that incidents had not always reported as quickly as they should have been (company policy stated within 24 hours).However, they also told us that reporting was much better and we saw evidence that this was monitored via monthly Governance and Patient Safety meetings.
- We saw examples of where changes had been made following incident reporting. For example, staff used to wait until oxygen cylinders were empty before changing them. After this issue was raised as an incident following an audit, the company policy was changed, and cylinders are now replaced sooner, reducing the risk of oxygen running out during a patient journey. We saw evidence of a clinical memo sent to every site and attached to the oxygen storage areas.
- We saw examples of incidents being discussed at team meetings. For example, following an injury to a crew member the incident was discussed in the team meeting along with how to avoid recurrence. This information was also kept in the crew room.
- Also saw evidence that ERS Medical North monitored incidents to identify trends, which included an increase

in falls. A joint memo was issued to remind staff about patient handling, particularly that patients should not be mobilised differently to the original booking requirements.

- Incidents were graded by technical leads who decided whether an incident was notifiable to the relevant regulatory body. The Duty of Candour responsibility sat with the regional manager who would action these as "soon as is practically possible".Whilst ERS Medical North did not have a separate Duty of Candour policy, details of when the Duty of Candour would be applicable was contained within its policy CQC Statutory Notifications – A Guide for Registered Managers. A flow chart clearly described how and when to use Duty of Candour.
- There was no joint policy to manage incidents that occurred involving some NHS organisations. Management staff told us they had attempted to investigate one incident with the support of an NHS organisation, but that organisation had refused to share information, including patient outcome.

Are patient transport services effective? (for example, treatment is effective)

Good

We rated effective as **good.**

Evidence-based care and treatment

- Staff could access policies via the intranet, and we saw a crew room displaying a sign that highlighted changes to policies.
- Standard operating procedures, including the administration of oxygen, was based on appropriate guidance.
- The restrictive interventions policies, including use of restraint, handcuffs and spit hoods were appropriate.
- The management team had some regard to best practice guidance. This included guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and the UK Ambulance Service Clinical Practice Guidelines (2016). However, we found that there was limited reference made to best practice guidance in clinical policies that were available to staff. This meant it was unclear if all clinical guidelines reflected the most up to date best practice.
- The service had a 'Language Translation Services' policy that set out steps for how the ensure the service was accessible for patients that did not speak English as a First Language. Staff were required to read the policy and take a test at the end to ensure the understood it and confirm that that they understood that the service did not discriminate against groups or individuals. The service had a mental health services policy in place for staff. During our initial inspection, we saw the policy included some relevant guidance for staff but did not reference key parts of the Mental Health Act including relevant guidance about conveying or transporting patients detained under the Act. An appendix outlining Mental Health Act documentation was incomplete and did not include H4 forms (which allow the transfer of a detained patient from one hospital to another).
- However, during the follow up visit we saw that relevant road crews carried a Mental Health Act section papers checklist. This set out the forms that were required for the transfer of a patient detained under the Mental Health Act; confirmation that the papers were lawful; and what to do if the papers were not completed correctly. The correct paperwork was in place for two mental health journeys that had taken place in the three months prior to this visit.
- The restraint policy included guidance indicating the circumstances where a single member of staff could undertake restraint. However, this put patients and staff at risk of injury as staff were trained in team restraint techniques.

Nutrition and hydration

- Guidance was issued to staff to ensure that there was sufficient water for patients was on each vehicle prior to transporting them. Drinking water was part of the daily vehicle check.
- We also spoke to several patients who confirmed that water was available on journeys if needed.

Response times / Patient outcomes

- ERS Medical North sent us key performance indicator data for one of the patient transport service contracts it

operates.From October 2017 to August 2018 the service carried out 4,517 journeys. Crews arrival times (within 60 minutes of booking) fluctuated between 79% and 81%. Late arrivals fluctuated between 8% and 21%.We saw evidence that waiting times were discussed in meetings between ERS Medical North and the commissioning organisation.

- ERS Medical North transported renal patients requiring dialysis. Its policy relating to these transfers was in line with relevant guidance issued by the national Institute for Health and Care Excellence.
- During our initial inspection, we found the Leeds site had an informal contract with a hospital in the region. As there was no official contract, calls did not go through the call centre but were taken by the crew directly. This meant the ERS Medical North, via the control centre, did not have oversight of the types of patients being transported. The lack of records for these patient journeys meant it was unclear if inappropriate patients were being transported.
- At our initial inspection, we found there were contracts and key performance indicators in place for some patient transport services provided to organisations, but this was not universal. We found that some commissioners of the service did not require performance measures, but ERS Medical North did not always consider it necessary to always have internal measurements in place. The lack of performance indicators meant that the service could not readily review its effectiveness.
- However, during the follow up inspection, we saw the service had contracts in place. Even where the commissioning organisation did not require performance statistics, the service set its own internal targets and monitored these to ensure that patient journeys were undertaken in a timely manner. For one contract, data showed that on average, in the three months prior to the inspection, road crews attended over 86% of appointments within 60 minutes.

Competent staff

- The service used a centralised electronic system to store and access training resources.
- The service had updated its observational audits form in January 2019.Senior road crew from each site acted as observers. They completed an observational audit form (a set of structured measures staff could be assessed against). The programme was applicable across all ERS Transition Limited locations. We saw evidence of a completed audit form, saved to the employees electronic file, which highlighted an issue and how it was addressed.
- Clinical training managers met weekly (via skype) and quarterly (face to face) to review staff training requirements.
- Managers could easily access training records to see whether staff had completed relevant training.
- The service employed two emergency care assistants who had received additional training to what an ambulance care practitioner would be expected to complete. This included training to monitor patients' vital signs, such as blood pressure, oxygen levels or an electrocardiogram (used to monitor the electrical activity of the heart).
- The training prospectus covered details of control and communication operator initial training.
- A personal development policy set out how competencies would be assessed, including via work activity observation.
- The service provided training that offered regulated qualifications. Training provision was developed in partnership with the NHS National Education Network for Ambulance Services.
- Most staff had completed allocated training and had been booked onto a conversion training course provided by a third party.We identified one member of staff who was not up to date with all their training requirements (including infection prevention and control), nor were they on the list of staff to attend the conversion training course. The operations manager added the staff member to the training schedule during the inspection.
- Staff received refresher training every 12 months and the majority were up to date.
- ERS Medical North were not required to provide major incident support for the local area.

- Staff had undertaken additional mental health training to support secure patients transfers. Training included restraint and self-protection.
- Staff told us that they had had opportunities to undertake additional training. For example, one crew member told us that they had requested additional mental health training, and this had been provided.
- The data sent to us by ERS Medical North showed that prior to the inspection, most operational staff (about 75%) had not had appraisals – this included three sites where no appraisals had taken place. The service told us that it was rolling out a new appraisal system (which would go live in December 2018) which managers would be trained on. All staff were targeted to have appraisals completed by the end of February 2019.
- At the time of the initial inspection the service had one member of staff that was self-employed. However, there were no arrangements for this staff member to have an appraisal. This meant that it was unclear how their performance was reviewed.ERS Medical North had induction training for new starters which included clinical training (first aid), driving assessment and observations. An updated training prospectus had recently been introduced that set out details of the Ambulance Care Assistant Initial Training Course – an eight day course (five days clinical training and three days driver training).There was a minimum of 20 hours of observation by an experienced ambulance care assistant. There was site specific training such as vehicle familiarisation and kitting list.

Multi-disciplinary working

- Staff told us that they provided support to other sites to help with holiday cover.
- Staff were being cross-trained in secure patient transfers to provide additional cover.
- We observed one patient journey during the inspection. The crew worked well with other members of clinical staff from a local hospital when handing over the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a policy outlining guidance in relation to the Deprivation of Liberty Safeguards and the service had reviewed this in 2018. However, during our initial inspection, we saw this contained out of date information in relation to deaths and involvement of the police which had changed over a year before this inspection. The policy also gave guidance to staff to check deprivation of liberty authorisations, but these were location specific and there was no power to convey as part of the safeguards. However, during our follow-up visit, we found that the service had updated its policy (in November2018) to reflect national guidance in relation to patient deaths and the involvement of the police. The policy also confirmed that there was no power to convey patients as part of the safeguards; staff could encourage cooperation from patients, but not force them to be transferred.
- On the day of the initial inspection, inspectors asked if there was a policy outlining the Mental Capacity Act. Managers explained that they had printed a summarised copy of the guidance for staff to read, but then provided the inspection team with a copy of the Mental Health Act code of practice. This was the easy read pictorial version which would not give sufficient guidance to staff to follow. However, ERS Medical North told us that staff had access to the medical care quality team and the clinical on call team should they have any queries regarding capacity. The service also had a Care to Care policy that provided staff with guidance on assessing a patient's capacity and consent".
- Prior to our follow-up visit, the service had updated its Mental Health Services policy. This now referenced up to date national guidance and included details about capacity and consent, and the health, safety and wellbeing of patients, drivers, escorts and others. The policy set out the initial process for transferring patients detained under the Mental Health Act which included obtaining a brief about the patient; checking section papers were correct; introducing themselves to the patient; and explaining details about the journey.
- At our initial inspection, we found most staff were up to date with up to date with statutory and mandatory training which include training in the Mental Capacity Act and consent. However, staff operating on the GP urgent care contract had a mixed knowledge of consent,

mental capacity, best interest decisions and deprivation of liberty safeguards. Not all staff were aware of the differences between the Mental Health Act and the Mental Capacity Act.

- In addition, staff on the GP urgent care contract did not have an understanding of Gillick competence. This was important as there was a potential for the service to transport children of a variety of ages. Gillick competent is a term used to describe if a child under 16 years of age can consent to their own medical treatment without the need for parental permission or knowledge.
- However, during our follow up visit we saw that staff had received updated training in consent and underwent a multiple-choice question test at the end to test understanding. They were also assessed, via the updated observational audit form, to see whether they were competent in this area. We spoke with a member of staff who could demonstrate their knowledge of the Mental Health Act and how to apply this to their role.
- Staff told us that they would speak to their operations manager for advice regarding the Mental Health Act if required.
- Staff demonstrated an awareness of the importance of obtaining consent prior to providing patient care. We observed staff seeking verbal consent from a patient when helping them from their home address to the ambulance.

Are patient transport services caring?

Good

We rated caring as **good.**

Compassionate care

- Staff we spoke with could provide examples of where they had provided compassionate care. This included a patient at the end of their life who they ensured was transferred so they could spend their last days at home.
- We observed an ambulance crew delivering caring and compassionate care to a patient during the inspection. Staff who we spoke with demonstrated a commitment to provide the best care possible to all patients.
- We found that patients' privacy and dignity was maintained, particularly when transferring a patient to the ambulance, as well as when transferring the patient from the ambulance into hospital.
- Staff told us that they would ensure that patients were comfortable and warm prior to journeys. Patients told us that staff had offered them drinks.
- We had feedback from 42 patients via comments cards and spoke to four patients who completed the cards. They told us that staff were "reliable, friendly [and] efficient".

Emotional support

- A patient told us that the crew that collected them "were really understanding of my needs" and helped them into their home and made them a drink.
- A patient told us that they had complex medical needs but that crews listened to make sure their needs were met.
- Staff could give us some examples of when patients or relatives had required reassuring during their journey, informing us that they had done their best to alleviate any anxieties or concerns that a patient or a relative had.
- Crews undertaking mental health transfers told us that they felt it was important to understand that patients were "poorly".

Understanding and involvement of patients and those close to them

- Staff could articulate examples of remaining with patients until their carers arrived to ensure they were not left alone.
- A services user told us that "staff were very professional and caring, got me to my appointment on time and were there waiting for me when I finished". Another patient told us that as they no longer had use of a car and would find it impossible to attend hospital appointments within the help of ERS Medical North staff who they praised for being "very friendly, helpful and caring".
- Another patient told us that crew members were "really respectful of my needs".

Good

Patient transport services

- We observed one occasion when the staff communicated with a patient clearly when helping them into a wheelchair. This meant that the patient understood what was happening and they were given the opportunity to say how they wanted the staff to support them.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- Operations managers met with local commissioners to understand how they could meet the needs of the local population.Meetings would include a review of performance and discussions about any complaints or compliments. However, there were not always formal contracts in place and so it could be difficult for the service to reliably know whether it was meeting the needs of local people. There were a number of commissioned services were there was limited business oversight.
- Whilst staffing levels had compromised the service to some commissioners, these issues had been raised as part of the regular meetings and steps put in place to remedy them, including recruiting three additional staff.

Meeting people's individual needs

- ERS Medical North had a 'Language Translation Services' policy that set out the steps staff should take to ensure that patients that spoke different languages could access the service.
- Control centre operators have access to language line if callers do not speak English as a first language. In addition, the system control centre operators use to book patient transport requires them to ask whether the patient requires "additional help with understanding or communicating with others".
- Staff informed us that they sometimes transferred patients who were living with dementia as part of the work that was undertaken. Members of the management team informed us that all staff received dementia awareness training. Staff could provide examples of caring for patients living with dementia. For example, they explained how they reassured and calmed a patient and stayed with them until carers arrived.
- Staff could access interpreters if required. In addition, vehicles contain language cards that can help crews convey basic information. These cards were in 41 different languages. There was also access to language line if needed.
- Crews had access to an emergency phrase book which they could use for patients who were deaf. This would allow patients to consent for examination, describe their pain level and location, and communicate their current symptoms. It also had a modified section for deaf patients who were pregnant.
- Crews had access to pictorial cards to help relay information to patients that had communication difficulties. For those patients that had additional needs, the service would recommend that the commissioner of the service provided a healthcare escort.
- ERS Medical North had wheelchair accessible and bariatric vehicles. The vehicles were adapted to take larger stretchers and wheelchairs. The was a clear policy in place to ensure the safer handling of bariatric patients to avoid aggravating pre-existing medical conditions.
- Control room staff recorded any special notes that need to be relayed to the crew about a patient needs, for example, patients living with dementia or learning disabilities, or approaching the end of their life. The special note would be reviewed prior to the transport to ensure that enough crew attend to help the patient.
- We spoke to the carer of a patient (the patient was blind) who told that the crew were attentive to their needs.
- Additional information was requested at the booking stage for mental health transfers to ensure that individual needs could be taken into consideration. For example, patients could request a preferred gender of the crew, although this could not always be guaranteed.
- Vehicles used for transporting mental health patients were unmarked and had mirrored privacy glass, which

protected the privacy and dignity of patients. The provider only used people carrier type vehicles for mental health transfers which allowed for greater legroom and headroom for patients and accompanying staff. The provider did not use caged vehicles.

Access and flow

- During our first visit we saw that ERS Medical North did not have service level agreements in place for all commissioned services. This meant that there was no central oversight of the service and it could not quickly monitor response times or see whether there had been delays. It also meant it was difficult to monitor resources levels or excess demand. For example, taking on an additional contract affected the performance of an existing one. This was highlighted to the service by the commissioner rather than being proactively identified and remedied. During our follow up visit, we saw evidence that ERS Medical North had introduced service level agreements.
- ERS Medical North had a policy in place to manage ad hoc booking requests. These bookings were managed via a central control room.
- Bookings could be received via email, telephone or fax and control room staff should ensure that suitable vehicles and qualified staff are used.
- ERS Medical North used technology to track the location of vehicles which helped with the allocation of resources.
- We saw that one of the bases had had issues with picking up patients in a satisfactory timescale and that this had been raised as a concern in meetings with two different commissioners. We saw evidence that additional staff had been recruited but it was too early to say for certain whether this had helped reduce waiting times.

Learning from complaints and concerns

- The service had an up to date complaints policy which set out a clear pathway for how complaints should be managed depending on the type of complaint received. All complaints were reviewed by the appropriate manager, and then passed to the relevant head of department. The complaints pathway referenced the Parliamentary and Health Service Ombudsman when the complaint was about NHS services.
- ERS Medical North's policy stated that a written response should be sent to complainants within 25 working days, a target it was generally meeting at the time of the inspection (the average response time was 26 days).
- We saw that complaint forms were kept on vehicles.
- We reviewed two complaint investigations. In one instance ERS Medical North identified that crews should have acted differently, and it apologised to the patient. Lessons learnt were sent to the operations manager to discuss with staff. The complaint was investigated and resolved quickly. A second complaint related to delays in collecting a patient. The issue was investigated quickly, and the service identified that winter pressures had affected the service. ERS Medical North apologised to the commissioning service who had raised the complaint.
- Complaint investigations were recorded electronically. We saw evidence of staff statements, technical reviews and learning saved to individual complaint files and that learning had been shared with individuals involved in the complaint.
- The contracts in place for the provision of services to NHS providers set out ERS Medical North's obligations for managing and reporting on complaints in line with NHS complaint regulations.
- Complaints were discussed as monthly Governance and Patient Safety meetings. The data showed that 50 complaints had been made between February and June 2018.
- ERS Medical North had recently begun to record the compliments it received from patients. Compliments were discussed at the monthly Governance and Patient Safety meetings.

Are patient transport services well-led?

Good

We rated well-led as **good.**

Leadership of service

- ERS Medical North had a clearly defined leadership structure. The regional manager had operational

responsibility for sites in Speke, Crewe, Manchester, Leeds and Mansfield (ERS Medical North).The operations managers at each of these sites oversaw local operations and managed the team leaders.

- Staff told us that the leadership team were visible and that heads of departments, and the regional manager, regularly visited sites. Staff described senior managers, including the managing director, as approachable.
- The regional manager had recently been brought into the region to provide stability and continuity across sites. This included ensuring that operations managers used the various computer systems to manage HR, vehicles and billing. The regional manager told us that the change in ownership at the end of 2017 had been a springboard to make changes. The regional manager acknowledged that standardisation was still an issue, but there was continual improvement.
- The regional manager told us that a key challenge was ensuring that staff at individual sites were aware of policies. Other key challenges included maintaining contracts, and commissioners trying to drive down costs. Incident management had also been an issue, but they had begun to educate operations managers to ensure their staff reported them immediately. The data sent to us by ERS Medical North demonstrated that most incidents were being reported in a timely manner.
- The regional manager, who was relatively new to the role in ERS Medical North (albeit they had been the manager of another region and had worked for the organisation for over four years), told us they were supported to carry out his duties and responsibilities.
- There was no leadership management programme, but staff could give us examples of how they had progressed in the company, including the regional manager.
- During our first visit we found that the leadership of ERS Medical North did not ensure that there were always formal contracts in place for the services it provided, and they did not always recognise the risk associated with the lack of these contracts. This meant that it could be difficult for the service to assure itself it was managing services effectively.In those circumstances where there was no contract in place, ERS Medical North was largely reliant on the operational managers meeting with commissioners and escalating concerns where appropriate. Whilst we saw some evidence in the monthly performance review meeting notes that contract issues were discussed, there were no actions assigned or deadlines given for completion.
- During our initial inspection, we also found leaders did not always understand the challenges to the quality and sustainability of services ERS Medical North provided. Leaders did not proactively assess the risk of taking on additional work or the impact this would have on operational performance. For example, ERS Medical North acknowledged to a commissioner that performance had deteriorated due to taking on additional work. Whilst additional staff had been taken on to resolve the issue, there was no evidence that leaders had assessed the risk or impact to other contracts prior to taking on the work.
- However, during our follow-up visit we found that a new operations manager had been appointed at the Leeds site. There was greater emphasis on reviewing performance across commissioned contracts, and a recognition of the risks associated with the lack of formal contracts. We saw examples of where the operations manager had considered the risk of taking on new business and the potential impact to other contracts.
- The operational manager at Leeds planned to improve consistency across the two sites they managed, including introducing a standardised meeting agenda.

Vision and strategy for this service

- Managers we spoke with could articulate the strategy and vision for the service; a five year plan (ending 2022) to become the leading independent ambulance provider in the area they operated.
- ERS Medical North had a clear set of values which it considered were important to its business and employees. These values included, integrity, compassion, patient focus, working partnership, innovation, professionalism and respect. Staffs' appraisals took account of these values.
- Each regional manager had their own directives based around 12 key measures they were measured against.

These measures included reference to performance of the business against financial targets. Importantly, the directive also highlighted that managers were responsible for delivering a "patient focused service".

- Staff told us that they had had the opportunity to visit the head office to speak with the managing director about the vision, strategy and values of the organisation.

Culture within the service

- The service had a freedom to speak up guardian and staff could articulate their role. We saw posters of the guardian's role in staff rooms.
- The regional manager praised the operational managers and crews for embracing the changes to the service since it was sold last year, including cross-site working.
- The operations managers we spoke with were spoke positively about the new regional manager who had only recently started managing sites within ERS Medical North.
- The staff we spoke to felt supported in their roles. One member of staff said that there had been uncertainty when the business was sold at the end of 2017, but they felt that the new managing director had "refocused" the business and they were now "much happier". Another member of staff told that that it was a "great place to work" and they "loved it". One member of staff told us that they felt informed and valued. A member of staff praised the operations manager at Mansfield base saying they were a "breath of fresh air".

Governance

- During our initial inspection, we found that whilst ERS Medical North had a process to review internal policies, several policies were outside of their review date. This meant that ERS Medical North could not be assured that they referenced up to date guidance. We found that the Deprivation of Liberty Safeguards policy, which had been reviewed by the provider in 2018, referenced out of date standards. In addition, the restraint policies did not reference appropriate guidelines. This meant that service users were not protected from abuse and improper treatment. The provider told us they would review these policies.
- During the follow up inspection, we found that the service had reviewed its policies and those that we checked had been updated and referenced appropriate guidelines. Copies of policies were kept in the staff room. However, a staff member told us that they were not aware that any policies, including mental health policies, had been updated recently and that they were not aware of any process for informing staff of updates. This issue was mitigated by the training they had received which occurred on the day of the visit.
- The GP urgent care service had provided support to a local NHS trust since November2017.The contract was initially set up for a two week trial period. We saw no evidence that the management team had reviewed the service provision following this period. In addition, because of there being no written agreement between the service and the NHS trust, it was unclear about other minimum requirements for the provision of the service. For example, what equipment was required and what records staff were required to complete.
- After our first visit, ERS Medical North had agreed a formal contract with the GP urgent care service (in November 2018).The contract highlighted that the service was for the "hospital managed transport booking for GPs referring 'urgent non-emergency' patients to [an acute medical unit] for assessment/ admission". It set out how bookings would be made, and that the clinical team at the GP federation were responsible for triaging patients to ensure they were suitable for transfer.
- ERS Medical North had an audit policy (amended in August 2018) that defined the audit process, and the roles of staff and their responsibilities for specific audits. Audits included, but were not limited to, health and safety, infection prevention and control, roller door safety, and patient review forms. We saw evidence that, where patient review forms were used, these had been audited. Where a technical review had identified the patient review forms had not been fully completed, feedback was recorded in the incident management system. However, during the first visit we found several examples of patient review forms that had not been completed correctly. We were not assured that the audit process was sufficiently robust to improve record keeping.

- The service completed patient review forms for any journey where there had been an incident, including the clinical deterioration of a patient. Despite not being set out as a requirement in the new GP urgent care contract, staff also told us that they completed patient review forms for those patients being transferred to the emergency department. However, during our follow up visit, we saw evidence that this process was not consistently followed by staff.
- ERS Medical North had a process whereby operations managers should collect uniforms and identification badges from staff when left the business, and this information recorded on the employee file. However, information about staff uniforms was not always recorded. This meant that there was no audit trail if this information subsequently needed to be checked which exposed the business to risk. This remained an issue during our follow up inspection.
- Operations managers at each base held crew meetings to discuss progression of the business, health and safety minutes, and training requirements. During our first visit we found that there were inconsistencies in how often the meetings were held at sites. One site held staff meetings regularly every quarter and had good staff attendance. Another site did not have set dates for meetings and those they did have were not well attended – the operations manager at Leeds told us that about 20% of staff had attended the meetings. However, the ad hoc nature of the work undertaken, and staffing rotas, meant that it was not always possible for staff to attend meetings. In addition, the Leeds site had access to technology to share information with all staff (a "notice board" on a software application).We saw minutes from some of these meetings which showed evidence of learning being shared.
- There was a change in operational managers at the Leeds site prior to our follow-up visit, and as a consequence, there had been no recent staff meetings. The operations manager had placed a poster in the communal areas advising staff that they could have a one to one with them to discuss any immediate concerns. The manager told us they planned to hold monthly meetings and have two sessions to coincide with shift times to reach as many staff as possible.
- Operations managers had different tools for managing shifts patterns and timesheets. One member of staff told us that they had concerns about the hours they worked and that they "often" worked long hours. Minutes from a regional meeting showed that managers were aware of the issue albeit there were no actions in place to address it.
- The Governance and Performance Review committee met once a month. There were clear terms of reference for the committee which set out the attendees, the chair, and the function of the committee. The scope was defined as "All patient care, quality and clinical issues arising from and related to CQC regulated activity within the CQC registration locations and pertaining to ERS Medical, its subsidiary companies and business activities in the UK."
- A Governance and Patient Safety committee met once a month to discuss complaints, compliments, safeguarding concerns or incidents across the entirety of the regions represented by ERS Medical. Relevant operations managers attended, as did the regional manager and clinical and health and safety managers.
- In June 2018, the new regional manager introduced a North Governance and Patient Safety committee meetings to discuss issues specific to the sites they managed. The committee was attended by the operations managers and the technical leads. The minutes of these meetings highlighted that incidents were discussed and learning shared – for example, following an incident with a wheelchair, an action was generated to produce a clinical memo and share with all sites. The action included an owner and a deadline date.
- Minutes from the monthly committees were sent to the head of care to review and the outputs of these reported to the quarterly patient safety meeting chaired by the medical director. They were also reported to the managing director via the monthly performance review meeting.
- Prior to the appointment of the new regional manager there had been no cross-region meetings. This changed in June 2018 when the regional manager brought together the North team and the North East region for monthly meetings. Prior to his appointment there had been little standardisation across regions and teams, and little guidance for operations managers about expectations. They had begun to introduce this

standardisation, including site presentation (see decontamination areas) and staff engagement - albeit that there were still some inconsistencies – for example, regularity of site specific crew meetings.

- Infection prevention and control audits highlighted poor compliance at the beginning of 2018.The data showed that the compliance for infection prevention and control audits improved and was over 80%.
- The sites we visited had had regular health and safety audits completed by the health and safety manager. These identified what the risks were, what the risk score was, what control measures were in place, and what the revised risk rating was. Hardcopies of the audit results were kept on site and recorded within the risk management system.
- ERS Medical North carried out a number of audits including uniforms, hand hygiene, mop, care quality and governance, and driver audits.
- Contracts were commissioned and managed at site level but could be escalated through the Governance and Performance Review committee if there were any issues.
- The service undertook enhanced disclosure and barring service checks for all staff who were employed. Checks were completed every three years unless there had been a clear break in employment with the service.
- The service reviewed all disclosure barring checks to review any issues or convictions. We saw evidence of risk assessments being conducted on those staff who had not had a disclosure and barring service check returned. This included a member of staff who had not been provided with a uniform until their certificate had been returned.

Management of risk, issues and performance

- During our first visit we had concerns about the management of organisational risks, including the lack of contracts in place for some commissioned services and the lack of performance monitoring. ERS Medical North had taken a number of steps to improve its service in this area.
- We spoke with the service's business relationship manager. They confirmed that there were performance indicators in place for contracts. Whilst some of these had previously been monitored centrally, a new process was being introduced whereby the local operations managers would take responsibility for reviewing, understanding contractual performance, and identifying and remedying issues.
- The business relationship manager explained that where some contracts had previously required manual input to produce performance reports, this had been automated to make analysis easier. This automation also allowed the commissioner of one service to view the performance reports remotely.
- At our follow-up inspection, we found the service had introduced performance monitoring into one of contracts even though the contract did not specify such monitoring. For example, the service now had a colour coded system used to easily identify how long it was taking road crews to attend appointments. Performance monitoring of this contract started in October 2018.It showed that, on average, in the three months prior to the inspection, road crews attended over 86% of appointments within 60 minutes.
- The operations manager at Leeds had also put steps in place to review contracts prior to taking them on to ensure they had the required resources in place to support them. For example, a hospital trust wanted the service to provide patient transport support over winter (a 24 hour per day service utilising two shifts).The service reviewed the contract and concluded that it required three shifts to provide effective support. It also identified that it did not have enough staff to achieve this and therefore recruited and trained more in advance of the contract starting.
- We also saw that the service was proactively reviewing the performance and trends in contracts. For example, it identified a trend for patient discharges from a hospital in the afternoon. The service had then introduced a double crew during this increasingly busy period to respond to the demand.
- The care quality manager conducted audits of patient review forms to ensure they had been completed appropriately. There was only one incident in the previous five months where a patient review form was required for the patient transport service.The audit

identified that the staff member had not completed a patient review form when they should have. They were reminded that this was a requirement and completed it retrospectively.

- Following the visit in September 2018, the service had introduced an updated process to monitor the performance of road crews; a Quality Audit – Observation Shift form was used. Questions included, amongst other things, how staff communicated with professionals, whether they understood the handover details, their communication with the patients and whether they obtained consent. Staff were also assessed on adherence to infection control procedures and the completion of relevant paperwork.
- The running sheets did not contain a section to record whether a patient review form had been completed. Staff told us that patient review forms completed should be stored with the corresponding running sheet. However, there were four occasions where there were no patient review forms completed for journeys to the emergency department, and one occasion when a review form was completed for a transfer to an acute medical unit, but there was no indication that the patient had deteriorated or there had been an incident. The evidence demonstrated that there was inconsistency in the completion of patient review forms.
- ERS Medical had a corporate risk register which detailed the risk, action needed to mitigate the risk and the original and current risk score. The register also included planned review dates and risk owner. Risks were graded based on the consequence of the risk and the likelihood of recurrence.
- Operations managers managed their own site specific risks and the managers we spoke with could tell us what these were.Within the minutes of regional site meetings we saw an example of risks being discussed; after a commissioner raised concerns regarding performance, ERS Medical North had committed to recruiting additional staff (which they told us they had done).
- The corporate risk register highlighted four levels of risk, low, moderate, high and extreme. No staff member below regional manager could record a risk. Examples of current risks included the absence of a permanent registered manager in another registered location.
- We saw evidence of ERS Medical working with software developers to improve the reporting abilities, including trend analysis, of its risk management system.
- The operations managers we spoke with could articulate the risks specific to their site. We could see that some of these risks were discussed at the Governance and Patients Safety committee, including staff leaving to work for NHS providers. However, there was no local register of these risks, other than the minutes from meetings. Therefore, if a risk was not considered serious enough to be recorded on the corporate risk register, it could be difficult to keep a track of progress towards mitigating these local risks.
- ERS Medical North had site specific business continuity plans that highlighted the actions staff needed to carry out in certain circumstances. These were readily available for site staff to review.
- Prior to the first visit, ERS Medical North sent us data that showed they had transferred at least one patient detained under the Mental Health Act from England to Scotland. Two different Mental Health Acts apply to England and Scotland.Therefore, once a formally detained patient crossed the border into Scotland, they become an informal patient unless a warrant from the secretary of state was in place. ERS Medical North's policies did not advise staff to check the paperwork for cross border transfers. Whilst there was no evidence that a warrant was not in place for the transfer(s) ERS Medical North carried out, the lack of clear guidance on this issue placed staff at risk of detaining patients without the required paperwork. However, as previously noted, the service had amended its policy and during our follow up visit, we were satisfied that staff were acting in accordance with this.
- During our initial inspection, we found evidence of policies that did not reflect current guidelines which resulted in patients and staff being placed at risk. However, during our follow up visit, we saw evidence that this issue had been resolved.

Information Management

- Staff we spoke with had sufficient access to computers. They could easily access training records, staff rotas and relevant policies.

- Operations managers could readily access the incident tracking system.
- Software used by ERS Medical North helped operations managers keep track of vehicles more efficiently then a paper based system.
- ERS Medical North had a Caldicott Guardian (the Head of Care Quality).We saw evidence that detail of the General Data Protection Regulation was circulated in the staff magazine, along with details of who the guardian was and what the Caldicott principles were. The corporate risk register also included an ongoing risk of systems being compromised by a virus. We saw that no threats had been detected but this would be monitored on an ongoing basis.
- All staff information, including references and disclosure and barring service checks were kept on an electronic system. However, we found that information for a self-employed technician was not held on this system, meaning that there was a risk that not all members of the management team would have access to this information if needed. The service told us that the disclosure and barring service check had been carried out within the last three years and there had not been a break in service. They were satisfied that that the checks they had conducted were appropriate.

Public and staff engagement

- There was a commitment for the senior management team to be represented at team meetings.
- A staff recognition scheme had been introduced and would be awarded each quarter. Nominated staff had the opportunity to win extra annual leave entitlement. All staff nominated also received a letter of thanks from the managing director.
- Patients could provide feedback via a questionnaire. The provider identified that there was only a small percentage (2%) of journeys generated patient feedback. However, it recognised that this feedback was important to improve service responsiveness and we saw evidence that sites had been reminded to ask patients to complete feedback forms. Data provided by ERS Medical North showed an increase in the feedback forms being returned from 14 in March 2018, to 150 in July 2018.
- Staff had free access to health and wellbeing services and we saw details of these displayed in crew rooms.
- ERS Medical produced a quarterly staff magazine, with the first issue being produced in Spring 2018.The magazine highlighted business developments, celebrated staff successes and patient stories.
- ERS Medical North analysed patient feedback forms in July 2018.Of the 31 responses received, over 85% of patients were highly likely to recommend the service to family and friends.

Innovation, improvement and sustainability

- Crews used hand held electronic devices to which they received patient transport instructions. Information included any special notes about the patients they were transporting, including do not attempt cardio-pulmonary resuscitation.
- ERS Medical North was working with a software provider to increase the functionality of the incident reporting system.Meetings had taken place prior to our inspection to look at additional reporting functions to allow benchmarking site performance and trend analysis. There were no timescales for this improvement project.
- The service used several online software packages to track vehicles and their speed (for resource planning and to monitor driver performance), and record and store training certificates, driving licence checks and disclosure and baring service certificates. Packages were also used to monitor and report on vehicle maintenance.
- Staff felt encouraged to share good practice. For example, an operations manager had redesigned the decontamination area within their base. This example was shared with other sites and was being adopted across the region (the Leeds site was developing their decontamination area and were waiting for an outside sink to be installed).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure appropriate documentation is completed on occasions when patient's own controlled drugs are transported as part of a patient journey.
- The service should ensure that all staff have appraisals.
- The service should consider steps to improve the consistency of recording when uniforms and badges are collected from staff leaving the organisation.
- The service should consider steps to help the Leeds site re-introduce team meetings.
- The service should consider how it reviews patient review forms to ensure that they are consistently completed when appropriate.