BAEMS Limited

Bristol Ambulance EMS

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Bristol Ambulance Emergency Medical Services (EMS) is operated by BAEMS Limited. The service provides emergency and urgent care and a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 and 21 February 2018, along with a further visit to the ambulance base on 21 June 2018.

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.

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

Services we do not rate

We regulate independent ambulance services and at the time of this inspection we did not currently have a legal duty to rate them. We highlight good practice and issues service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were strong, thorough and embedded systems, processes and procedures to keep people safe.
- There were reliable systems to monitor and maintain standards of cleanliness and hygiene which was well documented.
- The environment was secure and suitable for safe storage of ambulances and equipment.
- There were comprehensive governance arrangements, which allowed the organisation to work in line with best practice and deliver high quality care. Patient care was at the centre of everything the organisation and staff did.
- Frontline staff and senior managers were passionate about providing a high-quality service for patients with a continual drive to improve the delivery of care.
- There was excellent local leadership of the organisation. The registered manager had an inspiring shared purpose and was committed to the patients who used the organisation, as well as to staff.

However,

- The service was unable to provide evidence of the administration of medicines being recorded appropriately as patient clinical records were returned to the contracting trust.
- The service did not monitor response times and patient outcomes.
- The patient transport service did not have access to translation services, family escorts usually travelled with the patient to act as the translator.

Nigel Acheson

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		Bristol Ambulance EMS primarily provided urgent and emergency services. The service was well led with experienced and capable leaders who drove improvements in the service with a focus on the best possible care. Leaders promoted a positive staff culture and encouraged staff development to deliver the high quality and treatment for all patients. There were effective systems to ensure patients received safe and high-quality care and treatment at all times.
Patient transport services (PTS)		Bristol Ambulance EMS also provided non-emergency patient transport services. The service was well led with experienced and capable leaders who drove improvements in the service with a focus on the best possible care. Leaders promoted a positive staff culture and encouraged staff development to deliver the high quality and treatment for all patients. There were effective systems to ensure patients received safe and high-quality care and treatment at all times.

Bristol Ambulance EMS

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS);

Detailed findings

Contents

Background to Bristol Ambulance EMS

Bristol Ambulance EMS is operated by BAEMS Limited. The service opened in 1972, and came under new ownership in December 2017. It is an independent ambulance service in Bristol. The service primarily serves the communities of the South West of England. The service also has an ambulance base in Thatcham, Surrey

It is an independent ambulance service based in Bristol for both NHS and private healthcare providers, as well as private, individual patient transport. The service primarily services communities in the South West of England. The service provides services to children and adults.

The service provides both emergency and urgent care, and patient transport services, as well as covering events, and training. The service provides support to two local ambulance NHS trusts. It also has contract with other local NHS and private hospitals, local football clubs and events.

Bristol Ambulance reregistered with the Care Quality Commission under its new owner in December 2017, and has not been previously inspected.

The service is registered to provide the following regulated activities:

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

The service has had a registered manager in post since 5 December 2017, when the service re-registered with the Care Quality Commission.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspector, and a paramedic specialist advisor. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Facts and data about Bristol Ambulance EMS

Bristol Ambulance EMS has 81 vehicles – 51 for emergency and urgent care, and 30 for patient transport services. Both services are offered 24 hours a day, seven days a week. The service has its own workshop which undertakes MoTs and servicing, and training centre.

The service has a mobile treatment centre based on a 7.5 tonne lorry, which offers an "Ambulance" classroom simulation. The service supplies the vehicle and supporting staff into Bristol City centre on busy weekend nights to offer a visible place of safety for those who become vulnerable due to excessive alcohol or drugs.

Detailed findings

Between July and December 2017, the service undertook 8,718 patient journeys.

During the inspection, we visited the Bristol ambulance base and head office. We spoke with 24 staff including; registered paramedics, patient transport drivers and management. We spoke with two patients.

The service provided a dedicated neonatal ambulance service to the Newborn Emergency Stabilisation and Transfer (NEST) team and WATCh neonatal and paediatric service. The NEST Team responds to emergency calls regarding sick newborn babies and once they have been stabilised, transports them promptly and safely between neonatal units and hospitals across the South West.

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 registration with CQC.

The service employed 248 staff.

Activity (July 2017 to December 2017)

- In the reporting period July 2017 to December 2017 there were 8,718 emergency and urgent care and patient transport services patient journeys undertaken.

At the time of the inspection the company employed 248 staff, including 58 registered paramedics, 86 ambulance care assistants, 41 emergency care assistants and 25 Institute of Health and Care Development (IHCD) technicians. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events
- 141 incidents
- No serious injuries
- No complaints

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by this ambulance service was emergency and urgent care. The service also carried out patient transport services.

Summary of findings

We found the following areas of good practice:

- There were strong, comprehensive and embedded systems, processes and procedures to keep people safe. The organisation managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The organisation controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. The organisation had suitable premises and equipment and looked after them well.
- Arrangements for the management of medicines and medical gases provided assurance of safe practice. The medicines management policy and associated procedures were fit for purpose.
- The organisation provided mandatory training in key skills to all staff and made sure everyone completed it. The organisation had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm.
- There were comprehensive governance arrangements which allowed the organisation to work in line with best practice and deliver high quality care.
- The organisation provided care and treatment based on national guidance and audited evidence of its effectiveness.
- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.

Emergency and urgent care services

- Frontline staff and senior managers were passionate about providing a high-quality service for patients with a continual drive to improve the delivery of care.
- There was excellent local leadership of the organisation. The registered manager had a shared purpose and was committed to the patients who used the organisation and to staff.

However, we found the following issues the organisation needs to improve:

- There was no formal arrangement for disposing of soiled linen or collecting fresh linen. This was not monitored by the provider to ensure risks were safely managed.

Are emergency and urgent care services safe?

Incidents

- Never events are serious patient safety incidents that should never happen if healthcare providers follow national guidance on how to prevent them. Each never event has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event. Bristol Ambulance EMS reported no incidents classified as never events.
- Incidents were reported using the service's incident exporting form. The service logged 138 incidents from 1 January to 31 December 2017. These were logged on to a system, and included clinical incidents, complaints, control incidents, equipment issues, patients care, personal injury, security/theft; vehicle incident or violent/abuse/harassment. Staff were also encouraged to report near misses. A senior manager was assigned to investigate each incident.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally as appropriate. Staff were clear on their responsibilities for reporting incidents and how the organisation and staff were involved in investigations. Staff had access to incident forms, which were available on vehicles and in the crew room and control room. Staff we spoke with told us what they would do in the event of an incident and could clearly explain what actions they would take. This was in line with the service's incident policy.
- There were arrangements for reviewing and investigating safety and safeguarding incidents and events when things went wrong. All incidents and subsequent learning or action points were reviewed by a senior manager, and summarised and discussed at quarterly governance meetings. We saw where an incident had occurred, lessons learned had been shared across the organisation to reduce the risk of similar incidents taking place. Shared learning from incidents were discussed directly with staff involved in the incident.
- All relevant staff, services, partner organisations and people who used the service were involved in reviews and investigations. As part of the inspection we spoke to one of the local NHS ambulance trusts which worked

with Bristol Ambulance. They told us the service was very prompt in providing an initial investigation report if they had been involved in an incident. They confirmed Bristol Ambulance were not involved in many incidents.

- Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable incidents' and provide reasonable support to them. As most of the work the service had undertaken was on behalf of a third-party provider staff would work closely with them to ensure duty of candour regulations were met. If indicated a liability claim would be forthcoming managers would also work with insurers and ensure a full open and transparent investigation was completed.
- Staff we spoke with were clear about their responsibilities under duty of candour. Staff talked about being "open" and "honest" with people who were using their services.

Mandatory training

- Staff received mandatory training in the safety systems, processes and practices. All staff, including bank and agency received the same training programme. Staff we spoke with told us training was readily available and kept them up to date with changes.
- Mandatory training was delivered by Bristol Ambulance EMS. The provider had a dedicated training centre which was first aid accredited. There was an in-depth training programme provided internally to staff. This was flexible to meet the skill gaps of staff and linked to needs identified from annual appraisals and skill assessments.
- Staff completed mandatory training by combination of face to face classroom training and e-learning. The provider's target for training compliance was 100%. Training information was captured on the electronic staff database, this flagged when training was due to expire or had expired.
- At the time of our inspection the service was not meeting their target, due to the pressures of work and the ability to pull staff off the road to do training. However, compliance showed an improvement between January and February 2018 and on the date of our inspection on 21 February 2018 training compliance was reported as follows:
- Safeguarding face to face: 79%
- Safeguarding Adults: 89%
- Safeguarding Children: 79%
- Conflict Resolution: 88%
- Dementia Awareness: 87%
- Equality and Diversity: 86%
- Fire Safety: 87%
- Health and Safety: 88%
- Infection Prevention and Control: 82%
- Information Governance: 82%
- Moving and Handling: 83%
- However, this had improved by the time of our second visit in June 2018.
- The service ensured staff were appropriately trained to drive under blue lights and non-emergency driving, all staff received the appropriate driver training for their role. The provider confirmed at recruitment staff had completed this training or offered the training via an external provider. The external provider would complete assessments for staff who had completed their driver training prior to their employment with Bristol Ambulance EMS.
- Staff provided evidence of their C1 driving licence to drive vehicles of maximum authorised mass between 3.5 and 7.5 tonnes.

Safeguarding

- Systems, processes and practices which were essential to keep patients safe were in place and communicated to staff.
- Staff had the appropriate levels of safeguarding supervision and training. All staff were required to complete adult and child face to face training, and to complete e-learning modules on adult and child safeguarding with assessments. All staff were trained on induction and then had a refresher course every 36 months. At the time of the inspection, 69% of staff had completed the face to face training, 78% had completed the adult safeguarding e-learning course, and 78% had completed the adult safeguarding e-learning course. The service had achieved this by the time of the second inspection visit in June 2018.
- Staff spoken with were confident in the processes to report safeguarding, they received safeguarding training via face to face and e-learning to ensure they were up to date with changes to legislation. If a safeguarding concern was identified the staff member would phone control to report. Staff we spoke with were aware of the child and adult protection policy available on line.

- In the event of a safeguarding incident occurring while working for the NHS ambulance trusts, staff had local contacts at the trusts where they could refer their safeguarding concerns. The NHS ambulance trusts the service worked with took the lead on safeguarding with any patients, but the service reported they did not feedback to the service on any referrals made despite requests made.
- The safeguarding lead for the service was the control manager. There were two senior members of staff who were trained to Level 5 safeguarding for children and young people. Roles and competencies for child safeguarding training are outlined in 'Safeguarding children and young people: roles and competences for health care staff 'Intercollegiate Document Third edition: March 2014' states in the case of independent ambulance providers, there should be a minimum of one level 4, a named professional.
- The service had a process to identify if a protection plan was in place for a patient they were attending. Information was shared by local ambulance trusts with the service which ensured, due to patient confidentiality, only information relevant to the transport would be shared. Ambulance crews discussed this with relevant family and healthcare professional.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from a healthcare-associated infection. The service had an infection prevention and control policy which provide staff with advice and support.
- A clinical support team was responsible for the cleaning of vehicles to ensure infection control. We saw cleaning being completed during the inspection, and forms completed as evidence of what had been completed. We observed cleaning records to be up to date and demonstrate the ambulances were regularly cleaned.
- The service had 51 vehicles for transporting patients at the time of the inspection. We checked six urgent and emergency ambulances and one rapid response vehicle. We found the vehicles to be visibly clean and well maintained. Sterile consumables were stored correctly, personal protective equipment was readily available and hand sanitiser gel provided. Decontamination cleaning wipes were available on vehicles to ensure equipment was appropriately and safely cleaned after each patient use. Body fluid spillage kits were readily available for the clean-up of bodily fluids.
- Staff were required to complete a yearly infection control e-learning module and assessment. All staff receive training on induction and then refresher every 12 months. At the time of the inspection 82% of staff were up to date with their infection control training, and we saw the service had plans to ensure all staff had completed this by March 2018. We saw good hand hygiene practices were undertaken with patients on ambulances.
- However, there was no formal arrangement for disposing of soiled linen or collecting fresh linen. Linen was exchanged for like for like from hospitals but there was no service level agreement. This was not monitored by the provider to ensure risks were safely managed.

Environment and equipment

- The head office was based on a business park in the south of Bristol, with its own training centre and MoT testing centre and servicing workshop. The main building contained the control centre, crew areas, and offices for management. The vehicles were stored at the head office location.
- The design, maintenance and use of facilities and premises helped keep people safe. The service ensured all vehicles had a current MOT, service and were properly insured. The service had its own MoT testing centre and workshop which provided good access to services. We saw the fleet database which flagged vehicles when they required an MoT, service or road fund license. Mileage data returned from the fuel card system was also recorded to ensure vehicles were serviced by either the time or mileage indicators. Equipment was well maintained and serviced on a regular basis. We randomly sampled equipment and could confirm all had received a service.
- The service made sure vehicles and equipment were appropriately and safely cleaned and ready for use. All vehicles were subject to a quarterly deep clean, or when requested by staff. We saw records were kept which confirmed each vehicle had a regular deep clean as per the service's policy, to ensure there was no cross contamination, and cleaning was followed by a sanitising fog. At the same time as the deep clean relevant equipment was serviced, including the carry chair and surroundings, stretchers, tail lifts and fire extinguishers. We saw that records were maintained which showed vehicles and equipment were regularly cleaned, and when it was next due.

- Harnesses were available on ambulances to ensure patients were safely secured whilst being conveyed to hospital. Ambulances were also equipped to convey bariatric patients. They had clamp fittings on the floor of ambulance for transporting patients in wheelchairs. Restraints, for example seat belts and baby seats, ensured patients were safely restrained when being conveyed.
- The service had 51 accident and emergency double-crewed ambulances for urgent and emergency care at the time of the inspection, plus eight rapid reaction vehicles (RRV). We looked at seven double-crewed ambulances and one RRV. Managers confirmed the company had invested in vehicles and equipment, and the service was pre-emptive regarding what equipment was required. Staff we spoke with told us senior managers listen to staff and invested in equipment which was required.
- All the vehicles we looked at appeared to be damage free, with working radios and mobile phones. Essential checks, such as monitors, oxygen, suction, had been checked and this had been recorded. The service had daily vehicle inspections which were recorded and stored at the ambulance base. This included any defects found during inspection, which were recorded in a defect book, and information shared with the service's garage, so defects could be rectified.
- All equipment we looked at on vehicles, including ramps, harnesses and chairs had been serviced and we saw visible safety tested stickers indicating when the next service date. This information was also entered on to a database, so managers and staff could plan for servicing of equipment. The trolleys we looked at were clean and mattress covers were intact. Non-consumables, including single-use items were sealed and in date. Fire extinguishers and oxygen and nitrous oxide cylinders were in date and securely stored. Clean linen, hand-cleansing gel, and decontamination was available on all vehicles we looked at.
- Gas cylinders and equipment were stored securely, with designated areas for full and empty cylinders, in the service's locked store cupboard when not in use. Intravenous fluids and medicines were stored in a locked cupboard within a locked room.
- Where a fault in equipment had been identified the equipment was immediately taken out of use and we saw where red 'out of service' tags were attached to the item indicating it should not be used. All patient equipment including medical devices were repaired and/or maintained by an external company.
- Grab bags were available for staff when equipment was needed quickly. All grab bag equipment followed a structured standardised format to ensure all staff were familiar with the contents and storage. A member of staff was responsible for checking each bag before it was issued to crew staff and were tagged so bags were tamper-proof.
- Keys, including vehicle, medicine and stock keys were securely stored in a key safe within a locked room.
- The clinical support team ensured equipment and stock was available on the vehicles before the vehicle left the station. If equipment or stock required replenishing the crew would return the vehicle to the station before attending a subsequent job.
- The arrangements for managing waste kept people safe. Clinical waste was appropriately segregated and stored. Collection of waste was managed via an external contract and could be requested more frequently as required. We saw provisions for the safe disposal of waste and sharps (such as needles), however, during one vehicle check we did notice a sharps bin which was almost full and fully open. Sharps bins should be temporarily closed when not in use to ensure no risk of spillage.
- The training team provided additional training to staff to educate on the use of new equipment, for example, new harnesses which had recently been rolled out onto vehicles.

Medicines

- Medicines were safely managed. Medicines and controlled drugs were ordered, stored, recorded and disposed of correctly.
- The provider's medicine policy clearly set out the expectations for staff to manage medicines safely. This policy was available to staff on the intranet.
- Access to controlled drugs was restricted to authorised clinical support persons, paramedics and authorised senior management. Entries in the controlled drug register were accurate and stock levels were checked regularly. When taken off site controlled drugs were held on the paramedic's buckle. There was an auditable trail of controlled drug administration.

- The provider had the correct controlled drug home office licence. The licence identified the registered manager as an authorised witness to supervise the destruction of controlled drugs.
- Medicines and medical gases were securely stored and in date.
- The clinical support team would stock medicine bags, and it was the responsibility of the paramedic to check they had full and in date stock before signing out to take on the vehicle. We checked a medicine bag and confirmed stock was at an appropriate level and medication in date. Medicines were held securely on vehicles. First aid bags were held on patient transport vehicles.
- We reviewed the medicine store which was orderly. On a random check medication was in date. However, we did identify glucagon was not being stored in the fridge and as a result had not had its expiry date revised by 18 months. This was not in line with manufacturer's guidelines. We raised this with the provider at the time of the inspection, they were planning to rectify and had an auditable trail which would enable them to confirm the date they received each glucagon to put the correct revised expiry date. This was rectified by the time of our second visit.
- The provider did not require their own patient group direction (PGD). PGDs are written instructions to help you supply or administer medicines to patients, usually in planned circumstances. Where paramedics administered a prescription only medicine that was not on the exemption list, they followed the trust PGDs for which they were carrying out work. These PGDs were available to staff on the provider's intranet and staff we spoke with were aware of them.
- Medical gases were stored securely on site and on vehicles, in line with the British Compressed Gases Association. We noticed the empty cylinders had a faulty padlock and therefore were not secure. This was immediately rectified when raised with management.
- The service did not complete medicines audits. There was therefore no assurance mechanisms of the systems and processes for managing medicines. However, we were told the system was regularly reviewed via stock checks, we saw evidence stock levels were recorded and any errors investigated. There was a clear audit trail of batch numbers and stock levels for medicines held.
- We saw evidence medicine risks were considered and included on the risk register. A current risk was medication shortage, information was included on the risk register of how this was being mitigated.
- There had been no medicine incidents reported in the last year.

Records

- People's individual records were stored and managed in a way that kept patients safe. This included ensuring patient's records were accurate, complete, legible, up to date, and stored securely. The service kept records of each patient transported. Patient journey data was entered onto am electronic system. The service had a policy for the creation, storage, security and destruction of records.
- Records were clear and complete, dated, timed and signed and followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Staff were made aware of 'special notes' to alert them to patients with, for example, pre-existing conditions or safety risks or, those patients with an up-to-date 'do not attempt cardio-pulmonary resuscitation' (DNACPR) and end of life care plan, through the control centre. We saw DNAR orders were noted on the journey booking system which ambulance staff could access on their vehicles.
- Paper records were securely stored at the head office.
- We were unable to review whether the administration of medicines was being recorded appropriately because patient clinical records were returned to the contracting trust. The provider did not receive feedback on the quality of the patient care records their staff were completing and as a result were unable to complete patient record audits.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who use services and risk management plans were developed in line with national guidance. Risks were managed positively.
- Staff identified and responded appropriately to changing risks to people who used services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenged. Paramedics assessed patients against Joint Royal Colleges Ambulance Liaison Committee (JRCALC) protocols.

- Resuscitation training for adult and paediatric patients was delivered at the induction. Emergency care assistants and ambulance care assistants were resuscitation trained for basic life support, technicians immediate life support and paramedics advanced life support. Staff would also complete resuscitation scenarios to maintain their skills and would be assessed against criteria. A pre-hospital trauma life support training was provided by an external company and was aimed at paramedics and technicians.
- Staff were able to tell us how they would deal with violent or aggressive patients, although these situations were rare. Managers confirmed that staff were briefed in advanced on any concerns regarding patients, including the risks of violent and aggressive behaviour.
- Crews confirmed they could access specialist clinical advice through the control centre if required on scene or in transit.

Staffing

- Staffing was planned and managed to ensure appropriate levels of staff to meet people's care and treatment needs. Staffing was planned to meet the needs of the contracts with NHS trusts. The skill mix was determined based on the trust requests and the patient need.
- At the time of our inspection there were 248 staff. For patient facing operational staff this included 64 paramedics, 28 technicians, 47 emergency care assistants and 51 ambulance care assistants. The recruitment manager said they were currently concentrating on the recruitment of their ambulance care assistants due to the increasing demands of the business. These roles were advertised online and applicants were being interviewed at the time of our inspection.
- The resourcing service delivery manager would populate shifts one month prior. Any unfilled shifts or dropped shifts would be communicated to staff to fill. We were told there it was rare to have an unfilled shift as staff were willing to have overtime to ensure the shifts were fully covered and were flexible in their approach to work. Paramedics were typically on the bank, they would send their availability or preference of work. Bank staff were monitored for the number of dropped shifts, for example cancelling shift or sickness, to enable trends and themes to be reviewed.
- Staff sickness and turnover was low. Between 1 January and 31 December 2017 there was a 2% sickness rate. A leavers report between 6 April 2017 and 21 February 2018 showed a total of 29 staff had left, this included 12 bank staff and 17 contracted staff, none of which were long standing staff. Seven staff had left from the workshop department (maintenance of vehicles).
- The provider confirmed staff had completed an enhanced Disclosure and Barring Service (DBS) check at recruitment and on a three-yearly cycle. A DBS check confirms whether a person has or has not got a criminal record or whether they are prohibited from working with vulnerable adults or children. We reviewed nine staff files for active employees and saw evidence of the DBS number and validity recorded. The provider used an electronic system for employee information, which included the DBS number with start and end date, the system flagged if a DBS check was not completed or if the end date was due to or had expired. We reviewed this system and from all staff one paramedic had a recently expired DBS check. We discussed this with the recruitment manager who told us they were chasing the paramedic for their updated DBS, we saw email evidence this was being chased. We were told if this was not made available soon the paramedic would not be booked on shifts, although there was no formalised process for this.
- Paramedic registration with the Health Care Professional Council (HCPC) was checked on recruitment and every two years when registration expires and was renewed. The electronic staff record did not include the registration number; however, this was held on a separate excel staff database. We reviewed four paramedic files and saw evidence of their qualification and registration with the HCPC. We performed a random check of 10 paramedics on the HCPC register and confirmed there were no notes or restrictions to practice.
- A risk assessment could be used if there were any concerns or flags for a staff member's DBS or registration. We saw an example of a completed risk assessment for a potential employee who had flagged via the DBS check system. This showed the provider was considering the risk score for their staff and making a judgement about their safety and appropriateness to work.
- Recruitment and ongoing checks were clearly recorded on an electronic staff system. There was capability with

the new electronic staff system to prevent staff who were not compliant with recruitment and on-going checks (for example registration, driving licence, DBS) and training requirements, from working shifts. The provider was planning to implement this fully.
- Arrangements for using agency staff kept people safe. One agency was used to provide staff. All agency staff were considered normal employees therefore they followed the same recruitment checks, completed induction, and met face to face with management before they began a shift for the provider.
- There had been no staff turnover in the previous 12 months, and sickness was recorded for whole company at 2%.
- Although the service did not attend major incidents as this was outside their remit, they would be used to assist in the event of a major incident or when the NHS ambulance service was on black alert. Black alert is the highest level of pressure an NHS ambulance service can be placed under and escalation processes must be in place to cope and provide services to patients.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Policies and procedures were formulated and updated in line with relevant and current evidence-based guidance, standards, best practice and legislation. The service was provided in line with NICE guidelines and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. We saw policies referred to relevant national guidance and legislation, for example, National Institute for Health and Care Excellence (NICE), Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Social Care Act 2008, Medicines and Healthcare Products Regulatory Agency (MHRA) and Health and Safety Executive (HSE).
- All policies had been reviewed in October 2017 by the service's base doctor. Version controls were stamped on policies to help staff ensure they were looking at the latest version. Staff we spoke with told us they had access to policies on their mobile devices.
- Standard operating procedures (SOPs) were available for staff to follow. These provided details of the care that was required in line with recognised guidance. Examples of SOPs available for staff to use were management of; a deteriorating patient, anaphylaxis, and acute asthma. All staff, including remote staff, could access SOPs on their mobile devices.

Response times and patient outcomes

- The service had quarterly contract review meetings with the ambulance trusts and monthly review meetings with the commissioning groups in the trusts they supplied. We reviewed minutes of the meetings, and average response times were not monitored. The service could not therefore access response times for all journeys by its own crews. However, the service monitored activity data including date of travel, and where available arrival and departure times. We spoke to a contract manager of one of the ambulance trusts who confirmed they did not monitor response times and patient outcomes for Bristol Ambulance crews, but confirmed there were no issues.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. The provider regularly offered training to maintain competencies and skills of its staff.
- There was a robust recruitment process to ensure staff were competent to work. Prospective staff would complete an application form, supply two references, provide appropriate identity checks, complete a medical skills assessment in line with their skill grade They completed a multiple-choice question examination, complete a driving assessment pack and underwent an interview based on a standard template for each skill grade. We saw a recent applicant had submitted fraudulent certificate, but this has been identified by the service on submission.
- New staff completed an induction to familiarise themselves with the service. The induction covered base station familiarisation, clinical guidelines, vehicles, equipment, medication, communication equipment documentation, incident reporting, and behaviours and standards. Staff we spoke with told us the induction was comprehensive, and helped new starters gain confidence.
- All staff completed a provider training induction on recruitment and repeated the induction on a three-yearly basis. The induction linked to mandatory

training requirements. Additionally, an induction was completed for one of the ambulance trust who contracted work to the provider, and all staff had to complete this before they could be booked on to shifts.

- Emergency care assistants and ambulance care assistants completed the first response emergency care qualification level three and four internally. There were plans to deliver level five first response emergency care so technicians could receive in house qualification. All operational front-line staff were at least first response emergency care level three trained. Therefore, these staff had the knowledge, skills and competencies needed to deal with pre-hospital care emergencies to include the management of airways, catastrophic bleeding, management of fractures and medical emergencies.
- Staff received an annual appraisal. Appraisals used a new assessment criterion and scoring system against 10 key skills. Managers identified actions, and training and development needs, for everyone. Staff spoken with told us they had received an appraisal within the last year. However, appraisal data showed that only 33% of urgent and emergency care staff had an appraisal in the previous 12 months. Managers confirmed they had plans to ensure that all staff had a new style appraisal by April 2018.
- Skill assessment days were held in response to staff requests or needs. For example, patient transport staff wanted more development on monitoring blood pressure, a skill day was put on to deliver this to the staff group.
- Continued professional development (CPD) days were offered to staff and provided in house. For example, CPD was delivered on sepsis in line with the training and education being delivered in the ambulance trusts. Paediatric days were delivered by the acute transport for children service who were co-located at the provider's site. Other CPD delivered included mental health and fire simulations with the fire service.
- There was a simulation mannequin which enabled life like scenarios to be completed with front line staff performing interventions and reports being provided to assess skills and competencies.
- Driver behaviour was monitored. Reports were run looking at staff driving, for example looking at excessive speeds (when not on blue lights). This could be reviewed if an incident or complaint was received, or as part of the annual appraisal process. Any concerning data could be discussed with the individual and driving assessment or training may be offered.
- Poor or variable performance of staff would be identified and escalated appropriately to ensure the staff member could be managed and supported to improve. For example, an incident was raised about a training need for a staff member, this staff member was provided with one to one training and shadow opportunities.
- Three members of staff had been trained to support colleagues who had experienced traumatic events at work. Staff who had experienced trauma at work would have a three-day post incident catch up, and a one and three month catch up. Staff spoke very positively about being able to discuss traumatic incidents with colleagues. Staff told us they could self-refer themselves to occupational health if they required counselling.
- A licence check was completed on recruitment (with a DVLA check for ban, points, class of vehicle), these checks were then repeated every 12 months and recorded on the service's compliance system. A copy of the DVLA report was kept on file.

Multi-disciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patient's care and treatment. Control staff received information from referring organisations and commissioners to plan and deliver patient care. Information was logged onto the IT system which could be immediately accessed by crews on their mobile devices.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients are due to move between teams and services, including referral, discharge and transition. We saw good communication with the control centre team and ambulance crews. Managers were on site to provide support and guidance where required.

Access to information

- All information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included care and risk assessments,

care plans, case notes and test results. Crews had access to: special notes; advanced care plans/directives, and DNACPR orders, through information provided by the control room.
- Systems that managed information about people who used services supported staff to deliver effective care and treatment worked well. This included coordination between different electronic and paper based systems and appropriate access for staff to records through their mobile devices. Treatment protocols and clinical guidelines were computer based and we observed staff referring to them where necessary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, and the Children's Acts 1989 and 2004.
- Staff were clear about their responsibilities in obtaining consent. Staff we spoke with told us each patient should have their needs assessed on an individual basis, including their capacity to consent to treatment. Staff understood they may have to act in the patients' best interest, and this was recorded. This was in line with the service's Mental Health, Consent ion Adults and Consent in Children policies.
- Staff received training on the Mental Capacity Act 2005, Mental Health Act 1983 (MHA) and the transportation of patients experiencing a mental health crisis.
- Staff understood the differences between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty. Mental capacity act and deprivation of liberty training was included in the company mandatory induction. Staff received this training alongside adult and child safeguarding. Staff told us that this prepared them well for dealing with vulnerable patients.

Are emergency and urgent care services caring?

Compassionate care

- Due to the nature of patients' conditions were unable to speak directly to patients during the inspection. We did however, attend some patient journeys, and observed patient care.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way. We observed crew members attending a distressed patient with mental health needs. We observed crew being very caring and compassionate, and respectful of the patient's independence. Time was taken to clearly explain treatment.
- Staff told us they felt they would be able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes, but could not provide an example where they had witnessed such behaviour.
- All staff we spoke with demonstrated that compassion was important to them, and to the service they worked for. One member of staff told us "People matter… we're a patient focused organisation. We're given enough time to help patients".

Understanding and involvement of patients and those close to them

- Staff communicated with patients so they understood their care, treatment and condition. Patients had their proposed treatment and options explained to them by ambulance crews. We saw time was taken to clearly explain treatment, and staff checked patients understood what they had been told.
- Staff recognised when people who used services and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included language interpreters, sign language interpreters, specialist advice or advocates. Crews told us how they would access this information, through the control centre. Photo cards were also available on ambulances to help crews with basic translation.
- Staff made sure patients and those close to them could find further information or ask questions about their care and treatment. Staff we spoke with said they allowed time for the patient to ask whatever questions they wanted.

Emotional support

- Staff understood the impact a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. Staff we spoke with described treating patients 'like family members'.
- People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. The service shared feedback with us from patients. One patient stated they had scared and restless, but staff "were authoritative and calming which gave me confidence I was in good hands… they were very clear in their communication".
- Emotional support and information was available to those close to people who used the service, including carers and dependants. We spoke with staff about providing emotional support for patients and their friends or relatives. Staff told us they saw this as an important part of their role. Staff gave examples of encouraging relatives to travel in the vehicle with the patient to alleviate emotional distress and told us this was of particular importance when they were conveying a vulnerable patient, for example, a patient living with dementia or, a patient receiving end of life care

Are emergency and urgent care services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. The service had framework agreements with NHS ambulance trusts which fluctuated in resource requirements. Managers told us to achieve the level of resourcing required they were careful in what they agreed to cover and commitments they made. The service utilised their own staff and a large pool of 'bank' staff. We saw information was shared between the local ambulance trusts and the service, including activity and performance data, 'on scene to left scene' data, and hospital turnaround times.
- The service also provided a dedicated neonatal ambulance service to the Newborn Emergency Stabilisation and Transfer (NEST) team and WATCh neonatal and paediatric service. The NEST Team responds to emergency calls regarding sick newborn babies and once they have been stabilised, transports them promptly and safely between neonatal units and hospitals across the South West. The service had key performance indicators which it met, including 'red calls' response within three minutes; 'amber calls' responses within three hours, and 'green calls' within 24 hours or specified time.
- As part of the inspection we spoke to one of the local NHS ambulance trusts. They told us Bristol Ambulance were very responsive to requests for work, and had internal systems and procedures which enabled fast responses.
- The provider used their dedicated training centre to invite young parents in the area for a cardiopulmonary resuscitation day. This met the needs of local people to ensure parents had the basic knowledge and skills should their child have a cardiac arrest.
- The mobile treatment centre was used as an alcohol recovery centre, this was provided on behalf of the ambulance trust for the Bristol area. This was used to prevent attendances to local accident and emergency centres in hospitals and offered the local population a place of safety.

Meeting people's individual needs

- Services were planned to take account of the needs of different people, for example on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief, and sexual orientation. There was a system for flagging people with dementia, learning disabilities, physical disabilities, and for flagging people with DNACPR orders.
- Staff understood the adaptations required for patients with complex needs, including people who had learning disabilities, mental health illnesses, bariatric patients, patients who were hard of hearing or deaf, partially sighted or blind, and patients living with dementia.
- Translation support was available for staff in the treatment of people who were unable to understand or speak English. This was accessed through the local ambulance trust.

Learning from complaints and concerns

- People who used the service knew how to make a complaint or raise concerns, were encouraged to speak up, and were confident to do so. We saw complaints

leaflets on vehicles, and patients could also contact the service through its website. However, at the time of the inspection there had not been any complaints direct to Bristol Ambulance in the previous 12 months.
- Staff could describe what information they provided to patients and carers who wished to complain. Staff told us they would encourage patients to feedback to the company if patients complained to them.
- In most cases the NHS ambulance service retained responsibility for complaints and subsequent investigation. We saw the service and staff were actively involved in investigations. The service learned lessons and acted as a result of investigations following a complaint. Timelines were agreed on an individual basis, to ensure the service met with third party timelines. Feedback from one of the local ambulance trusts showed Bristol Ambulance would undertake an investigation and feedback within five days of being notified of a complaint.
- One of the local NHS ambulance trusts that Bristol Ambulance worked with told us there were low numbers of complaints involving the services staff, numbers of complaints were either in line with or below those of other independent ambulance providers.

Are emergency and urgent care services well-led?

Leadership of service

- The leadership team included the chief executive officer, the director of operations and the head of operations. The senior managers demonstrated they had the skills, knowledge, experience and integrity they needed to run the service. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. The registered manager was experienced and passionate about the organisation with a commitment to the patients who used the organisation, and to staff.
- Leaders had a good understanding of issues, challenges and priorities in their service, and beyond. The senior management team worked closely to coordinate the organisations agendas ensuring the service met all regulatory, corporate and mandatory obligations. Leaders had a full understanding of the caseload and issues experienced by staff.
- Leaders were visible and approachable. All staff we spoke to could identify the different leads, their roles and responsibilities. Operational road staff we spoke with told us they regularly saw their managers, and they encouraged appreciative, supportive relationships among staff. Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns. They told us that there was a 'no blame' culture that made it easier to admit mistakes and to learn from them.
- Leaders encouraged appreciative, supportive relationships among staff. Managers we spoke with told u they were proud of the team they worked with. Staff confirmed managers had an 'open door' policy and they could talk to managers openly and transparently. They also spoke about how teams 'were like family'.

Vision and strategy for this this core service

- There was a clear vision and a set of values, with quality and safety the top priority. The services mission was "to be a provider of excellence in the Independent Ambulance Sector, delivering unsurpassed care to the patients entrusted to us". This included meeting all essential standards of quality and safety.
- All the staff we spoke with were aware of the vision of the service. The services' strategy included continuing to develop best practices an emulate good NHS ambulance services, continuing the ethos of 'family values' in management decisions, investing in staff training, and at all times deliver the best patient care through best practice.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- Governance and risk management processes were fit for purpose and demonstrated a positive working relationship between all staff teams and the senior management team. The governance framework was focused on supporting the delivery of safe, quality care.
- There was an effective governance framework to support the delivery of the strategy and good quality

care. The service held quarterly governance meetings which were minuted. A standing agenda covered: policies; duty of candour; safeguarding; training; incidents; patient feedback; staff feedback; and audits.

- The service ensured clinical ambulance staff declared working arrangements outside of the service and monitored this to make sure staff were not working excessive hours that may adversely impact on the care and treatment was provided.
- There was a programme of clinical and internal audit which was used to monitor quality and systems to identify where action should be taken. The information recorded in patient care records was used for clinical audits to evidence good patient care. These were audited and reports generated to identify themes and highlight training needs.
- A comprehensive set of policies was readily available on the intranet and was supported by procedures which outlined the steps or actions individuals and teams must take to meet the aims of the policies. This ensured staff could work according to best practice guidance.
- The service understood, recognised and reported their risks. The organisation had a corporate risk register and this had been kept up-to-date. There was alignment between the recorded risks and what people told us was on their 'worry list'. The service's risk register included vehicle breakdown, faulty equipment, medicines shortages, and crew overruns or delayed starts.
- Bristol Ambulance senior managers held regular meetings with the NHS ambulance trust they worked with. We were provided with copies of meeting minutes, which covered safeguarding, operational issue, clinical issues, and complaints.

Culture within the service

- Staff felt respected and valued. All staff we spoke with where overwhelmingly positive about the service. Staff told us they could speak to their manager or any of the senior managers candidly.
- Action was taken to address behaviours and performance which was inconsistent with the vision and values, regardless of seniority. Managers and staff we spoke with talked about the importance of a patient centred organisation, and the importance of supporting or addressing the behaviours of staff that were not in line with service's values.
- Staff could get support when required. There were three members of staff who staff were trained to support staff who had experienced traumatic or potentially traumatic situations. Staff we spoke with told us this was very supportive. They could talk to one of the three trained staff, who were colleagues and not managers.
- There was a very strong emphasis on promoting the safety and wellbeing of staff. Several staff we spoke with told us about support provided by their manager and senior managers when they experienced personal issues. Staff spoke about being allowed time off, with no pressure to return to work, and supportive home visits. One member of staff told us a senior manager "went above and beyond what was expected" and they had been given "a huge amount of support". These staff all referred to Bristol Ambulance as a family environment, where you could rely on the support of all staff.
- When managers received positive feedback, this was shared on social media platforms. We were given an example of a consultant providing feedback for crew dealing with a young child with sepsis. The feedback was shared with the crew concerned, and then with all members of staff.

Public and staff engagement

- Staff felt actively engaged so their views were reflected in the planning and delivery of the service. Managers told us staff were encouraged to feedback on how the service was delivered. Social media was used for staff engagement. The management team found this a useful tool to cascade messages to staff quickly. Staff also commented how this was effective and kept them up to date with information and changes.
- The service had a staff side representative who regularly met with staff and fed back to the management team. We saw minutes of staff representatives' meetings. We saw managers acted based on staff feedback, such as speed limiters being removed from vehicles, and changes to shift patterns. Minutes also provided an opportunity for managers to feedback to staff, for example, being encouraged not to use their personal mobile phones when attending to patients. Minutes were distributed to staff in print, available in the crew room, and available electronically through on-line discussion groups.
- Staff confirmed the senior managers had an open-door policy and all staff we spoke with told us they were confident to raise any issues with senior managers.

Emergency and urgent care services

Innovation, improvement and sustainability

- The service had a mobile treatment centre and supporting staff which was used in Bristol city centre on busy weekend nights to offer a visible place of safety for those that became vulnerable due to excessive alcohol or drugs, and to act as an alternative to taking those vulnerable through drink or drugs to hospital.
- The service had received recognition from a local college for their work with Health and Social Care students.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by this ambulance service was emergency and urgent care. The service also carried out patient transport services.

Summary of findings

We found the following areas of good practice:

- There were strong, comprehensive and embedded systems, processes and procedures to keep people safe. The organisation managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The organisation controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. The organisation had suitable premises and equipment and looked after them well.
- Arrangements for the management of medicines and medical gases provided assurance of safe practice. The medicines management policy and associated procedures were comprehensive and fit for purpose.
- The organisation provided mandatory training in key skills to all staff and made sure everyone completed it. The organisation had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm.
- There were comprehensive governance arrangements which allowed the organisation to work in line with best practice and deliver high quality care.
- The organisation provided care and treatment based on national guidance and audited evidence of its effectiveness.
- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.

Patient transport services (PTS)

- Frontline staff and senior managers were passionate about providing a high-quality service for patients with a continual drive to improve the delivery of care.
- There was excellent local leadership of the organisation. The registered manager had an inspiring shared purpose and was committed to the patients who used the organisation and also to staff.

However, we found the following issues the organisation needs to improve:

- There was no formal arrangement for disposing of soiled linen or collecting fresh linen. This was not monitored by the provider to ensure risks were safely managed.

Are patient transport services safe?

Incidents

See information under this sub-heading in the urgent and emergency care section.

Mandatory training

See information under this sub-heading in the urgent and emergency care section.

Safeguarding

See information under this sub-heading in the urgent and emergency care section.

Cleanliness, infection control and hygiene

See information under this sub-heading in the urgent and emergency care section.

Environment and equipment

See information under this sub-heading in the urgent and emergency care section.

- The service had 30 vehicles for transporting patients at the time of the inspection. We checked two patient transport vehicles. We found the vehicles to be visibly clean and well maintained. Sterile consumables were stored correctly, personal protective equipment was readily available and hand sanitiser gel provided. Decontamination cleaning wipes were available on vehicles to ensure equipment was appropriately and safely cleaned after each patient use. Body fluid spillage kits were readily available for the clean-up of bodily fluids.

Medicines

See information under this sub-heading in the urgent and emergency care section.

- Patient own medication remained the responsibility of the patient and was therefore carried with the patient. The patient transport service crew would not administer medication.

Records

See information under this sub-heading in the urgent and emergency care section.

Assessing and responding to patient risk

Patient transport services (PTS)

See information under this sub-heading in the urgent and emergency care section.

Staffing

See information under this sub-heading in the urgent and emergency care section.

Response to major incidents

See information under this sub-heading in the urgent and emergency care section.

Are patient transport services effective?

Evidence-based care and treatment

See information under this sub-heading in the urgent and emergency care section.

Assessment and planning of care

See information under this sub-heading in the urgent and emergency care section.

Response times and patient outcomes

See information under this sub-heading in the urgent and emergency care section.

Competent staff

See information under this sub-heading in the urgent and emergency care section.

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. At the time of the inspection all patient transport staff had completed basic life support training, driving training, equipment training and had received continuous professional development.

Multi-disciplinary working

See information under this sub-heading in the urgent and emergency care section.

Access to information

See information under this sub-heading in the urgent and emergency care section.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

See information under this sub-heading in the urgent and emergency care section.

Are patient transport services caring?

Compassionate care

See information under this sub-heading in the urgent and emergency care section.

- All staff we spoke with demonstrated compassion was important to them, and to the service they worked for. We were given examples of taking a patient to a chip shop on the way home, and taking a palliative care patient into their garden before being taken inside for care.

Understanding and involvement of patients and those close to them

See information under this sub-heading in the urgent and emergency care section.

Emotional support

See information under this sub-heading in the urgent and emergency care section.

- Staff understood the impact a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. On the day of inspection, the service transported a terminally ill patient from their home to a family wedding. Managers had supported the family and crews by ensuring the crew would stay with the patient for the day. We saw the patient and their family were supported during the journey, and the patient made comfortable by the crew.
- The service provided ambulance support to several local charities for free. Many of these were charities that were important to staff members.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

See information under this sub-heading in the urgent and emergency care section.

Patient transport services (PTS)

Meeting people's individual needs

See information under this sub-heading in the urgent and emergency care section.

- Staff understood the adaptations required for patients with complex needs, including people who had learning disabilities, mental health illnesses, bariatric patients, patients who were hard of hearing or deaf, partially sighted or blind, and patients living with dementia. For patients living with dementia or people with learning disabilities, the service ensured there was a two-person crew, and either had the patient travel alone in the vehicle, or had the patient be the last to be picked up and the first to be dropped off, to minimise any distress to the patient.
- The PTS service did not have access to translation services, family escorts usually travelled with the patient to act as the translator.

Access and flow

See information under this sub-heading in the urgent and emergency care section.

Learning from complaints and concerns

See information under this sub-heading in the urgent and emergency care section.

Are patient transport services well-led?

Vision and strategy for this this core service

See information under this sub-heading in the urgent and emergency care section.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

See information under this sub-heading in the urgent and emergency care section.

- The service did not have key performance indicators for the patient transport services. Most of the work completed was 'on the day' requests where other providers were not able to assist - therefore the agreement was to will arrive as quickly as possible and is therefore difficult to performance measure.

Leadership of service

See information under this sub-heading in the urgent and emergency care section.

Culture within the service

See information under this sub-heading in the urgent and emergency care section.

Public and staff engagement

See information under this sub-heading in the urgent and emergency care section.

Innovation, improvement and sustainability

See information under this sub-heading in the urgent and emergency care section.

Outstanding practice and areas for improvement

Outstanding practice

In house training enabled the provider to ensure the competency of their staff across skill grades. The training offered was dynamic and flexible to address staff skills gaps, with the resource and equipment available, for example simulation training. The provider also linked with external providers as required, for example for driving training. The mobile medical treatment centre could be used internally and externally for training delivery. The provider also invited young mums to attend a day on cardio pulmonary resuscitation considering the needs of the local population.

Areas for improvement

Action the hospital SHOULD take to improve

- Review arrangements for used linen and ensure a formalised process for its disposal.
- Record the administration of medicines.
- Monitor response times and patient outcomes.
- Provide access to translation services for patient transport services.