Supportive SRC Ltd

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Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	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 managed safety incidents well and learned lessons from them.
- 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 had access to good information.
- 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 and took account of patients' individual needs. People could access the service when they needed it and did not have to wait too long for transport.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.

However:

- Leaders did not have robust governance systems in place to provide assurance that processes were being followed and that performance and risk was managed effectively.
- Leaders needed to improve how they managed compliance by reviewing the way it audited and monitored standards.
- The service had poor feedback systems for patients receiving care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Supportive SRC Ltd

- Supportive SRC Ltd is an independent ambulance service based in Ferryhill, County Durham which provides patient transport services.
- Supportive SRC Ltd also operates a homecare agency from its premises in Ferryhill.
- They are a not for profit charity. The provider has 13 ambulances for patient transport services. The provider has two premises both located in County Durham. One is the administrative base and the other is an office plus a unit for storing vehicles and equipment.
- The service was subcontracted by an NHS ambulance trust to deliver patient transport across the North East. The service also undertook work for two other organisations on an ad hoc basis.
- The service was registered with the CQC in 2016 to provide transport services, triage and medical advice remotely.
- The service has had a registered manager in post since 2016. A registered manager is a person who has registered with CQC to manage a service. They are 'registered persons.' Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2012 (Regulated Activities) Regulations 2014, and associated regulations about how a service is managed.
- This was the first time the services had been inspected.

How we carried out this inspection

On 24 May 2022, we carried out a comprehensive inspection[HB1] [HC2] of the service. During the inspection, the inspection team:

- visited both premises in County Durham and inspected three ambulance vehicles.
- spoke with three managers.
- spoke to eight members of ambulance staff.
- looked at the training files for five staff.
- looked at the recruitment files for five staff.
- looked at equipment.
- looked at a range of documents and records relating to the running of the service.

The inspection was unannounced which meant the provider did not know we were visiting. The inspection team comprised of one CQC inspector and a specialist advisor. The inspection team was supported by an inspection manager and the inspection was overseen by Sarah Dronsfield, Head of hospital inspection.

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

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that it has assurance and oversight of safeguarding referrals made by staff.
- The service should consider reviewing the safeguarding training needs of patient-facing staff to meet requirements as set out by national guidance.
- The service should consider how it meets the needs of people whose first language is not English.

Summary of this inspection

- The service should ensure that it has a policy on how to manage and care for deteriorating patients and a policy for patient eligibility criteria.
- The service should ensure that it has an audit programme to monitor quality, compliance and performance.
- The service should ensure that it has a station cleaning programme and a station cleaning audit.
- The service should ensure that it audits patient care records and monitors standards with a documentation audit.
- The service should consider reviewing its policies to ensure that they are specific and relatable to patient transport services.
- The service should consider staff development and their additional or extra training needs.
- The service should consider a way of collecting patient feedback that is an improvement on the current process.
- The service should consider better ways of analysing and collecting data to have oversight of performance and risk.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Good	Good	Requires Improvement	Good
Overall	Good	Good	Good	Good	Requires Improvement	Good

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Patient transport services safe?

Good

Mandatory training

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

All staff had undertaken a wide-ranging induction programme and mandatory training to equip them with the skills required to perform their role.

Mandatory training was delivered through a mixture of face to face and online learning. Staff accessed an online learning system to complete theory modules and competency tests using personal logins. Training was delivered annually or every three years dependent on the subject.

The provider used a mandatory training tracker to identify when refresher training was required to be completed. The tracker alerted managers when training lapsed for individuals. Training compliance was at 95% for mandatory training. If staff did not attend mandatory training or if this had expired, their duties were restricted to reflect the missed training.

Safeguarding

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

The service had a safeguarding policy for adults and children. The organisation had a named manager who was responsible for safeguarding and staff we spoke with confirmed they knew who to report any concerns to.

Staff had all completed safeguarding training. We saw certificates in all records we looked at. Patient transport staff were trained to level one in safeguarding adults and children. The safeguarding lead was trained to level three.

The subcontracting NHS ambulance trust investigated all safeguarding concerns and made onward referrals to the relevant local safeguarding authority where applicable. However, the provider did not have any oversight of the referrals made. There were no completed safeguarding referrals produced by the provider when requested.

Some members of staff had only a basic understanding of how to identify adults and children at risk of, or suffering, significant harm but they suggested they would seek help from colleagues if needed. Other staff could recall making safeguarding referrals in the past.

The service had not raised a safeguarding notification to the CQC in the reporting period though understood their responsibility to do so.

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, however, there were no station cleaning audits.

All areas inspected were clean and had suitable furnishings which were clean and well-maintained. However, no station cleaning audit had been undertaken. We asked to see audits but were advised none had been completed as the provider had recently located to the current premises.

Staff used equipment and control measures to protect patients, themselves, and others from infection. Staff cleaned equipment after patient contact. Deep cleans were carried out every 12 weeks.

We inspected three vehicles. All vehicles inspected appeared visibly clean and daily vehicle and equipment cleanliness checks had been completed by the crew on shift for each vehicle inspected.

Staff followed infection control principles including the use of personal protective equipment (PPE). All the vehicles we inspected had supplies of personal protective equipment (PPE) and replacement linen available.

The provider managed clinical waste streams in line with guidance. We saw clinical waste bins in the stations we inspected were stored safely and locked. The provider had a service level agreement in place with an external provider for the disposal of clinical waste.

The provider had processes in place to ensure safe handling of cleaning products. We observed safe storage of chemicals and cleaning equipment required for the cleaning of ambulances at the stations we inspected. There were notices displayed to explain to staff as to how to dispose of various kinds of waste safely.

Staff we spoke with told us they could access replacement PPE and cleaning materials whenever they need them. In the equipment storerooms we inspected we saw evidence different consumable items were stored in plastic boxes with lids. This meant they were free of dirt and dust.

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 station was properly designed, maintained and well ordered. The premises were safe and secure. The front gate remained locked when the offices were closed and there were security cameras on site. Vehicles were locked when unattended. There was a locked box on the garage wall which contained the vehicle keys.

Managers could explain the process surrounding vehicle servicing and repair.

Good

Patient transport services

On inspection we reviewed three vehicle files. The files had evidence of current ministry of transport (MOT) test certificates and service and repair records for each of the vehicles.

The service had enough suitable equipment to help them to safely care for patients. All vehicles were checked daily. Staff carried out daily safety checks of specialist equipment. We observed a crew completing daily checks of equipment at the time of inspection. All vehicles had been recently fitted with an AED (automated external defibrillator) and there was also an AED ready to be installed at the station.

Electronic devices were collected at start of the shift and were used to provide the crews with patients details and where to collect and take the patient.

Equipment carried on the vehicles had service stickers showing the date serviced and a unique reference number. The servicing was carried out an external company. The provider maintained an asset register which contained all equipment held recorded by a unique reference number and date of service.

There was a contract ensure that all medical devices were regularly maintained and serviced in accordance with manufacturer's guidelines and where applicable in accordance with current governance, to ensure that all medical equipment purchased from the provider met with manufacturers guidelines and where appropriate met current British Standards (BS) standards.

All the equipment carried on the vehicles and in the station which required safety testing displayed the test date and was in date.

We observed the environment of each station inspected and saw appropriate safe storage of cleaning equipment, PPE, medical gases, and replacement equipment for the fleet vehicles. There was Control of Substances Hazardous to Health Regulations (COSHH) information reference book available for staff in the offices of each station inspected.

Fire extinguishers fixed securely on wall mounts, all had labels indicating they had been tested. The fire extinguishers were stored in accordance with the Fire Extinguisher regulations which form part of the Regulatory Reform (Fire Safety) Order 2005.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff knew how to identify and act upon patients at risk of deterioration.

Basic first aid training gave staff enough skills to recognise when to seek help. Staff were taught how to manage a patient who became unwell and subsequently deteriorated during a journey. All vehicles carried a basic first aid kit and in the event of a medical emergency the drivers contacted the emergency services by calling 999.

However, there was no deteriorating patient policy that gave instruction or documented procedures on the course of action to follow in the event of an emergency.

The digital tool used for all patient transport jobs for the subcontracting ambulance trust included key risk information to keep patients safe and staff ensured this was shared when both receiving and handing over their care to others.

Good

Patient transport services

There was no provider policy on patient eligibility criteria. Individual managers did risk assessments to decide whether a patient was suitable to transport or not for non NHS work. Patient assessments were primarily of a person's transport and mobility needs and ambulance crews. Patient mobility was assessed to determine who could walk and those needing aids such as wheelchair, carry chair or stretcher.

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.

There were 33 operational members of staff and the service provided two regular shifts, six days a week as part of a regular contract. The shifts started at 05:15 am and completed at midnight. There was also one shift that operated on Sundays. Rotas were generated six months in advance and all shifts filled to meet the needs of the service. There were no current staff vacancies and the provider had low staff turnover.

There was an induction programme and there were supervision arrangements for newly recruited staff.

Staff driving licences were confirmed with the Driver and Vehicle Licensing Agency (DVLA) as being valid and appropriate for the class of vehicle they were driving when the staff member was appointed. All staff required Disclosure and Barring Service (DBS) checks. We reviewed recruitment records and proper pre-employment and pre-appointment checks were conducted.

Records

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

The provider did not retain any patient records for its NHS work. Records were digital and held on a portable tool used by each crew.

All records reviewed for other jobs were clear, legible and complete.

The provider did not have a process to audit patient records so had no assurances that staff were documenting and completing records correctly.

Medicines

The service used systems and processes to store medicines.

Vehicles did not carry medicines for emergency treatment, other than a basic first aid kit and an oxygen canister should it be prescribed to a patient.

Staff followed systems and processes to administer oxygen safely. Training on the use of oxygen was provided to staff, and staff who had not been trained understood they could not administer oxygen.

The only medicines carried on the vehicle were those that travelled with a patient upon discharge from hospital. These medicines were signed for by staff on handover at the hospital and then signed for when the patient reached their destination address.

Good

Patient transport services

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them using the provider's internal reporting policy and processes. Staff we spoke with advised that they received feedback from investigation of incidents, both internal and external to the service.

After every incident there was an investigation and a root cause analysis followed by a lessons learnt analysis. Managers gave patients and families a full explanation if and when things went wrong.

We learned of an incident that occurred after a driver needed to make an emergency stop. A patient who was an amputee was travelling on the vehicle and they slid from their chair despite wearing a seatbelt. The patient was unhurt but as a consequence of the investigation, a third point fixing was added to the seatbelt strapping for extra safety.

Are Patient transport services effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Relevant standards, guidance and legislation were discussed at monthly management meetings and action taken as necessary. Managers keep up to date with current guidance. Changes in guidance and processes were communicated to staff via email, notices displayed in the crew room and print outs filed in plastic wallets.

There was no audit schedule and no programme of repeated audits to monitor compliance and to ensure consistency of care.

Policies and procedures had all been updated therefore were in date, had a version number and had a review date. However, some policies pertained more to the homecare aspect of the provider's business and were not tailored to patient transport services. For instance, the dignity in care policy dated June 2021 was specifically homecare related and made no reference to patient transport at all. Similarly, the provider shared its quality assurance framework but this was also not pertinent to patient transport services.

Response times

The service monitored, and met agreed response times so that they could facilitate good outcomes for patients.

The providers who requested the service managed response times. Commissioners contracted the vehicle, with equipment, consumables and staff, they then utilised that resource through their own computer system and they managed all the response timings.

Good

Patient transport services

The provider had meetings with the NHS ambulance provider which used their service to discuss performance. Performance data supplied by the NHS trust showed that the provider met 97% of journeys on time or ahead of time in the six months prior to inspection.

The service collected the number of journeys booked and whether the patient required a wheelchair or if they could walk

As part of ensuring that they arrived on time, where possible and safely, the vehicles GPS systems calculated the fastest route.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff had the right skills and knowledge to meet the needs of patients. Staff we spoke with told us that they received a full induction before they started to work with patients. When new staff commenced work, the provider considered skill mix and ensured they buddied with an experienced crew member.

Managers did yearly spot checks on staff. These checks were unannounced and often managers would meet a crew at a hospital without prior notification. Employee observations were also undertaken before any team member was allowed to work alone.

The provider had undertaken appropriate driving licence checks with the DVLA as part of staff recruitment and

Managers supported staff through yearly appraisals of their work, all of which were up to date.

Managers encouraged staff to attended team meetings and ensured that they had access to full notes.

Managers provided the basic training required for staff to do their job but there was no additional or complementary training that might enhance job satisfaction or develop staff. There was also no career pathway although there was a plan to have team leaders at base in the future.

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 together to care for patients and each other. The provider liaised the ambulance NHS trusts on a monthly basis to discuss performance.

Staff worked with hospital staff and ambulance trust staff when collecting and dropping off patients.

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.

Good

Patient transport services

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

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.

Are Patient transport services caring?

Good

Compassionate care

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

We did not observe any direct patient care during the inspection.

Staff demonstrated an awareness of the needs of patients and their relatives and carers and how they would support them at times of distress during emergency situations. We were told that one crew had received acknowledgment after they voluntarily stopped mid journey to assist a distressed individual. The person was planning to jump from a bridge. Their prompt action and care for the individual was commended by managers.

All patient transport staff had received dementia training and training in learning disabilities and mental health awareness to equip them with skills to provide compassionate care for patients.

Emotional support

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

Staff made sure patients and those close to them understood their care and treatment. Staff gave an example of how they regularly assisted an anxious patient. One of the provisions made was to hire a particular type of car. Travelling in this vehicle helped appease the patient's anxiety. Staff were all aware of the patient's needs and aimed to alleviate any distress caused by the journeys made.

If possible, the provider aimed to have regular crews transporting the same cohort of patients to their appointments to ensure consistency and familiarity.

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 talked to patients in a way they could understand, using communication aids where necessary. This was evident in the reporting format used to assess staff by managers undertaking observational spot checks.

Good

Patient transport services

The provider attempted to survey patients to find out their experiences of care by posting out questionnaires. The response to most recent survey was poor with only 11 questionnaires returned. Those who did respond on the whole gave positive replies with seven out of the twelve questions receiving 100% maximum scores.

Are Patient transport services responsive?

Good

Service delivery to meet the needs of local people

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

The service provided patient transport services mainly from home to outpatient appointments and back. The majority of the work undertaken was with patients requiring regular dialysis appointments at hospital. In the six months prior to inspection, there had been 1332 patient transport journeys completed for the ambulance trust.

The provider said they continued to assess the demand for transport in the local area and aimed to respond as required. The service had grown from six vehicles to 13 since registration with the CQC.

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.

All vehicles had ramps, tailgates and handrails to help those with disabilities or difficulties mobilising to access the vehicles.

All staff records we reviewed contained equality and diversity training certificates. This meant the provider was assured that all staff had been trained to consider the needs of different people when delivering care, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

Staff understood how to meet the information and communication needs of patients with a disability or sensory loss. Staff could give us examples of when they had adapted their communication to support patients. Examples included staff members writing information down on paper and using smart phones to provide visual aids to enhance patient understanding. The provider did not have a contract with any interpreting service for patients who did not have English as a first language.

When taking bookings for journeys other than NHS contracted ones, staff asked questions to assess patient needs whilst being transported. These included patient mobility, special requirements such as oxygen and checked to see if the patient was symptomatic of any infections. Female only crews had been provided when requested by patients.

Bottled drinking water was available on vehicles and if journeys were long, welfare stops at service stations would be mapped en route.

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.

Good

Patient transport services

The service provided dedicated vehicles to an NHS ambulance service and undertook ad hoc work for two other organisations. The contracting organisation determined the timeliness of responses and patient discharges. Response times were monitored on a monthly basis by the NHS ambulance trust and these met key performance indicators.

Managers told us they had no control over access and flow arrangements. The service recognised the volume of transport outlined in the digital platforms and framework agreements to be able to provide the service.

Staff recorded journey information including the destinations and pick up and drop off times on patient forms for the non NHS work. Managers used a basic logging sheet to keep account of whether patients received timely transport and care for the NHS work.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The provider had received two complaints in the 12 months prior to the inspection.

The provider had a complaints policy which was in date. The policy set out the process for the management of complaints about the service provided by and would respond to complaints within three working days.

We saw evidence of a complaints process flow chart for staff and managers to follow. The flow chart outlined the various stages of the complaint investigation process and roles and responsibilities of staff and managers.

We did not see any feedback forms on vehicles for patients to complete and the provider website did not advise people about how to complain about the service. We reviewed one complaint concerning an issue with a property and a gate being left open by crews. Managers had responded to the complaint in a timely way, addressed the issue and taken action to advise crews of the matter.

Are Patient transport services well-led?

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. However, they did not support staff to develop their skills and take on more senior roles.

The service was led by a senior leadership team consisting of the Chief Executive Officer, a head of transport and a deputy head of transport. They were supported by a transport coordinator and a transport supervisor.

The leadership team had all been subject to a fit and proper person checks which evidenced they were qualified, competent, sufficiently experienced, sufficiently healthy, and had no personal history of serious misconduct or mismanagement in carrying out a regulated care activity which would make them ineligible for the role.

Good

Patient transport services

The management team was small, but they could lend and lean on colleagues in the homecare division of the business. Managers could articulate what the providers priorities were. Staff we spoke with told us managers were open, friendly and supportive. Staff told us that managers were understanding and if they had domestic or problems at work, they were accommodating.

When asked about career development and development, apart from one individual undertaking a management course, managers told us that there were few opportunities for staff to take on more senior roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

The vision and strategy were being revised at the time of inspection though proposals were in draft. The visionary goal was to build capacity, grow value and realise potential. The strategic aims were the same for both the patient transport part of the business and the homecare sector. Managers wanted to expand the transport business and hoped to double the number of vehicles available.

The strategy placed patient care at the centre of all work undertaken. The providers values were 'Trusted, Quality, Sustainability, Caring and Reliability'.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.

All the staff we spoke said that the provider had an open culture where they felt they could raise any issues to managers without fear. Staff told us they could speak to managers in confidence. Staff said that they saw managers on a regular basis which made them feel connected to the overall service.

There was a contracted occupational health service available to all staff. The provider also had a hardship fund to help staff in need of financial assistance.

The service had a whistleblowing policy which outlined the process for staff to follow if they wanted to raise serious concerns.

The service had an equality and diversity policy. It outlined the responsibilities of the organisation and staff to ensure no direct or indirect discrimination occurred within the business.

Every year the provider arranged social outings for staff to popular seaside resorts.

Governance

Leaders did not always operate effective governance processes throughout the service. Staff were mostly clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was no compliance manager dedicated to patient transport at the time of the inspection although this appointment was imminent. The provider had a compliance manager for the homecare service who had previously worked with patient transport managers.

Good

Patient transport services

Even though roles, responsibilities, and systems of accountability were in place to support governance and management, governance systems were not robust. The provider did not complete regular audits nor did all policies pertain to patient transport services. There were also policies that the provider did not have at all. The provider had no oversight of safeguarding referrals made nor did they audit patient records to ensure that staff documentation was pertinent and complete.

However, the provider had a board of trustees and the board met with senior managers monthly. There were regular management meetings with a set agenda, minutes and actions recorded. There was evidence of meetings between the provider and the providers who requested the service to discuss performance.

Thorough checks were made to ensure that staff who worked for the service had the necessary skills and competencies to carry out their roles. The recruitment process was well organised and had a documented process to demonstrate how these checks were made.

Management of risk, issues and performance

Leaders and teams sometimes used systems to manage performance. They identified and escalated relevant risks and issues but did not identify actions to reduce their impact. They had plans to cope with unexpected events.

A management team meeting was held monthly during which all risks were reviewed, including re-visiting any mitigated risk to ensure accuracy.

The provider had a corporate risk assessment register. All risks had a score and a risk mitigation. None of the risks were RAG (Red, Amber, Green) rated nor had a risk owner or actions associated with each risk.

Although general performance and concerns were regularly monitored between the provider and other organisations, managers were reliant on those organisations to supply key performance data information. They did not scrutinise processes themselves.

The provider understood potential risks to business continuity and had a clear escalation process in the event of any unforeseen difficulties.

Information Management

Leaders did not always analyse performance data. However, the information systems in use were integrated and secure.

The service was not requested to collect performance data by its commissioners, some data was gathered on journey numbers, but not analysed. However, leaders understood analysing performance data could help drive future improvements in quality. The provider relied upon the organisations that requested the service to ensure the accuracy of KPI data which were their performance measures.

The information systems were secure. Managers kept paper staff files in locked cupboards. Digital records were stored on secured computers which staff accessed with individual names and passwords.

All vehicles were tracked which allowed the service to monitor the standard of driving for all staff.

Good

Patient transport services

Engagement

Leaders and staff actively and openly engaged with staff and stakeholders to plan and manage services.

Staff were surveyed yearly and asked a series of questions about working for the provider. The last survey had 17 responses (70% of staff at that time) which had mainly positive answers. Staff had been surveyed about their uniform following some complaints made about colour and style. Following the survey, managers had agreed to completely change the uniform.

The provider maintained its links with the local NHS trusts to support with timely patient discharges from local hospitals, as well as ensuring patients accessed pre-arranged hospital appointments. All parties met on a regular basis to review performance and service development.

Team meetings were held every quarter with an invitation for all staff to attend. If staff were unable to attend the meeting in person, they could dial in and participate remotely.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Managers were committed to improvement and had invested in the service to improve. These plans were in the draft strategy review. The service had employed a consultancy to look at key areas of its business. They had engaged with staff to consider issues, share ideas and find ways to improve.

Managers were keen to train staff in first aid for mental health which they felt would benefit staff and patients alike.