Care Quality Commission

Elite Emergency Medical Services Ltd

Elite EMS Headquarters

Inspection report

21 Darwell Park
Mica Close
Tamworth
B77 4DR
Tel: 01827307841
www.eliteems.com

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

Ratings

Overall rating for this location	Good	●
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Good	●
Are services responsive to people's needs?	Good	●
Are services well-led?	Requires Improvement	●

Summary of findings

Overall summary

We rated it as good because:

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

However:

- There were not systems in place for reporting significant events for NHS patients and some incidents had not been reported to the Care Quality Commission (CQC) as required by the regulations.
- While the processes to support the duty of candour were appropriate for private patients, for NHS patients the commissioning ambulance service completed this as identified in the commissioning contracts.
- The guidance for dealing with unresolved complaints for NHS patients did not reference the Health and Public Service Ombudsman.
- The service did not always meet agreed response times.
- Staff did not consistently ensure patient records were completed when transferring patients into the care of a third-party provider.
- NEWS scores were not always recorded accurately However, there had been a noticeable improvement over time.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

- There were not systems in place for reporting significant events for NHS patients and some incidents had not been reported to the Care Quality Commission (CQC) as required by the regulations.
- While the processes to support the duty of candour were appropriate for private patients, for NHS patients the commissioning ambulance service completed this as identified in the commissioning contracts.
- The guidance for dealing with unresolved complaints did not reference the Health and Public Service Ombudsman.
- The service did not always meet agreed response times.
- Staff did not consistently ensure patient records were completed when transferring patients into the care of a third-party provider.
- NEWS scores were not always recorded accurately However, there had been a noticeable improvement over time.

Patient transport services	Good ●	We rated it as good because: - The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service mostly managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. - Staff provided good care and treatment. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care. - Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- While the processes to report deaths and significant events were appropriate for private patients for NHS patients they passed the responsibility to the commissioning ambulance service
- While the processes to support the duty of candour were appropriate for private patients for NHS patients they passed the responsibility to the commissioning ambulance service.
- The guidance for dealing with unresolved complaints did not reference the Health and Public Service Ombudsman and incorrectly stated that the CQC could deal with complaints.

Summary of findings

Contents

Summary of this inspection

Background to Elite EMS Headquarters

Elite Emergency service is a large independent ambulance service that provides urgent and emergency support to NHS ambulance services. The service has a new purpose-built operation centre which is in Tamworth, Staffordshire, with several other ambulance bases centres across the country.

Since the last inspection in February 2018 there were no compliance actions/enforcement that the service needed to address.

The current registered manager has been registered with the CQC since 2018.

The service provides the following services:

Emergency and Urgent Care Services (EUC)

Elite provides paramedic and technician crewed emergency ambulances to several NHS ambulance trusts mainly in the midlands, and the south of England.

Elite provides comprehensive cover to events including sporting meetings and festivals. Unless transport to hospital is provided such provision is outside of the scope of registration. Provision within the scope of registration is reported under the EUC core service.

Patient Transport Services (PTS)

Elite provides patient transport ambulances to several NHS ambulance trusts Part of the provision is secure transport for patients suffering from mental health conditions. PTS services are also provided to private individuals including repatriation. Repatriation services when paid for through travel insurance are outside of the scope of registration. The provider also offers support to people who need help moving and repositioning in their own homes. This too falls outside of the scope of registration as does the transport of people.

Elite provide around 1000 patient journeys each month of which the vast majority are on behalf of NHs Ambulance Trusts, around 25 are transfers for dental appointments and less than 10 are privately commissioned.

How we carried out this inspection

We carried out an unannounced comprehensive inspection, looking at all five key questions; safe, effective, caring, responsive and well led.

We visited the Tamworth Headquarters of the provider where we inspected premises, vehicles and equipment.

We approached the NHS trusts that commissioned services form the provider and made use of their contract and quality monitoring information where it was provided.

Summary of this inspection

The urgent and emergency core service inspection was carried out by two CQC inspectors and one specialist advisor with paramedic experience.

During the inspection we looked at seven patient records and spoke with one patient over the telephone.

We spoke with 13 staff members on site and eight staff members over the telephone. We looked at 10 staff files.

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

Outstanding practice

We found the following outstanding practice:

- The service had developed an online safeguarding form that the staff could access whilst out on the vehicles and this is completed electronically. The management team reviewed this information and identified any required actions.
- The service had developed a specific patient safety form to record patients' safety and waiting times on the ambulance, this information was then shared with the trusts. The service was contracted to four different NHS ambulance trusts that had different processes. To support staff to follow the correct trust process, managers created an app that provided relevant information to the crews, to enable them to access this whilst out in the vehicles and at the time they needed the information.

Areas for improvement

Action the service MUST take to improve: We told the service that it must take action to bring services into line with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action the service MUST take to improve:

- The service must ensure that the death of a service user is reported to the CQC in compliance with regulation 16 of the Care Quality Commission (Registration) Regulations 2009.
- The service must ensure that incidents are reported to the CQC in compliance with regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Action the service SHOULD take to improve: We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportioned to find a breach of regulation overall

Action the service SHOULD take to improve:

- The service should ensure that when staff hand over a patient to another provider they ensure the third-party provider staff, such as ED nurses, fully complete the service handover sheet to confirm they have received the patient into their care.
- The service should ensure that processes for the duty of candour are in line with the relevant regulation and that duties are carried out by the provider including the keeping of written records
- The service should ensure that the complaints policy references recurse to the Health and Public Service Ombudsman for NHS commissioned patients and makes clear that the CQC cannot take up unresolved complaints.

Summary of this inspection

- The service must ensure that NEWS2 scores are record and calculated accurately, to ensure the correct monitoring of deteriorating patients.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	Good	Good	Requires Improvement	Good
Patient transport services	Good	Good	Good	Good	Requires Improvement	Good
Overall	Good	Good	Good	Good	Requires Improvement	Good

Emergency and urgent care

Good 🟢

Safe	**Good** 🟢
Effective	**Good** 🟢
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Requires Improvement** 🟠

Are Emergency and urgent care safe?

Good 🟢

We rated it as Good

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

All staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff.

The service had a training target of 85% for every mandatory training module. All were met except for one staff member which was at 78%. Managers monitored staff who undertook training at alternative places of work such as NHS trusts and requested evidence of completion of all mandatory training.

Staff who drove ambulances undertook training which was approved by the NHS Ambulance Service Driver Training Advisory Group (DTAG).

All staff completed BLS (Basic Life support) Training.

The service has suitable training facilities for staff to access all training.

All staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

We reviewed training modules covering these topics. Training materials were up to date and reflected current practice. Staff had awareness of patient's diverse needs and knew how to seek specialist support if required.

Managers monitored mandatory training and alerted staff when they needed to undertake update or refresher training.

Staff received reminders about training that was out of date or they needed to complete. There were clear guidelines about the expectation of staff, for example if staff had not completed safeguarding training, they were not permitted to deliver care.

Emergency and urgent care

The service had a clear learning and strategy dated 2020 to 2023, with clear objectives.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse.

All staff received training in safeguarding children and adults for level two training, and frontline staff level three, and they knew how to recognise and report abuse. This was reported to be 100% completion rate. Staff were able to give examples of safeguarding concerns. Staff completed training including terrorism (PREVENT) and modern-day slavery.

The safeguarding lead had relevant experience, knowledge to complete the role, and was trained in safeguarding children and adults' level four. The safeguarding lead was based at the main office in Tamworth. Staff knew who this was and were able to approach them for advice and support.

Staff could make safeguarding referrals in different ways depending on the NHS ambulance trust they were working for that shift. For example, some trusts submitted electronic safeguarding referrals. Each vehicle has access to a QR code. Staff used this to access online safeguarding advice, support and to report safeguarding concerns to the provider.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff shared with us examples of how they supported patients giving consideration to any protected characteristics. For example, they had identified a patient who was vulnerable due to their age and had taken steps to ensure the person was protected from abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

We saw an example where staff called the police to help support a vulnerable patient who had been harmed.

The service had safeguarding policies and protocols in place for both children and adults.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

Entry to building was restricted to prevent the risk of COVID-19 infections with reception staff being diligent in the examination of Lateral Flow Device test results. There was also a computerised questionnaire to assess the risk of visitors bringing COVID-19 into the building

Staff were seen to observe COVID-19 precautions including the use of masks and hand sanitiser. There were dispensers for masks and hand sanitiser throughout the building.

Emergency and urgent care

Rooms were risk assessed for occupancy and this was displayed outside of the room. Where staff were particularly vulnerable this had been risk assessed and enhanced arrangements made for their safety including extra space and working from home.

When absolutely necessary leaders made dynamic risk assessments to increase room occupancy to support the inspection process and directed the inspection team to maintain social distancing while improved ventilation and minimised the time people spent together

Staff took routine Lateral Flow Tests twice a week and if unwell or having a high temperature a PCR (polymerase chain reaction) test was arranged in line with guidance in place at the time of the inspection.

The service was aware of the vaccination status of all staff, and they were encouraged to use the immunisation programme. Where staff were not vaccinated, they were not allocated to jobs requiring access to care homes during the time that this was a requirement.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained.

All vehicles were visibly clean and well maintained. During the inspection there was approximately eight vehicles in the garage and three vehicles were checked. Vehicles that were not suitable to go out on the road were clearly labelled VOR (vehicle of road).

There was a dedicated cleaning bay equipped with vehicle wash equipment, benches, sinks and a washing machine. Cleaning materials were safely stored and there was usage and Control of Substances Hazardous to Health (COSHH) information displayed. Mops had disposable heads, were colour coded and stored upright off the floor.

The service performed well for cleanliness.

Managers audited cleanliness to ensure compliance to required standards. Data from the service showed evidence these audits were conducted monthly along with a monthly infection prevention and control report. The report for February 2022 showed vehicle IPC compliance was between 98% and 99% for all ambulance bases and deep cleaning compliance was between 98-100% compliant across the bases. The service tests vehicles using adenosine triphosphate (ATP) which is a molecule found in all living cells. ATP levels act as an indicator of whether your environment has been properly cleaned. Four vehicles per base were swabbed on a monthly basis. Data from the service showed that the most recent results (February 2022) showed all vehicles had passed demonstrating an acceptable level of cleanliness.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

There were robust procedures in place to safely manage the risk of infection relating to COVID – 19 on the vehicles and within the offices.

Staff cleaned equipment after patient contact to reduce the risk of cross infection.

The service used a deep clean chart with a QR code, this identified what was required during the deep clean and when it has been completed. Managers monitored deep clean compliance to ensure this was completed.

Emergency and urgent care

Staff followed infection control principles including the use of personal protective equipment (PPE). There was adequate PPE available on the vehicle. All staff were observed wearing PPE in accordance with current infection control guidance.

Staff had received training in the safe use of PPE.

Environment and equipment

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

The design of the environment followed national guidance.

The service had designated 'make ready' areas where vehicles were cleaned, washed and re-stocked.

The garage was secure and there was CCTV, staff were present 24 hours a day.

All vehicles were in an identified parking space within the garage. We observed two crews preparing to go on shift and noted that they carried out vehicle and equipment checks against a written checklist.

The service held comprehensive records of vehicle maintenance, including servicing of the vehicles.

The service had comprehensive systems to manage vehicle safety testing/insurance and road tax and there were accurate records.

Vehicles had been assessed to their gross weight and those over 3500kg requiring a C1 licence were identified.

Staff carried out daily safety checks of specialist equipment.

The service had a process in place to monitor medical device recall alerts, and how these notices are discussed with the team.

The service had enough suitable equipment to help them to safely care for patients.

The service had enough stock which was linked to each vehicle. Stock was checked and was in date. An electronic system enabled a full stock audit and stock review.

All essential emergency equipment was serviced, electrical safety tested and secured in the vehicles.

The service has an agreement with the NHS to enable clean linen was made available. Staff swapped this out for each patient when a patient was handed over therefore all linen was washed by the hospitals.

Staff disposed of clinical waste safely.

Staff understood guidance relating to the safe disposal of clinical waste. Policies and procedures were in place to support this.

Emergency and urgent care

Assessing and responding to patient risk

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

Data from the service included an audit of the use of the National Early Warning Score (NEWS2) from June 2021 to March 2022. This showed that in this time period, the service monitored these monthly, these showed that there were occasions where NEWS scores were not always recorded accurately, However, over the last three months these had improved. Staff had access to a provider policy for managing deteriorating patients.

Staff completed risk assessments for each patient using a recognised tool, and reviewed this regularly, including after any incident.

This included sepsis risk assessments and stroke risk assessments. Staff had the knowledge to identify and deal with any specific risk issues. Managers audited staff compliance to undertaking sepsis and stroke assessments. Audits from January to December 2021 showed overall compliance to be reasonable (between 89% - 100%). One exception to this was August 2021 where staff recorded the stroke assessment 89% of the time which was below the standard set by the service.

The service followed a major trauma triage tool, which indicated what action to take when they attended an event where patients had experienced a major trauma.

The service had a policy in place for physical intervention.

Staff completed risk assessment forms when a physical intervention was used. These were reviewed by the management team to ensure staff had taken appropriate action to support patients and to identify any actions or any further training needs. This policy advocated the least restrictive measures possible in line with Department of Health guidance.

The service had 24-hour access to mental health liaison and specialist mental health support. Designated clinical leads were available to provide advice and support to staff.

Staff completed risk assessments for patients thought to be at risk of self-harm or suicide in order to determine the best pathway for the patient.

Staff demonstrated a good understanding of patients at risk of self-harm. They shared with us examples of supporting a patient to hospital for suspected overdose.

Staff shared key information to keep patients safe when handing over their care to others. However, staff did not ensure that hospital staff receiving patients fully completed the patient record to indicate the patient had been handed over.

Staffing

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

The service had enough paramedic and IHCD Ambulance Technician to keep patients safe.

Emergency and urgent care

Staff comprised of contracted staff and zero hour contracted staff. All vehicles had two staff allocated which always comprised at least one paramedic or emergency care technician.

Managers accurately calculated and reviewed the number and grade of Paramedic or IHCD Ambulance Technician / Associate Ambulance Practitioner and Emergency Care Assistant needed for each shift in accordance with national guidance.

The number of paramedics and emergency care assistants matched the planned numbers.

The service had clinical leaders and mentors who supported the paramedics in the community when required.

The service had low vacancy rates.

At the time of our inspection there was one vacancy for front line staff.

The service had reducing turnover rates. In the last three months this had reduced from 10% to 1%.

The service had reducing sickness rates. In the last three months this had reduced from 12% to 4%.

The service used zero-hour staff that were familiar to the service. There had been no use of agency staff since 2017.

Managers made sure all zero hours staff had a full induction and understood the service.

All staff completed an induction, which identified the company values, the vision of the company, what is expected of staff and the training that the staff will complete. This also included code of conduct and training for the care certificate.

The service had a 24 hour on call system and a process in place for escalation to ensure that the staff could seek support from a senior member of staff when needed.

Records
Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely.

Patient notes were comprehensive, and all staff could access them easily.

There was a clear policy in relation to record keeping. all patient records were all logged and reviewed for audit prior to being sent to the relevant trust. We reviewed patient record audits through 2021 and saw managers had a series of measures to monitor compliance which included six quality indicators (at least three sets of patient observations if on scene more than 30 minutes, pain score recorded, NEWS2 score recorded, stroke assessment completed, clinical impression section completed and whether a safeguarding referral is required completed). The audits showed that staff compliance with completing the safeguarding referral section (to state if a safeguarding referral was required or not required) needed improvement; although we acknowledged that staff did make safeguarding referrals to the relevant authorities when needed for vulnerable patients.

The service had policies in place and a good understanding of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

Emergency and urgent care

Patient notes were well documented, However, details for patient conveyed to hospital section was not signed or dated by the trust during handover.

Records were stored securely.

Records were stored in filing cabinets in a locked office, which was behind a security door. Only people with approved authorisation could access this area.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

The service had a clear medication management policy in place. The service also completed weekly and monthly audit checks. The service used an online QR system which is accessible to all company medicine leads. All audits are remotely reviewed and monitored by the service clinical lead.

Staff completed medicines records accurately and kept them up to date.

Medicines records were signed by two staff members to reduce the risk of error. No medicines were stored on the vehicles overnight and were signed back into a locked cupboard in a locked room covered by CCTV.

Staff stored and managed all medicines and prescribing documents safely.

All medicines we checked were securely stored and within their expiry date. Some medicines were stored in the fridge. The temperatures of the fridge were recorded daily and recorded. The temperatures were within the recommended range. The service held a stock list of medicines electronically enabling a clear process for replacing stock.

The service held controlled medication on site. Controlled Drugs are drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful. These were stored correctly, checked and audited by clinicians. The service had a system in place to track all controlled drugs, and all medicines were electronically recorded. Paramedics scanned medicines when administering them to accurately record the dosage.

The service holds a Home Office licence that enables the service to possess and supply controlled medicines.

Medical gases were stored separately in a locked area which was dry, well ventilated and regularly checked. Empty gas cylinders were stored in a separate space from full cylinders.

Staff learned from safety alerts and incidents to improve practice.

Manager had a good overview of safety alerts and disseminated this information to staff. Staff confirmed learning was shared with them to improve practice. Data from the service showed managers undertook medicine audits regularly. Where issues were identified these were clearly documented.

Good ●

Emergency and urgent care

Incidents

The service worked with local trusts in relation to duty of candour. The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents all staff received feedback from this. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff had access to electronic systems to report incidents when on the road. This meant information could be shared in real time and reviewed without delay to ensure prompt action could be taken. Staff we spoke with described reporting incidents and raising safeguarding concerns whilst working with patients.

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

Staff reported serious incidents clearly and in line with services policy.

The service had a clear major incident polices and major incident plan in place.

Staff had a good understanding the duty of candour as there was a reliance on contracting organisations to take the lead.

The duty of candour requires that providers must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress., The service worked with the commissioning trust when duty of candour was identified as agreed within their contracts with the NHS trusts.

Elite EMS provided feedback to individual members of staff relating to incidents that they have raised. When it is deemed that all staff would benefit a "Learning from Incidents Notice" is generated and shared with all staff. We saw that managers encouraged staff to report incidents within a team meeting held in March 2022 (after our inspection) and we saw notices distributed in the garage.

Managers investigated incidents thoroughly. There was evidence that changes had been made as a result of investigations.

The service discussed individually within the clinical lead meetings and learning was identified.

Managers debriefed and supported staff after any serious incident.

Staff received support after serious incidents. Staff were also offered counselling support if required.

Are Emergency and urgent care effective?

Good ●

We rated it as good.

Emergency and urgent care

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff and the service were following Joint Royal Colleges Ambulance Liaison Committee (JRCALC) national guidelines. JRCALC combines expert advice with practical guidance to help paramedics in their roles and supports them in providing patient care. Staff had access to this information remotely. Staff also followed the trust processes and policies they were working on behalf of. This meant that at times, staff would follow different processes depending on the trust they were working for. Staff also had regular updates on NHS trust policies that had changed.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Staff had handovers with the trusts. Staff routinely referred to the emotional needs of patients, their relatives and carers

Staff were able to tell us that they understood the procedure for not conveying patients to hospital.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after it was identified they needed it, or they requested it.

Data reviewed from the service reflected the number of patients whose pain levels had been assessed each month. The service audited the use of pain relief that had been given and if this was appropriate, this was monitored on a clinical quality review tool. This meant managers could ensure staff were monitoring patients' pain and responding accordingly.

Staff prescribed, administered and recorded pain relief accurately.

Staff completed a pain assessment tool, the average for this was 99% completion rate. Staff could offer a range of pain relief depending on the needs of the patients.

Response times

The service monitored agreed response times so that they could monitor outcomes for patients. Data from the service showed they were not quite meeting all required targets at the time of inspection. They used the findings to make improvements.

Data from the service showed they were not quite meeting all required targets at the time of inspection.

The service monitored response times and they had set targets, these were:

• See and Treat.

Emergency and urgent care

The 'see and treat' model is one which provides clinical assessment at the patient's location, followed by appropriate immediate treatment, discharge and / or referral. Often a patient may be referred to other services that are more appropriate to the patient's needs such as the patient's GP.

The 'see and treat' target for the service was to do so within 60 minutes. For the three months prior to our inspection, the service had met this target 84% of the time. However, we saw in patient records viewing during the inspection that on some occasions where this target was not met; this was due to the staff being responsive to the individual patients' needs and ensuring they were safe and had adequate community support.

- See and Convey

The 'see and convey' model is one which results in an emergency response arriving to the patient, followed by ambulance conveyance to a healthcare facility such as an NHS emergency department.

The 'see and convey' target for the service was 45 minutes. For the three months prior to our inspection this had been met 77% of the time.

- Handover to clear

The NHS standard contract states that all handovers of patients between ambulances and emergency department must take place within 15 minutes. For the three months prior to our inspection the service had met this 85% of the time. We acknowledged that delayed handover of care to emergency departments was a national problem at the time of the inspection due to the pandemic and the number of patients outweighing the capacity of many emergency departments.

The service discussed this in clinical governance meetings and discussed with NHS trusts with whom they had contracts.

Competent staff
The service made sure staff were competent for their roles. Managers appraised most staff's work performance. Not all staff had access to regular team meetings.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

The service employed staff with a wide mix of skills and experience. Staff had good understanding of their roles supported by relevant qualifications and training. Clinical staff were available as mentors to newer, less experienced members of the staff team.

Not all staff had an appraisal at the time of our inspection. Data from the service showed at this time, 84% of staff had been appraised. Managers were aware of who was outstanding and had plans to complete these.

The training team supported the learning and development needs of staff.

All contracted operational staff were required to undertake the Care Certificate as part of their role.

Not all staff had access to regular team meetings.

Emergency and urgent care

During our inspection, some staff told us they attended meetings. We requested minutes for team meetings held within the six months prior to our inspection. Data sent through showed one team meeting for operational staff and one team meeting for patient transport service staff had been held; both after our visit.

Managers identified poor staff performance promptly and supported staff to improve.

The service operated clear policies and procedures to support staff performance. Staff were aware of the expectations of their individual role and action was taken promptly to address any concerns with staff performance. We saw examples where poor performance had been identified indicating training and support needs. In these instances, individual plans were created with the staff member involved to support them to develop in their knowledge and competency.

Multidisciplinary working

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

Staff worked with their colleagues and NHS staff to discuss patients and improve their care.

Staff worked closely with hospital staff to be able to transfer patients into hospital safely and quickly, to meet the needs of the patients.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff worked with NHS trusts and with other agencies when required to care for patients, including (but not limited to), the police, coroner and fire service.

Health Promotion

At the time of our inspection, staff were not actively engaged with health promotion.

The service did not have information promoting healthy lifestyles and support on the vehicles at the time of inspection due to COVID -19. However, the service did provide leaflets advising the patients of information in relation to their health, which would be made available when safe to do so.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

The service had a clear policy and procedure for capacity to consent which covers the Mental Capacity Act.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw this was documented in patient records.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records.

Emergency and urgent care

Good ●

The service had a policy and procedure in place which staff followed to ensure patients were given the opportunity to consent to their care. Where possible staff supported patients to sign to say they consented to any decisions made. We reviewed seven patient records and consent for any decisions made had been sought and recorded in all cases.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Where appropriate staff discussed patient's care with their relatives and made decisions in patients' best interests.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

All staff had received training in relation to the Mental Capacity Act and understood how this applied to their role. Managers were available to give advice and support relating capacity and consent. Staff had access to the provider policy which covered the Children Act, consent for under 18s and how to assess for Gillick Competence for those under 16. Gillick competency is often used to assess whether a child is mature enough to consent to treatment.

Are Emergency and urgent care caring?

Good ●

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

During our inspection we spoke with one patient and reviewed written feedback to the service from September 2021 to February 2022. The service received 62 compliments in this timeframe from patients, family members and carers.

We identified themes within the feedback such as caring staff who went over and above to ensure patients were supported. Many of the comments reflected that staff took time to interact positively with the patients and their loved ones.

Patients said staff treated them well and with kindness.

Themes within patient feedback included kind staff who did not rush patients, and supported patients to take their time.

Staff followed policy to keep patient care and treatment confidential.

Emergency and urgent care

Staff were aware of their responsibilities in relation to confidentiality and followed policies and procedures to protect patient's information.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We had one example of feedback whereby a relative reported that staff showed a non-judgemental approach when working with a person with dementia and took time to adapt their communication style to support the patient.

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

As above, we reviewed patient feedback and spoke with one patient. Many patients spoke of a good level of emotional support that staff gave them and to their loved ones.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Feedback from relatives and patients described how staff supported them when they were distressed. One example demonstrated gratitude to staff after they attended to their relative who subsequently passed away. The relative commented upon the exceptional level of emotional support and kindness shown at this time.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Feedback from patients, relatives and carers showed staff were able to identify the impact that patients' medical conditions had on their wellbeing. We saw examples of staff using humour to put patients at ease and to instil confidence.

Understanding and involvement of patients and those close to them
Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff supported patients to make informed decisions about their care.

We reviewed patient records which shoed staff supported patients to understand their options and to consent and agree with decisions made.

Staff talked to patients and family members in a way they could understand and were able to ask questions and seek more support if needed.

Emergency and urgent care

Good 🟢

Feedback from patients and relatives showed that they were involved in care and staff took the time to communicate clearly.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients could give feedback; either compliments or complaints to the service. We saw, as above, numerous examples of patient feedback.

Are Emergency and urgent care responsive?

Good 🟢

We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population.

The urgent and emergency provision of the service was, in the main, contracted by four NHS ambulance trust. Therefore, the services were designed around the requirements of the trust. We saw within senior leadership team meeting minutes that managers regularly reviewed this.

The service also provided urgent and emergency care at events. CQC do not regulate any care given at the event; however, we do regulate the service if they convey a patient to hospital for ongoing treatment. The service provided cover for events in line with requests from event management.

Facilities and premises were appropriate for the services being delivered.

The service headquarters was housed in a purpose configured industrial unit with a dedicated training centre. The garage, office and training space were suitable for the needs of the staff and the vehicles. Patients did not visit the premises.

Meeting people's individual needs

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

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

The service had multilingual cards available in different languages for patients who did not speak English.

Managers made sure staff and patients, loved ones and carers could get help from a specialist language line to access interpreters when needed.

Emergency and urgent care

Staff had access to communication aids to help patients become partners in their care and treatment.

The service had picture cards available for patients with communication needs

Staff had an understanding how to support patients living with dementia and learning disabilities. Staff had received training to enable them to support patients living with dementia and learning disabilities. Patient feedback we reviewed showed staff were able to support patients with dementia appropriately.

Access and flow

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

Staff supported patients when they were transferred between services.

The service was monitoring response times for each see and treat on scene, convey, handover to clear. Please see the 'effective' section for more details.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives and carers knew how to complain or raise concerns.The service clearly displayed information about how to raise a concern in patient areas.

The service had electronic codes which could be scanned to make giving feedback easier for patients and their families

We reviewed the complaints policy and found it did not fully reflect patients' options when following up on complaints. The policy did not mention that for care commissioned by the NHS if a complainant has exhausted the provider's complaints procedure and are still not satisfied, they may take their complaint to the Health and Public Service Ombudsman (HPSO).

The policy also noted that should a complainant be dissatisfied with the response they could contact the Care Quality Commission. The commission can be informed of concerns at any time, but it cannot take up or investigate any complaint on behalf of a patient, resolved or otherwise. This was not made clear.

Staff understood the policy on complaints and knew how to handle them.Managers investigated complaints and identified themes.

The service had received 19 complaints from March 2021 to February 2022. Investigations into complaints were carried by the management team and where appropriate a response was provided to the patient or relative. Themes included clinical care below standard (four) and conduct/ attitude (six).

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Emergency and urgent care

We saw evidence of actions taken following complaints which involved sharing learning and feedback with patients and third-party organisations as appropriate.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Where learning had taken place following a complaint information was shared with staff to improve practice and reduce the risk of reoccurrence.

Are Emergency and urgent care well-led?

Requires Improvement ●

We rated it as requires improvement.

Leadership

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

The CEO was supported by the head of operations, the operations general manager and the director of people and culture, head of corporate services and the head of quality. Below this grade were area managers, and operation managers such as the fleet manager. They were supported by shift supervisors.

The senior leadership team were able to identify and prioritise issues that arose, these were addressed in a timely manner.

Staff told us that site managers were approachable and supportive and senior managers and the CEO were also visible and very approachable.

Staff told us that they were supported to develop their skills and roles.

There was always an on-call manager available 24 hours a day.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a five-year strategy in place from 2021 to 2026. The strategy stated the vision of the service which was to become the largest private provider of ambulance vehicles across the UK and to be the provider of choice for UK ambulance trusts. This vision was underpinned by specific objectives and strategies such as the vehicle replacement strategy.

Emergency and urgent care

The strategy clearly identified the values of the service which were respect, valued staff, teamwork and supportive culture.

The service had a two-year apprenticeship strategy in place, and this identified the path for staff that are completing an apprenticeship.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt there is a positive culture in the service and felt very supported by managers and senior managers. The levels of staff turnover and staff sickness was low within the service, however staff told us they had frustrations which were out of the services control and they felt they can raise these concerns with managers and are felt listened too. For example, ambulance crews felt they were sometimes made to wait longer at emergency departments than crews who worked directly for the NHS. This was being addressed by managers at the time of our inspection and was on the service risk register.

Staff spoke highly of their colleagues and stated it was a pleasure to work with the crews and a pleasure to work for the service. Feedback from patients, relatives, carers and third-party providers indicated they were able to share feedback openly with the service.

The service completed equality and diversity training as part of their training and could seek advice from managers and staff diverse groups.

The service provided support and de-briefing for staff after complicated calls, A counselling service was provided that all staff could access to help with their well-being.

The evidence we saw supporting the complaints and incident investigation processes was indicative of a culture of openness and honesty.

Governance

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

The service had a clear structure in place, which identified the senior manager structure and middle management structure. This was evidenced through a documented organisational structure and comprehensive and well written documentation such as policies, procedures and forms.

However, managers were not fully aware of their requirements to provide statutory notifications (CQC Registration Regulations 16 and 18). Instead they had an agreement with the contracted NHS ambulance trusts that the trust governance teams would undertake these statutory requirements as part of their contract. This was explored fully at the inspection. The senior leadership team were open about this finding and expressed that they would adopt their processes to be compliant with their legal requirements. After our inspection, the service submitted a notification of a police incident demonstrating they understood this requirement.

Emergency and urgent care

Staff were employed in specific roles with job descriptions and responsibilities. Staff at all levels understood their roles and responsibilities.

There were various groups that had oversight of areas such as medicines, incidents, complaints and training. There was a dedicated HR department and a training department.

There was a clear process in place for learning from incidents, including serious incidents, and how these were reviewed and then training identified if needed. However not all staff reported receiving feedback after incidents.

The service held regular clinical governance meetings with NHS trusts who they hold a contract with.

We saw that quality of service meetings took place with commissioners.

Where processes and procedures were in place they ran effectively.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had a risk register in place. This identified the risk and any mitigation taken to reduce the impact of risks. The risk register was comprehensive, regularly reviewed and clearly showed mitigating actions.

All identified risks were relevant to the service and linked to the NHS trust relevant to that risk. Clinical risks included staff not always pre-alerting trusts for patients scoring high for sepsis, gaps in documentation such as completing pain scores, and delays outside of emergency departments.

Managers and senior managers were able to explain what their three top risks were for the service and how they were addressing these.

Staff told us they received feedback from risks and incidents and were aware if learning from these had taken place.

Vehicles were equipped with GPS systems linked to the NHS Ambulance service computer aided dispatch system. Staff had access to handheld radios and mobile phones.

Managers monitored performance and met regularly with NHS trusts to review this.

The service had a major incident plan and business continuity policies. The impact of Covid-19 had been added to the risk register at the start of the pandemic.

Some of the processes meant that events requiring notifications be reported to the CQC were reported instead to the commissioning NHS ambulance trust and sent to the National Reporting and Learning Service (NRLS) alongside those of the trust. This meant that reports of unexpected deaths, serious incidents and allegations of abuse against staff had not been reported appropriately.

Emergency and urgent care

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. However, notifications were not submitted to the CQC as required.

There were effective information systems in place to support the activities of the provider. Data was comprehensive and we saw it used to both operate day to day systems, manage the service and provide strategic information.

Some approaches were innovative including the use of mobile phone apps to distribute information to staff and for them to report incidents and other matters.

The provider operated a staff portal which enabled the distribution of information such as policy updates and bulletins.

Vehicles were equipped with GPS based navigation and location systems. Staff had access to handheld radios and mobile phones.

The service had effective processes in place, and worked well with NHS trusts, However the service was not submitting notifications to CQC as required by their registration under the CQC Registration Regulations. We discussed this at the time of the inspection and senior leaders understood they had not undertaken this in line with legislation. They stated this was due to NHS providers submitting statutory notifications on their behalf. Following the inspection, we saw the service started submitting statutory notifications as required. For example, we received a notification of a police incident from April 2022.

The service completed audits to monitor the performance and these were discussed in the clinical governance meetings. Action plans were put in place to monitor this.

Elite EMS use multiple ways to communicate notices to all staff these include, Staff notice boards, Digital displays, Staff Intranet (Staff Zone) and "in cab" news letters

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service worked closely with NHS trusts to improve services for patients.

The service held regular meetings with NHS trusts who commissioned services, to discuss audits and learning form incidents.

Staff told us they were involved in decision making within the service, and ideas of change were listened too and implemented where possible.

The service and in particular the CEO had been a part of a bespoke vehicle design to develop new vehicles. The CEO also gained the thoughts of the staff who used the vehicles daily and gave suggestions to support both staff and patients when using them.

Emergency and urgent care

Learning, continuous improvement and innovation

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

The service had developed an online safeguarding form that the staff could access whilst out on the vehicles which was completed electronically. The management team reviewed this information and identified any required actions.

The service had developed a specific patient safety form to record patient's safety and waiting times on the ambulance, this information was then shared with commissioning trusts.

The service was contracted by four different NHS ambulance trusts that had different processes. To support staff to ensure they are following the correct trust process, service created an 'app' that provides relevant information to the crews, to enable them to access this whilst out in the vehicles and at the time they may need this information.

Patient transport services

Good 🟢

Safe	**Good** 🟢
Effective	**Good** 🟢
Caring	**Good** 🟢
Responsive	**Good** 🟢
Well-led	**Requires Improvement** 🟠

Are Patient transport services safe?

Good 🟢

We rated it as good.

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

Staff throughout the service received and were mostly kept up-to-date with their mandatory training.

The service had a target of 85% of mandatory training to be completed. Records showed that this was achieved overall and where one staff group did not meet the target it was being addressed.

The mandatory training was comprehensive and met the needs of patients and staff.

As well as the corporate training staff in the Patient Transport Service (PTS) had specific training modules relevant to their role and this was aligned to the Core Skills Training Framework (CSTF). Staff to whom we spoke were complementary of the online mandatory training courses and we noted that staff returning to work following absence were required to complete all outstanding training before going on shift. There was a detailed and comprehensive driving policy with specific reference and limitations for PTS driving.

The provider had a dedicated trainers and a training centre with a clinical skills room, lecture rooms and an IT suite which contributed to the effectiveness of training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

There was a module in the mandatory training for "Mental Health, Dementia and Learning Disability"

Managers monitored mandatory training and alerted staff when they needed to update their training.

The training system alerted staff and their managers of modules that needed completing three months in advance of the expiry date.

Patient transport services

Safeguarding

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

All staff were trained to level 2 in both adult and children's safeguarding and those with patient contact to level 3.

Staff told us that they had not been allowed to start work until their Disclosure and Baring Service (DBS) checks had been received and assessed.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

There were separate adult and children's safeguarding policies, and these described how to operate within the different areas and with the NHS commissioners that the service operated.

The policies either incorporated, or there were separate policies for, domestic violence, forced marriage, female genital mutilation, honour-based violence, concealed pregnancy and the PREVENT counter terrorism strategy.

There was an internal policy for dealing with allegations against staff. This listed immediate actions, liaison with the local authority and commissioners, informing other employers and the police as necessary. It also detailed how other colleagues and the member of staff concerned would be supported.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff were able to give examples of having reported safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service had a safeguarding lead with previous experience as a lead in the NHS and was trained to level four for children's safeguarding They demonstrated appropriate knowledge and experience and all staff we asked knew their name and role.

Staff were confident in describing abuse and how to make an internal safeguarding report. They also described circumstances in which they would contact the police or the local authority directly. There was positive culture with respect to safeguarding.

Staff followed safe procedures for children using the service.

There was a separate children's safeguarding policy although the numbers of children transported was very low.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

Patient transport services

Entry to building was restricted to prevent the risk of COVID-19 infections with reception staff being diligent in the examination of Lateral Flow Device test results. There was also a computerised questionnaire to assess the risk of visitors bringing COVID-19 into the building

Staff were seen to observe COVID-19 precautions including the use of masks and hand sanitiser. There were dispensers for masks and hand sanitiser throughout the building.

Rooms were risk assessed for occupancy and this was displayed outside of the room. Where staff were particularly vulnerable this had been risk assessed and enhanced arrangements made for their safety including extra space and working from home.

When absolutely necessary leaders made dynamic risk assessments to increase room occupancy to support the inspection process and directed the inspection team to maintain social distancing while improved ventilation and minimised the time people spent together

Staff took routine Lateral Flow Tests twice a week and if unwell or having a high temperature a PCR test was arranged in line with guidance in place at the time of the inspection.

We were told by a patient who had recently used the service that staff took appropriate COVID-19 precautions during their journey.

The service was aware of the vaccination status of all staff and they were encouraged to use the immunisation programme. Where staff were not vaccinated they were not allocated to jobs requiring access to care homes during the time that this was a requirement.

Vehicles were visibly clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

All the vehicles we looked at which were prepared to go out on the road were clean and labelled as ready. Vehicles which were not yet cleaned and prepared were also labelled as such.

There was a dedicated cleaning bay equipped with vehicle wash equipment, benches, sinks and a washing machine. Cleaning materials were safely stored and there was usage and Control Of Substances Hazardous to Health (COSHH) information displayed. Mops had disposable heads, were colour coded and stored upright off of the floor.

The service performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Cleaning records were kept and audited. We saw audits for the previous six months that demonstrated compliance between 97% and 100%.

Staff followed infection control principles including the use of Personal Protective Equipment (PPE).

Although we did not see staff delivering care they wore short sleeve uniforms and were bare below the elbow.

Patient transport services

Good ●

Environment and equipment

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

The design of the environment followed national guidance.

The fleet garage was very well equipped with vehicles assigned to marked specific areas in marked parking bays. Vehicles were clearly labelled on the windscreen as to their status, for example, "ready", waiting for "make ready", or "vehicle off road".

The garage was visibly clean and tidy with equipment and cables neatly stowed. We noted that all vehicle movements took place at walking pace and under the supervision of a member of staff outside of the vehicle. Like other visitors the provider supplied CQC inspectors with high visibility jackets and required that they be worn.

The garage was secure and there were staff present 24 hours a day. Senior staff were aware of the risk of trojan terrorist attacks and the need to keep vehicles safe.

There was a fleet manager responsible for the fleet of specially designed vehicles. Although only a few years old the vehicles had high mileage and senior staff explained and showed us there was a fleet replacement strategy. Many vehicles were waiting replacement, but this had been delayed because of manufacture production problems due to COVID-19. However, all in use vehicles were suitable, well maintained and their mileage posed no concerns.

The fleet management office held comprehensive records of vehicle maintenance and servicing, this was under control and well managed. There were comprehensive systems to manage MOT tests, insurance and road tax and detailed and accurate records were available.

An external company was subcontracted to perform regular maintenance, and this included vehicle recovery. A separate company carried out body repairs and manufacturers carried out warranty work.

There were two specialist vehicles allocated for patients who required secure transport. We inspected one on these and saw video of the other. They were suitable for the purpose with a soft environment and a separate secure compartment.

Staff carried out daily safety checks of specialist equipment.

We observed two crews preparing to go on shift and observed they carried out vehicle and equipment checks against a written checklist.

Crews told us that if a vehicle developed a fault this was rectified by to taking the vehicle off the road and getting a replacement. One member of staff told us they recently rejected a vehicle that had a permissible fault and there was no problem in doing that.

The service had enough suitable equipment to help them to safely care for patients.

There was a logistics and stores manager. Stores were generally tidy and organised. Equipment which was unserviceable was identified with a red tab. Those assessed as needing repair it was identified with a yellow tag. Equipment not in use was quarantined.

Patient transport services

Training equipment was also identified and was not used on patients.

There was an asset register of medical device assets and equipment was labelled. The asset register comprised of around 1000 items and was held on a spreadsheet.

Oxygen systems were maintained locally by technicians trained by a suitable company.

The PTS vehicles had standardised stretchers from a single manufacturer which supported training in their use. There were suitable restraints available, including for children of different ages on the occasions that they were transported.

We were told by a patient who had recently used the service that they were suitably secured into the stretcher on their journey and that the stretcher was attached to the vehicle.

There was a medical devices policy which was in line with guidance form the Medical and Healthcare products Regulatory Agency (MHRA). There was a process to ensure medical devices alerts were received through manufacturers, suppliers and the NHS Central Alerting System and a record was kept of these and subsequent actions.

We asked for and saw evidence that medical device service records were available.

Staff disposed of clinical waste safely.

Vehicles had suitable storage for clinical waste. Clinical waste bins located in the garage were noted to be secure, locked and the waste was disposed of through a suitable contractor.

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

Staff responded promptly to any sudden deterioration in a patient's health.

Patient transport vehicles were double crewed, and staff monitored patients' health during the journey. Should there be any concerns staff would contact their own or the NHS ambulance service control room for advice and support. PTS staff were trained in first aid and basic life support.

Staff completed risk assessments for each patient. Staff knew about and dealt with any specific risk issues.

Where transport was requested from the service outside of NHS contracts there was a process to assess the patient's needs and ensure they were safely met. This was supported by a patient transport request form and we saw several completed examples. For NHS patients information was handed over by the ambulance trust's control room.

Aside from the transportation needs the risk and needs assessments included the patient's mobility and whether any aids such as a stretcher, wheelchair or carry chair were needed. The provider did not use patient's own hoists because staff would not be trained to use them.

If from the initial assessment a more detailed risk assessment was needed this was done either virtually or through a site visit to the patient's address.

Patient transport services

For the secure transport service, we saw examples of risk assessments that included any required restraint plans which involved multiple agencies and were signed off by a senior member of staff.

The service had access to mental health liaison and specialist mental health support.

All staff received training in mental health and safeguarding as part of their mandatory training and could identify and raise issues if necessary.

Staff shared key information to keep patients safe when handing over their care to others.

The activity log and individual risk assessments allowed information to be shared when handing over care to another party.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough ambulance and support staff to keep patients safe. Managers accurately calculated and reviewed the number of staff needed for each shift and adjusted staffing levels to demand.

We saw that rotas were developed from the contracted demand and examination of records showed this was met. Staff told us they had never failed to meet their obligations and were usually able to provide resources in excess of the contract which was usually "taken up".

The number of nurses and healthcare assistants matched the planned numbers and the service had reducing vacancy rates.

The provider was actively recruiting PTS staff, but this did not have an effect on the quality service as work was not taken on beyond their capacity.

The service had low turnover and sickness rates.

Sickness rates for the last two months were less than 5% although they had been 12% in December due to COVID-19. Turnover rates were less than 5%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

No bank, agency or locum staff were used by the service.

Records

Staff kept sufficiently detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were suitable and staff could access them easily. Records were stored securely.

Patient transport services

Risk assessments, journey logs and other documents such as DNACPR and Advanced Directives were available to the crews who transported the patient.

At the end of the shift the records were passed to the support team for storage.

There was audit of record forms with feedback provided to the relevant members of staff.

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

Staff followed systems and processes to administer oxygen safely. Staff completed medicines records accurately.

Patients provided with transport were not provided with or administered medicines by staff from the provider nor were any self-administered medicines supervised.

The exception was oxygen which was supplied to those patients who had it prescribed for self-administration. When oxygen was to be provided this was identified in the patient needs assessment and the vehicle was crewed by an Emergency Care Assistant who was qualified to administer the oxygen.

Staff stored and managed all medicines safely.

Oxygen and the associated equipment was installed and maintained correctly.

Incidents
The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.However, the providers processes required that for NHS patients the duty of candour was carried out by the commissioning NHS ambulance service.

Staff knew what incidents to report and how to report them.Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff reported serious incidents clearly and in line with the service's policy.

Staff were confident in describing how to make an incident report and many gave examples of when they had done so This process was facilitated by reporting taking place through the provider's mobile phone "app" via a QR code found on all vehicles.

There was a low threshold for, and a high level of incident reporting which represented a positive approach by both managers and staff.

The service had no never events.

Managers shared learning with their staff about never events that happened elsewhere. Staff received feedback from investigation of incidents, both internal and external to the service.

Patient transport services

Staff told us incident reporting was encouraged and they were involved in the investigation and told of the outcome. Staff said they were also told of incidents they had not been involved in through internal bulletins and that they were also provided with "operational notices" from the commissioning NHS trust.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback.

Recent incidents included reports of use of a mobile device while driving and use of seatbelts. We saw that both of these had been investigated, action taken, and all staff reminded of their duties.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Senior staff were candid about incidents and how they were investigated and this was usually completed alongside the commissioning NHS trust.

Internally this was done through a serious incident panel, which supervised a Root Cause Analysis (RCA), recommendations, actions and feedback.

Managers debriefed and supported staff after any serious incident.

Staff did not fully understand the duty of candour as there was a reliance on contracting organisations to take the lead. While they were open and transparent, and gave patients and families a full explanation if and when things went wrong, for NHS patients this was done through the commissioning ambulance service.

The provider had a process for carrying out the duty of candour for private bookings in accordance with regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, for NHS patients this was done through the commissioning ambulance service while the regulation requires it be done by the provider in whose care the patient was at the time of the incident.

We saw no examples of harm for the PTS service that met the duty of candour threshold.

Are Patient transport services effective?

Good ●

We rated it as good.

Evidence-based care and treatment
The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Patient transport services

There were policies and procedures for staff to follow and these were modified to accommodate the different NHS commissioners.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

There were policies and procedures for the secure transport service including a separate restraint policy. These were aligned with national guidance and good practice.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink.

Where patients took their own food and drink on their journey this was supported and supervised. All vehicles were supplied with sufficient quantities of sealed bottled drinking water for patients to use during the journey.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

The service monitored its performance against its contracted obligations and generally journeys were completed on time and appointments met. It was noted through notes of staff meetings and conversations with staff and commissioners that there were sometimes issues getting to areas on time when there were severe travel delays. However, we were told that when this happened communication was good so alternative arrangements could be made.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role

All PTS staff were trained or working to a Level 3 award in patient care.

Staff were required to produce their driving licence during recruitment and these were rechecked every six months. The provider accepted up to six points on a licence.

Other requirements of driving restrictions , for example when drivers had a medically restricted licence or requirements to drive a minibus were adhered to.

Managers gave all new staff a full induction tailored to their role before they started work.

Staff underwent a skills assessment through a pre-learning questionnaire on recruitment and had a tailored learning pack.

Patient transport services

We spoke to a newly recruited member of staff and they told us they went through an induction process in line with the organisation's procedures. This included all mandatory training.

They further said that they were not allowed to start work until they had a medical and their certificates and references had been provided.

A staff member returning after a period of leave told us they were given update training and familiarisation with changes before they went back on shift

Managers supported staff to develop through yearly, constructive appraisals of their work.

There was a system of appraisal undertake in line with the organisation's appraisal policy. Completion rate for PTS was 100% of all staff able to be appraised.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

We saw examples of notes from staff meetings and that they were distributed to all staff through the provider's bulletins system.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The provider had an overall learning and development strategy and within this staff had their own learning and development needs analysis. We saw, in a recent newsletter, opportunities advertised for PTS staff to express interest in developing by taking an Emergency Care Assistant course.

Managers identified poor staff performance promptly and supported staff to improve.

During our inspection we saw examples of staff performance issues being assessed and addressed in a supportive fashion through training and appraisal.

There was specific training for staff assigned to secure transport work and this was required in the provider's policy. Only specially trained staff were allocated to secure mental health transport jobs. A member of staff described the specialist training that they had received which included the Mental Health Act 1983, record keeping and the safe use of restraint.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care in line with legislation and guidance. Staff could describe and knew how to access the policy on Mental Capacity Act.

The provider had a Capacity to Consent policy which established the legal framework in which the service operated and the duties and responsibilities of staff.

Patient transport services

Staff were trained in the policy and the associated Mental Capacity Act as part of their training and kept up to date through mandatory refresher training.

There was a separate Do Not Attempt Cardio Pulmonary Resuscitation policy which also addressed advanced decisions and was suited to the patient transport activity.

Staff clearly recorded consent in the patients' records.

We asked for examples of when capacity had been of concern and were told of a recent example where a patient had refused transport to an appointment and we saw records of how this was dealt with.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff received and kept up to date with training in the Mental Capacity Act.

Staff received regular updates through the relevant module in their mandatory training.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

This was addressed through the provider's mandatory and induction training.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

The provider's policy on secure transport and restraint detailed when restraint could be used and when physical restraint should be applying the principle of the least restrictive option.

Staff who worked on the secure mental health transport vehicles told us that restraint was only used if absolutely necessary in line with the organisations policies. One member of staff told us that the secure compartment of the vehicle had only been used twice by them and they had never used physical restraints such as handcuffs.

Another member of staff described an incident where a patient had become aggressive and their response was to withdraw and observe while waiting the attendance of the police. The patient was persuaded to return to the vehicle without intervention and they considered this had been the best outcome. We saw the risk assessment for this event, and it was correctly documented.

Patient transport services

Good 🟢

Are Patient transport services caring?

Good 🟢

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

We were told by a patient who regularly used the service that the staff were "absolutely brilliant" and went out of their way to help.

Administrative staff who supported the PTS service told us they often received cards, flowers and other gifts from patients who had used the service and showed us examples which they had readily to hand. These expressed satisfaction with the service and sometimes described examples of care beyond that of the contracted service.

Staff followed policy to keep patient care and treatment confidential.

Staff were trained to afford patients dignity and privacy through a mandatory training module.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff were trained to understand equality and diversity through a mandatory training module and expectations were set through an equal opportunities policy.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We were told by a patient who regularly used the service that they were put at their ease by the friendly manner, knowledge and "banter" of the staff. They said the staff always asked about their day.

Patient transport services

Understanding and involvement of patients and those close to them

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

All vehicles carried a communication pack which contained a comprehensive set of communication aids.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

There were notices on all vehicles as to how to provide feedback to the service. There was a QR code, an email address and a telephone number. Staff told us however, that patients rarely used this facility.

Patients gave positive feedback about the service.

We were told by a patient who had recently used the service that their complex and significant needs were understood, and that staff were "very good with them".

Are Patient transport services responsive?

Good 🟢

We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system to plan care.

Managers planned and organised services so they met the changing needs of the local population.

The service planned the service provision to meet the expected privately and NHS contracted needs. There was a strategic plan to ensure that future needs were explored and invested for.

Facilities and premises were appropriate for the services being delivered.

The service's headquarters was housed in a purposely configured industrial unit with a dedicated training centre that was used internal and commercial training. Garage, office and training space was suitable. Patients did not visit the premises.

The service had systems to help care for patients in need of additional support or specialist intervention.

For privately contracted patients there were comprehensive assessments of needs so that a suitable service could be provided.

Patient transport services

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff were trained to support patients with a variety of cognitive and mental conditions through mandatory training modules.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to communication aids to help patients become partners in their care.

Comprehensive communication packs which were available on all vehicles contained the "This is me" documentation that staff used to understand the needs of patients with them, their families and carers. These packs were also aligned to the services provided. For example, there was information about dental care as this formed a specific service provided to patients with learning difficulties.

The service did not have information leaflets available in languages spoken by the patients and local community but did have access to translation services.

At the time of the inspection information leaflets had been removed from vehicles following COVID-19-19 risk assessments.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

All crews had access to a commercial telephone translation service with details on how to use it contained within the communication packs. Needs assessment for patients included any language difficulties and plans were made in advance.

Access and flow

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

Managers made sure patients could access services when needed.

Managers worked to keep the number of cancelled journeys to a minimum.

For the service provided through contracts with NHS ambulance trusts work was allocated to crews through the trust's operations centre and the provider fulfilled the jobs allocated. We were told the service always allocated resources in excess of the contracted minimum as the work was always "absorbed" and this ensured they always met their performance targets which were described in terms of vehicle availability.

We saw examples of NHS ambulance trust contract monitoring documents that confirmed that a satisfactory service was being provided.

Patient transport services

The service contracted directly with members of the public to provide patient transport services only in the Tamworth area. This work was largely to facilitate hospital discharge or changes of address and the workload was in the order of five jobs each month. We were told that on no occasion had a booked service failed to be provided.

A single vehicle was contracted by an NHS trust in the Birmingham area to be available to transport cardiac patients of up to level two acuity between the trust's two sites. This was provided by a paramedic crewed emergency ambulance and our inspection of the Emergency and Urgent Care service assured us that this service provision was safe. The commissioner told us that a reliable service was provided and although on a very few occasions the vehicle was delayed because of severe traffic. However, when this happened communication was good so that alternative arrangements might be made.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations. However, some information for complainants who were dissatisfied with the response to their complaint was wrong.

Patients, relatives and carers knew how to complain or raise concerns.The service clearly displayed information about how to raise a concern in patient areas.

Vehicles proximately displayed an email address, telephone number and a QR Code to allow patients to give feedback including complaints from patients. All negative feedback was processed as a complaint.

Staff understood the policy on complaints and knew how to handle them.

There was a comprehensive complaints policy which directed how complaints should be investigated including how this would be done alongside commissioners or other parties.

However, the policy noted that should a complainant be dissatisfied with the response they could contact the Care Quality Commission. The commission can be informed of concerns at any time, but it cannot take up or investigate any complaint on behalf of a patient, resolved or otherwise. This was not made clear.

The policy did not mention that for care commissioned by the NHS if a complainant has exhausted the provider's complaints procedure and are still not satisfied they may take their complaint to the Health and Public Service Ombudsman (HPSO).

Managers investigated complaints and identified themes.Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Complaints were investigated in line with the provider's policy and feedback provided to the complainant

We asked for and were provided with recent complaints and saw good practice.

When a complaint or comment was received it triggered a quality review. Reviews took place to identify themes although none were present for complaints about the PTS service.

Patient transport services

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Staff told us information was shared about complaints and any resulting actions. We saw evidence of this in the notes of team meetings and bulletins.

Are Patient transport services well-led?

Requires Improvement ●

We rated it as requires improvement.

Leadership

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

Senior leaders were professionals from ambulance or other healthcare disciplines and had the necessary skills and knowledge to manage the service effectively. There was a clear leadership structure with a Head of Operations reporting to the Chief Executive Office. Below them were area managers, station managers and shift supervisors.

Most staff spoke highly of their leaders. A staff member from a satellite depot told us their station manager was very supportive and that when the senior team from headquarters visited they sought out staff to talk to.

One member of staff told us that it was the first company they had worked for where they could directly approach the Chief Executive Officer.

There was always an on-call manager available 24 hours a day.

A member of staff described an incident when a patient became aggressive and that after they contacted the NHS control room a senior manager from Elite was immediately on the phone to check on them and offer support.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to the plans of commissioners. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a comprehensive 5-year plan with financial and quality initiatives. This appeared aligned with needs and expectations of commissioners and had ambition for the growth of the quality in both size and quality.

We saw evidence of long-term planning, for example an apprenticeship programme, recruitment and training plans and fleet replacement.

Patient transport services

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Several staff to whom we spoke told us they had a good employer and contrasted this experience with other places where they had worked. In turn the senior leaders were both proud and complimentary of their colleagues and staff.

There was a tangible sense of pride in the service amongst staff to whom we spoke. There was a relaxed atmosphere and staff seemed comfortable talking to us and in discussing potentially difficult issues.

There was a clear focus on the needs of patients. Some of the patients were regular customers and staff spoke fondly of them when discussing needs and risk assessments.

Frontline staff told us that while the service provided zero hours and self-employed contracts the organisation's preference was for staff to be on substantive contracts to promote personal development and belonging in the company.

The evidence we saw supporting the complaints and incident investigation processes was indicative of a culture of openness and honesty.

We saw examples of when staff had acted poorly disciplinary action had been taken and when they were struggling they were given additional support.

We saw examples of how staff had their individual needs considered. There were examples of staff who were particularly vulnerable to COVID-19 being able to work from home or given a work environment with enhanced social distancing.

Suitable arrangements were in place to support women who were pregnant to work safely

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. **However, notification practices were not fully embedded in the governance of the organisation and there was devolvement of responsibility to commissioning organisations**

The service had a clear governance structure appropriate to the size and scope of the service and systems and processes were well implemented and managed. This was evidenced through a documented organisational structure and comprehensive and well written documentation such as policies, procedures and forms.

Staff were employed in specific roles with job descriptions and responsibilities.

There were various groups that had oversight of areas such as medicines, incidents, complaints and training. There was a dedicated HR department and a training department.

We saw that quality of service meetings took place with commissioners.

Patient transport services

Where processes and procedures were in place they ran effectively.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The provider used a "risk register", covering clinical and non-clinical risks to describe, assess and mitigate risks to the provision of services. This was implemented using a scoring system which was then rescored following mitigating actions. Each risk was assigned to a named member of staff and the required actions noted.

We reviewed the risk register and it corresponded with the awareness of senior leaders when we asked about the top risks to the organisation. Significant risks to the PTS service included recruitment and moving staff through the training programme to qualification.

There were audit systems in place, and we saw examples of these being effectively carried out and the results acted on.

There were business continuity planning arrangements in place with written processes and action cards available to work from.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. However, notifications were not submitted to the CQC as required.

There were effective information systems in place both electronic and paper to support the activities of the provider. Data was comprehensive but not excessive and we saw it used to both operate day to day systems, manage the service and provide strategic information.

Some approaches were innovative including the use of mobile phone apps to distribute information to staff and for them to report incidents and other matters.

The provider operated a staff portal which enabled the distribution of information such as policy updates and bulletins.

Vehicles were equipped with GPS based navigation and location systems. Staff had access to mobile phones.

Some of the processes meant that events requiring notifications be reported to the CQC were reported instead to the commissioning NHS ambulance trust and sent to the National Reporting and Learning Service (NRLS) alongside those of the trust. This meant that reports of unexpected deaths, serious incidents and allegations of abuse against staff had not been reported appropriately.

Learning, continuous improvement and innovation

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

Patient transport services

We saw examples of innovation including the use of mobile phone apps for distributing information to staff and for staff to report incidents and other issues.

The provision of a specialised service for patients who had recently undergone a general anaesthetic to be afforded clinical supervision on the journey home had been given an award. It had also been the subject of a visit from NHS commissioners to see the innovative practice.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services • The service must ensure that events are reported to the CQC in compliance with regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents • The service must ensure that events are reported to the CQC in compliance with regulation 18 of the Care Quality Commission (Registration) Regulations 2009.