F4Control Limited

first4care

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?	Outstanding

Summary of findings

Overall summary

We have not previously rated this service. 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 transport records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care. 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of people using the service and made it easy for people to give feedback. People could access the service when they needed it.
- 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, commissioners, and NHS managers to plan services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	We rated this service as good because it was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Summary of this inspection

Page

Background to first4care 5

Information about first4care 5

Our findings from this inspection

Overview of ratings 7

Our findings by main service 8

Summary of this inspection

Background to first4care

First4care is operated by F4Control Limited and provides non-emergency patient transport services, such as between medical facilities and between hospital discharge units and patients' homes. Most work is commissioned by Integrated Care Boards on behalf of NHS trusts and the service offers private transport on request.

The service has its head office in Edwinstowe, Nottinghamshire and provides transport services across a wide geographic area, included Northants and Kettering, Derby, York, Peterborough, Northampton, and across East Anglia.

The service registered with us in September 2015 to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

A registered manager was in post. Transport services are provided with a fleet of 38 vehicles equipped with facilities for safe moving and handling and are adapted to the requirements of each contract. The service operates approximately 3,900 journeys per month. The service typically operates 5 days per week, Monday to Friday, and had the operational capacity to provide weekend services on request.

We have not previously inspected this service.

How we carried out this inspection

We carried out a short notice announced inspection of the service using our comprehensive methodology on 31 May 2023. We gave the provider 24 hours' notice of our inspection because we needed to be sure the service would be in operation with staff and vehicles available.

Our inspection team consisted of a lead inspector and 2 specialist advisors with support from an off-site operations manager. After our inspection the registered manager sent us a range of data and other evidence to provide details of standards of care.

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:

- Safeguarding procedures reflected best practice and exceeded the requirements and expectations of the service. Staff action to protect people from harm had resulted in better home care and support for highly vulnerable individuals not adequately addressed by other organisations. Safeguarding was embedded across all aspects of the service. It was multidisciplinary by nature and staff worked closely with a range of organisations to coordinate responsive, safe care.
- The service completed significant work in recruitment and retention that resulted in an innovative staffing model, based on grassroots ownership, which empowered staff in decision-making to drive quality and service.

Summary of this inspection

- The senior team had a commitment to developing the future healthcare workforce of the region and implemented a staffing policy that supported work and training for university students outside of teaching semesters and support for qualified staff who preferred to work on a gig economy basis ('gig economy' work refers to freelance, ad-hoc and uncontracted work). This approach stabilised capacity and helped to develop future regional sustainability.
- The senior management team had restructured the leadership model in response to staff feedback. The team provided tailored support to staff to help them manage personal and professional challenges, which supported retention and significantly improved morale.

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	☆ Outstanding	Good
Overall	Good	Good	Good	Good	☆ Outstanding	Good

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Outstanding

Is the service safe?

Good

We have not previously rated safe.

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 received and kept up to date with their mandatory training, which was comprehensive and met the needs of patients. Mandatory training included 11 modules such as infection prevention and control (IPC), basic life support (BLS), safeguarding, and conflict resolution. Ambulance crews, called ambulance care assistants (ACAs), completed practical vehicle familiarisation training.

Training was tailored to the ambulance and patient transport environment, which ensured staff could adapt generic courses such as IPC to their specific work environment.

The provider set mandatory training as a core requirement. Staff completed additional training delivered by NHS trusts as part of contractual arrangements. For example, some trusts booked transport for patients receiving palliative care or paediatric patients. The provider worked with each trust to establish specific training needs and ensured only ACAs with the appropriate training provided care under those contracts.

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

Managers monitored mandatory training and alerted staff 2 months in advance of when they needed to update their training. This ensured consistently high completion rates, with 98% of staff up to date at the time of our inspection.

Safeguarding

Good

Patient transport services

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.

Staff received training specific for their role on how to recognise and report abuse. All staff completed safeguarding adults and children to level 3. They also completed national preventing radicalisation training level 2 and human rights and equality training.

The service did not routinely provide regulated activities to children and young people and staff maintained training as good practice in the event children accompanied adult patients.

The registered manager was the safeguarding lead and trained to level 5. This level of training was higher than the national standard and reflected the diverse range of patients who received care from the service. They worked with contracting NHS trusts and other professional bodies, such as local authorities, social services, and the police, to contribute to serious case reviews and other incidents when this would be beneficial for the investigating body. There had been no serious safeguarding incidents in this service and instead the process helped ensure the manager maintained an up-to-date awareness of issues and challenges across the region.

Staff reported 15 safeguarding incidents in the previous 8 months and reports reflected good standards of practice and awareness. The senior team demonstrated consistent follow-up and appropriate action. The nature of the service meant it was not always immediately clear which organisation was responsible for the area of concern and staff knew how to find this information. For example, a crew raised a safeguarding concern where they found dangerous living conditions of a patient who received in-home social care. They liaised with the contracting NHS trust to ensure the appropriate organisation was alerted and acted.

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

The service maintained a comprehensive safeguarding system that included monthly team meetings, a staff newsletter, and continual professional development. The in-house safeguarding protocol worked alongside the requirements of each NHS contract and meant the service was always compliant with specific trust needs. For example, 1 trust required the head of care, quality, and compliance to provide evidence of their level 4 learning and certification from examples of practice.

The service operated safeguarding as a multidisciplinary process and ensured ACAs worked with hospital teams during safeguarding investigations or after incidents. This reflected best practice and facilitated multi-agency learning. For example, ACAs worked with a trust to review the care of a patient who died at home after being transported from hospital. The outcome highlighted a good standard of service from the provider's ambulance crew and the potential benefit of increasing crew training on the emergency call systems vulnerable patients might have access to in their home.

Staff demonstrated compassionate attention to detail when providing care for patients with high levels of vulnerability. For example, they stayed with a patient whose mental health deteriorated significantly during a journey home, liaised with NHS emergency services, and kept them safe until specialist help arrived.

The service established a single point of contact for safeguarding queries for each NHS contract. This meant ambulance crews and NHS staff working with them always had a named person to reach in the event they needed support or advice.

Good

Patient transport services

Staff were confident in the use of safeguarding training and knowledge and those we spoke with provided examples of when they had raised concerns. The service used an electronic reporting system that flagged an issue to the duty operations manager, who followed up immediately. Staff said they received feedback on the actions and outcomes of safeguarding issues.

Staff worked to the provider's safeguarding policy and reporting system and to the systems of the NHS trust responsible for the patient. This meant the responsible organisation took the most appropriate action in the event of an issue, including when staff had an urgent concern. The system worked well in safeguarding incidents. For example, an ambulance crew had reported concerns of neglect to the contracting NHS trust and secured rapid support through their system for a vulnerable patient.

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 and vehicles visibly clean.

Vehicles were visibly clean and had suitable equipment and fittings, which were clean and well-maintained. Staff maintained up to date records of cleaning and infection control measures for each vehicle. During our inspection we assessed 7 vehicles and found them all to be visibly clean, tidy, and ready for use. This included reusable equipment, such as trollies.

The service performed well for cleanliness. Staff cleaned the interior of their vehicle at the end of each shift and made sure it was sanitised and ready for use for the next crew. They also removed used linen and ensured it was stocked with fresh sheets and pillowcases for the next shift. During our inspection staff demonstrated good attention to detail in IPC procedures and cleaned equipment and vehicles appropriately between patients.

Staff followed infection control principles including the use of personal protective equipment (PPE). Each vehicle was equipped with PPE, antibacterial hand gel, and antibacterial cleaning equipment.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service arranged a deep clean for each vehicle on a pre-planned 12-weekly basis. An external contractor provided on-demand deep cleans in the event of a hazardous spillage. Some NHS trusts required vehicles used to transport their patients to be deep cleaned more frequently, such as every 35 days. The service worked with each contract manager to ensure schedules met their requirements.

ACAs worked to the same uniform standards as NHS clinical staff, such as the 'bare below the elbow' policy. This was best practice and contributed to good levels of hygiene.

Staff improved standards of vehicle cleanliness as a result of audits. For example, deep clean audits showed steering wheels and door handles as key areas for more consistent cleaning.

Environment and equipment

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

Good

Patient transport services

The service used a fleet of 38 multi-purpose vehicles modified to the needs of patients as determined by contracting NHS trusts. Staff stored and secured vehicles safely and in line with legal requirements and insurance policies.

Vehicles were well equipped with safety equipment such as first aid kits, fire extinguishers, oxygen masks, and straps to secure wheelchairs or other movable seating. The service adapted vehicles based on individual contracts, which predetermined patient needs. For example, some NHS trusts required vehicles be fitted with paediatric equipment and more advanced emergency equipment such as automatic external defibrillators (AEDs).

Staff included all onboard equipment in daily checks and carried these out before they put vehicles into service. Safety checks included for oil level, water and screen wash, tyre treads and pressure, satellite navigation systems, and lights.

Staff carried out and documented daily safety checks of specialist equipment. Vehicles were equipped with harnesses and adapted secure chairs to enable the safe transport of patients with mobility or other safety needs.

Staff disposed of clinical waste safely. ACAs removed waste at the end of each shift or more frequently if hazardous waste was collected or the vehicle was soiled. Clinical waste was securely stored and appropriately streamed during our inspection.

The service maintained vehicles to a high standard in line with manufacturer guidance and legal requirements. All vehicles had up to date insurance, servicing, and maintenance documentation.

Staff stored and secured medical gases in each vehicle in line with safety standards.

Staff used a stock rotation system to ensure consumables, such as spill kits and aprons, were in date and ready for use. Each vehicle had a stock of items to support staff and patients during journeys such as antibacterial spray, spill kits, vomit bowls, and incontinence pads.

The main crew base had a sluice room that was well stocked with cleaning equipment and supplies. Where staff provided services a significant distance from the main base, the service arranged for sluice and waste disposal systems more locally.

A sluice room was available at the provider's base and staff used this for processing waste materials from ambulances. Where crews worked remotely from the base, arrangements were in place for the use of local NHS sluice facilities.

The senior team based vehicle and equipment maintenance and safety audits on national and legal requirements. For example, they maintained vehicles to the requirements of the Driver and Vehicle Licensing Agency (DVLA) and carried out annual maintenance and checks on equipment subject to the Health and Safety Executive's Lifting Operations and Lifting Equipment Regulations 1998, including weight testing and mandatory servicing.

The provider delivered services across wide geographic areas, including remote rural communities. As learning from incidents in which crews found it difficult to explain their precise location, the service implemented use a new international digital platform that enabled the control centre and emergency services to pinpoint a location within 1 square metre.

Crew were trained to act as banksmen to ensure the safe manoeuvring of vehicles in tight spaces. This reflected good safety standards and reduced instances of unsafe driving and vehicle damage.

Good

Patient transport services

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 were trained to use dynamic risk assessments during transport duties. This meant they assessed individual, specific risks based on patient needs and the type of vehicle in use. For example, crews used such risk assessments when supporting patients who used an electric wheelchair.

ACAs completed training in emergency first aid at work training, wheelchair security, and safety risk assessments. They used a standard operating procedure (SOP) to manage the sudden deterioration of a patient. ACAs were trained in basic life support and vehicles were equipped with first aid kits and some had AEDs, the SOP guided staff to support patients until appropriate services arrived. Staff provided verbal handovers to emergency teams.

Staff shared key information to keep patients safe when handing over their care to others. The contracting NHS trust had overall responsibility for patient care, and they provided information to each crew to help them transport patients safely. Staff were trained to support patients with needs relating to dementia and mental health as well as physical needs such as those who required bariatric equipment.

If a patient was booked for transport and the crew felt their needs exceeded the scope of the contract and their training, they worked with local staff to identify risks and potential alternative options for the journey.

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 staff to keep patients safe. The patient transport services (PTS) manager, a planning and liaison coordinator, operations assistants, PTS mentors and the PTS team, including ACAs, delivered the regulated service. At the time of our inspection 70 ACAs worked for the provider on flexible contracts that meant they could choose their own working pattern, including hours and frequency.

The provider used a geographic staffing model that meant they recruited ACAs local to specific NHS contracts. This improved reliability as it reduced the commuting distance of staff to the area of work. As each NHS contract provided care for patients with different needs, the senior team recruited staff to suit each area of work.

The service was compliant with recruitment requirements, such as by obtaining a disclosure barring service (DBS) check for each new member of staff. The service obtained 2 references and details of gaps in employment for new staff in line with national standards. Employment records were comprehensive and reflected a good standard of pre-employment checks. The service had good processes in place to address circumstances where the previous employers of new staff failed to provide references. This included an extended 3-month supervised period of work and a Home Office right to work check.

Managers adjusted staffing levels daily according to the needs of patients and worked with contracting NHS trusts to make staffing changes more permanent if this was indicated by feedback.

The planning and liaison coordinator worked with staff to incorporate their preferences into the schedule and matched these with the contractual requirements of each trust. This worked well and resulted in a significant improvement in staffing reliability in the previous 6 months.

The senior management team developed a recruitment process that targeted a mix of undergraduates and postgraduates in healthcare and a diverse representation of the local region. In the previous 12 months this approach led to a significant increase in successful applicants to new posts.

Records

Staff kept records of patient journeys. Records were clear, up to date, stored securely and easily available to relevant managers.

Staff provided a transport service that did not include administering clinical treatment. They kept records of journey details that included the name of each patient and their pick-up and drop-off points.

Records were stored securely in line with the requirements of the contracting NHS trust. Each trust had different instructions for staff on the handling of documentation. For example, some required patient journeys to be documented on paper, and others issued staff with electronic devices to record and transmit information. In all cases staff adhered to their own organisation's core training in records management and adapted this to the particular trust with which they were providing transport.

Medicines

The service followed best practice when administering medical gases or transporting patients with their own oxygen.

Staff followed systems and processes to manage medical gases safely. They segregated full and empty cylinders in line with manufacturer guidelines and secured cylinders safely during transport.

Patients or their escorts were responsible for carrying their own medicines safely. Staff transported patients with Controlled Drugs if they had mental capacity to keep them safe. Where patients lacked capacity, the service transported the patient with a medical escort.

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. When things went wrong, staff apologised and gave patients honest information and suitable support.

At the time of our inspection, 99% of services were provided for the patients of NHS trusts. Each NHS contract had specific requirements around incident reporting, which meant crews often reported incidents to both organisations. The provider operated an electronic incident reporting system that was standardised across contracts and crews and the head office support team then duplicated this information with the trust responsible for the patient's overall care. This meant incident investigations were multidisciplinary and enabled cross-organisational learning.

Good

Patient transport services

Staff knew what incidents to report and how to report them and raised concerns and reported incidents and near misses in line with the service's policy. In the previous 12 months, staff reported 16 incidents, all of which resulted in no or low harm to a patient or staff.

The head of care, quality, and compliance reviewed incident reports to identify themes and trends. All of the incidents involving minor harm related to skin tears caused by patients bumping an arm or leg when being moved on or off vehicles on stretchers or wheelchairs. While this was a theme, it reflected fewer than 0.01% of the total patients seen, which reflected good standards of safe care. In the same period no patients were returned to hospital as the result of an incident.

The service had a policy in place to manage serious incidents, including staff and patients involved in road traffic accidents. There had been no such incidents and staff maintained up to date knowledge as good practice.

The senior management team made changes as a result of incident investigations. For example, they updated the risk assessment for using ambulance ramps and lifting equipment during wet weather after a member of staff slipped.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from the investigation of incidents, both internal and external to the service. The multidisciplinary, cross-organisational nature of the incident management system meant staff learned and updated practice alongside colleagues from other organisations.

Staff met to discuss the feedback and look at improvements to patient care. This led to changes in wheelchair moving and handling training following a series of incidents. After staff completed new training, the service found a significant reduction in issues. Similarly, the service updated training on the use of oxygen masks following an incident involving a patient who was discharged from hospital with a mask type that was unfamiliar to the crew.

Staff reported near misses as part of a culture of reflective learning in safety. Near misses typically related to moving and handling challenges or to inappropriate discharges. Reporting helped the service to better coordinate effective and safe discharge with hospitals and ensure crews had the information they needed to keep patients safe and well during a journey.

The provider operated the incident process as a learning exercise and the senior management team facilitated a culture of no blame to encourage open and honest discussion. This led to positive changed practices in different working scenarios. For example, a minor patient injury occurred when 2 ACAs were manoeuvring a patient on a stretcher and a third-party member of staff who was assisting worked to a different procedure. As a result, staff received new training on effective communication when relying on others for help.

Is the service effective?

Good

We have not previously rated effective.

We rated it as good.

Good

Patient transport services

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. The nature of the service meant patients' needs during transport, and the requirements of contracting NHS trusts, were diverse. The provider's policies and standard operating procedures (SOPs) reflected this need and meant staff had guidance and protocols to safely transport patients who used equipment such as urinary catheters, syringe drivers, and Controlled Drugs whilst under medical escort. This approach provided staff with the flexibility to offer safe transport to a wide range of patients.

The service worked closely with NHS trusts to develop policies and SOPs that reflected patient need and the experiences of crews working on a specific contract. For example, the service was working with a trust to develop defined policies for transporting patients being cared for at the end of life following a series of deaths during transport.

The senior management team (SMT) held team meetings quarterly for each region or geographic contract area. This included learning from incidents and feedback and changes to policy or practice.

The service updated policies following learning from incidents, changes to national standards, or feedback from other organisations. Staff shared such updates with contracting NHS trusts and worked to match policies that contributed to effective working practices. For example, the SMT developed a new policy to help manage delays to routine transport from discharge lounges if crews were assisting emergency colleagues at an incident they encountered whilst on route, such as a traffic collision.

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 provided transport to patients either as a directly contracted provider or as a third-party provider through contracts with NHS trusts. Each trust set their own patient safety timeline requirements, which were the nearest measurement to a response time indicator. Crews worked to individual trust requirements, whose control centres allocated work, journey times, and other requirements.

At the time of our inspection, 3 NHS trusts used and shared key performance indicators (KPIs) for crew response times. This measured the time of ambulance arrival after being booked, the journey time, and the time the vehicle was available for another journey against contractual expectations. The service performed consistently well, with 94% compliance in the previous 12 months. Another trust used a single measure KPI to check the time of patient pick up after being referred to a crew, which the service consistently met at 100%. Across KPIs for the 3 trusts, the service achieved an average 97% compliance rate with 13 instances of monthly performance over 99% or at 100%.

Some trusts monitored response times internally and did not release the information to this provider. In most areas commissioners monitored such data and liaised with the provider and contracting trust if performance did not meet expectations. This had not happened to date, and services typically asked for more block times and crews due to consistently good standards of service.

Good

Patient transport services

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. In addition to mandatory training, ambulance care assistants (ACAs) completed a range of competencies that enabled them to work safely and confidently when transporting patients.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The SMT embedded learning and development throughout the work culture of the organisation and provided staff with ad-hoc opportunities to build their skills. This was closely linked with the recruitment policy and meant new starters who were undertaking healthcare degrees or formal qualifications built experience in the sector.

Managers gave all new staff a full induction tailored to their role before they started work. The induction included a patient transport service course tailored to the needs of patients and specific third-party contracts in addition to mandatory training. Each new ACA spent time with a mentor for the first 3 months of their work and the service required this to be completed successfully before they completed their probation.

Managers supported staff to develop through yearly, constructive appraisals. This included a practical observation of their work to assess standards of patient care and communication in line with expected standards. We looked at a sample of 10 appraisals from the previous 6 months and saw they were comprehensive and focused on the standards of care staff applied to patients and had a positive focus on opportunities for improvement.

The nature of the service, with a geographically spread team, meant it was difficult for ACAs to consistently attend team meetings. Instead, the head of care, quality, and compliance arranged smaller meetings with crews opportunistically, or following changes in policy, and distributed monthly newsletters to all staff. A tracking system required staff to acknowledge receipt, so the senior team had assurance everyone was up to date.

A team of mentors provided learning and development support for new staff during their induction and ensured they achieved the required competencies before working without supervision. Mentors worked flexibly with established members of the team, such as to support changes in performance or to assist the application of new learning or practices.

Mentors carried out bi-monthly assessments of staff during patient transport to maintain an ongoing understanding of staff abilities and identify learning and development needs.

The operations team carried out monthly 'on the road' audits of a sample of crews to assess standards of practice, including in relation to safeguarding, road safety, and infection control. Action plans demonstrated this was an effective process that supported staff development. For example, auditors found areas for improvement in how some staff used safety harnesses during transport, which led to more involvement from mentors. This process reflected a focus on continuing professional development.

The staff team had a wealth of diverse experience amongst them, and mentors helped them share their expertise with colleagues. For example, some staff were certified mental health first aiders and a senior member of staff had completed a trauma-informed training programme. The provider valued such skills and supported staff to develop them.

Good

Patient transport services

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 held regular and effective multidisciplinary meetings to discuss patients and improve their care. The needs of patients varied between NHS contracts and the SMT worked with trust colleagues to coordinate services and ensure there was a clear understanding of areas of responsibility.

Staff worked across health care disciplines and with other agencies when required to care for patients. Many patients who used the service were vulnerable and living with varying degrees of frailty. Staff recognised the need for more coordination between hospitals, the transport service, and adult social care services to help protect people from avoidable harm, such as inadequate living conditions.

The SMT had established working practices with a hospital following a series of deaths during transport of patients cared for on end-of-life pathways. Contractual arrangements had been vague, and ACAs had encountered occasions where patients died during transport despite the booking information excluding any information about end-of-life care. New multidisciplinary relationships meant crews received more detailed information on patients with such needs in advance and the trust provided them with training and support.

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.

Patients were under the overarching care of an NHS trust, whose staff were responsible for assessing mental capacity. This meant ambulance crews were not responsible for assessing mental capacity as hospital staff had already established this prior to booking transport. However, if a patient refused to board a vehicle or was confused about where they were being taken, staff liaised with hospital colleagues to decide if the patient could be safely transported.

ACAs completed capacity to consent training and ensured patients consented to being assisted before each journey.

Staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards as part of an approach to understanding the needs of patients they transported.

Staff were trained to understand do not resuscitate (DNACPR) documentation, which they used in the event a patient deteriorated or died during a journey.

Is the service caring?

Good

We have not previously rated caring.

We rated it as good.

Good

Patient transport services

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. They 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. A recent patient noted in feedback, “I cannot express my gratitude enough to these wonderful people. A friendly rapport was struck up immediately and I felt very relaxed in their company. It was lovely to engage in humorous and interesting conversation.” Other recent feedback included, “I have been looked after very well,” and, “[I] could not wish for a better team to take care of me.”

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Relatives and carers of patients living with mental health needs provided consistently positive feedback about the service.

Staff understood and respected the personal needs of patients and how they may relate to care needs. A recent patient provided positive feedback about a journey and asked for the same crew on their next trip due to the rapport they had built up.

Staff provided kind and compassionate care to patients when collecting them from discharge lounges. They addressed them by name using a friendly, professional approach, and skilfully built a rapport with each person. Discharge lounge staff, who coordinated with the transport provider, described good standards of care from ambulance staff and said they always found them helpful and caring.

Ambulance care assistants (ACAs) adapted their driving to improve comfort for patients. For example, a crew had recently transported a patient who was in severe discomfort and was receiving complex care. The crew drove at minimal speed over speed bumps and avoided them where possible. An ACA sat with the patient and provided continuous reassurance. The commissioning NHS manager complimented the crew on their compassionate care.

Emotional support

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

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

Staff supported patients who became distressed during shared transport and helped them maintain their privacy and dignity. During a transfer between 2 medical facilities, staff provided dignified care and understanding to a patient who was living with dementia and was prone to violent outbursts. Other patients being transported at the same time contacted the provider to praise the crew for skilfully reassuring the anxious patient.

Good

Patient transport services

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. For example, they understood when patients might want to sleep during transport after a treatment and when a more interactive approach would provide reassurance.

Staff often provided care beyond their contracted role to ensure patients were safe and looked after. For example, a crew that recently transported a patient home after they were discharged from hospital found a booked carer could not attend the patient until later. They escorted the individual into their home, made sure they were comfortable, and prepared them a drink. On another occasion staff provided tea, coffee, and milk for a patient who they found had nothing to drink at home. Such attention to individual needs was a consistent feature of the service and was reflected in feedback.

Crews acted instinctively and intuitively during volatile, unpredictable situations to protect patients and members of the public from harm. For example, a crew stopped to help members of the public injured in a road traffic accident, stabilised them whilst awaiting paramedics, called their family, and worked with the police to calm an escalating situation. At all times the crew demonstrated a focus on care and compassion.

The service received dozens of unsolicited thank you emails from patients, relatives, and contracting NHS discharge coordinators. Recent feedback included, "Heartfelt thanks and gratitude for the caring nature [of the crew]." Another patient noted, "[Crew] were excellent, they made it very pleasant and made me laugh all the way. They both made sure I was looked after on pick up and arrival, I cannot thank you enough."

A senior member of staff from a contracting NHS trust praised the professionalism of crew who experienced a patient death during transport. They noted, "It is clear [crews] are selected for their wonderful personality traits and interpersonal skills."

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers and involved them in transport decisions.

Staff provided transport services with respect and dignity for patients. For example, they offered blankets to protect privacy or improve comfort and adapted their communication style to meet the needs and expectations of each person.

A patient complimented staff on how they had supported another patient who experienced anxiety and confusion caused by dementia during a transfer. They patient noted staff provided reassurance and conversation, which helped the person relax and enjoy the ride. For example, from speaking with the patient, staff understood the patient enjoyed travel and pointed out landmarks and interesting sights along their journey. This had a calming impact on the patient and helped to make it more enjoyable for everyone.

Is the service responsive?

Good

We have not previously rated responsive.

We rated it as good.

Good

Patient transport services

Service delivery to meet the needs of people.

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

NHS trusts that contracted the patient transport service (PTS) established the level of need of patients in advance of specific journeys. The head of care, quality, and compliance and the operations team then planned and organised services to meet trust and patient needs. Ambulance care assistants (ACAs) did not always receive detailed personal information before they collected each patient and worked flexibly to meet individual needs as far as possible and within their remit.

Vehicles were appropriate for the services being delivered. They were equipped with a range of specialist and multi-purpose equipment, including to secure wheelchairs, harnesses, and comfortable seating.

ACAs completed patient liaison training to help them adapt communication approaches to individual need. This included developing effective communication and overcoming barriers to communication.

The service was highly adaptable to the needs of patients and NHS trusts and staff worked to identify opportunities for improvements and adaptations to the service. For example, staff identified an increase in patients living with dementia in one region and worked with a local organisation to procure tools to help distract and reduce anxiety during journeys, such as poppets.

The service did not routinely transport patients being treated under a Mental Health Act Section. However, staff were trained to provide transport services to such patients if they were accompanied by an escort.

The service worked proactively with NHS colleagues to ensure transport met individual needs. For example, the planning and liaison coordinator worked to ensure crew complements, ambulance coverage, and crew skills met the needs of patients. This was a reflective process and staff worked with NHS colleagues and patients during the initial process of a contract to adapt the service to ensure it met the needs of patients.

The provider's staffing and recruitment model focused on local contract areas to ensure staff had cultural empathy with the local population and its needs and challenges.

Most transport was for patient discharge from hospital to their home, which meant hospital staff had assessed each individual as suitable to travel before they booked a crew. The service established eligibility criteria for each transport contract and crews were trained in its application. This meant if a patient presented for transport who was clinically unstable, or who would be unsafe to transport, they worked with the trust's control centre to identify other alternatives.

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 the service.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received safe, comfortable transport. Vehicles were equipped with blankets, pillows, and sheets.

Good

Patient transport services

Staff provided vulnerable patients with a welfare pack on arrival at home after a stay in hospital. This included tea, coffee, and milk, and helped patients returning home without provisions.

Some PTS contracts required staff to transport people receiving end of life care. They ensured patients were transported in a private vehicle without other patients present and ensured they understood the patient's 'do not resuscitate' (DNACPR) status in advance. PTS policies were in place to ensure this process was effective and to ensure staff followed national DNACPR requirements. The head of care, quality, and compliance worked with senior colleagues in hospitals to ensure discharge teams had the same understanding of requirements following instances where ward staff gave verbal DNACPR status to ambulance crews without providing corresponding paperwork.

Staff used communication aids to help interact with patients who could not communicate verbally.

Staff spoke with patients before transport commenced to identify any specific needs or personal requests. This was good practice and meant they provided an individually tailored service beyond basic contractual requirements.

The service empowered crews to influence care and patient experience however they saw fit within the remit of specific contracts.

Access and flow

People could access the service when they needed it, in line with contractual standards.

The service provided patient transport services to NHS patients under specific contracts with individual trusts. Each contract or commissioning arrangement established how patient transport was assigned to crews along with geographic restrictions and expected journey times. Crews worked to local arrangements when responding to requests for transport. For example, 1 trust had issued crews with electronic devices that provided patient details such as pick up location and times. Other trusts arranged annualised block contracts, which meant crews were in position and ready to provide transport, but the frequency of trips was based on patient need and not pre-determined.

The service was flexible and adaptable to trust needs and worked with operations leads and commissioners to change vehicle and crew availability. For example, the service had increased the availability and capacity of transport services with less than 2 days' notice when a trust experienced a significant increase in demand. The senior team met with trust colleagues and commissioners at a frequency dictated by the contract and worked together to identify opportunities for improvement.

Managers worked to keep the number of cancelled journeys to a minimum and monitored this through governance systems. There were no instances of cancelled journeys at short notice by the provider in the previous 12 months.

The service determined ambulance numbers and crew levels on a contractual level. Some NHS trusts booked a predetermined block of work for a specific period and others required an on-demand approach. Coordinators worked with each trust individually to ensure the service could meet patient requirements before they adopted a contract. Most contracts were on a third-party basis, and they service had one contract as a direct provider. Staff understood such arrangements and used them to provide individualised care at an appropriate level.

Learning from complaints and concerns

Good

Patient transport services

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. Each vehicle included a QR code for digital access to the feedback and complaints procedure as well as printed forms and contact details. Contracting NHS trusts held a copy of the provider's complaints process and provided it to patients on request.

Staff were trained and empowered to address and resolve minor complaints. They reported such issues to the head office team and where a complaint was complex or more serious, they referred patients to the registered manager. NHS trusts held overall responsibility for the care of most patients, which meant patients could contact patient advice and liaison services (PALS) to resolve to a complaint with a contracted transport provider. Staff signposted patients to PALS although such instances were rare, and the service received no such complaints in the previous 12 months.

The service received no formal complaints in the previous 12 months.

Is the service well-led?

Outstanding ☆

We have not previously rated well-led.

We rated it as outstanding.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and worked tirelessly to address them. They were visible and approachable in the service for patients and staff and had a clear track record of effective, evidence-based leadership strategy. They supported staff to develop their skills and take on more senior roles through 'stretch' goals.

The head of care, quality, and compliance was the registered manager and led the day-to-day service with support from the patient transport service (PTS) manager, the managing director, and other senior staff.

There was a strong, embedded focus on developing, recognising, and promoting internal talent to take up leadership posts. Staff had access to accredited leadership courses including at higher education level. The senior management team (SMT) took an exploratory approach to leadership development and acted on successes and failures to make sure opportunities were individualised to staff abilities and needs and to the leadership needs of the service and its values.

A duty manager was on call 24/7, which meant staff always had on-demand support. The system also meant NHS managers had a point of contact for urgent changes in need. The provider was highly responsive to such requests and provided short notice increases in capacity when asked.

Managers were operational and could fill in for transport duties at short notice, such as to cover staff sickness or crews who were delayed due to incidents or patient need. This provided a margin for error in planning and reduced the risk of cancelled trips.

Good

Patient transport services

Vision and Strategy

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

The provider's vision focused on meeting the needs of contracting NHS trusts and their patients and on building a more secure, skilled workforce that would contribute to regional health developments. The induction for new staff included learning about the vision and values and mentors embedded this in supervision and developmental work through the probationary period.

Organisational values reflected a need for responsive and caring customer focus, team-oriented culture, fair, open, and honest leadership and polite, respectful, and caring attitudes and behaviours.

The provider's mission statement focused on themes of care, compassion, competence, commitment, and communication. The SMT embedded the values across business processes including recruitment, training, and engagement with NHS partners. Staff at all levels understood the provider's objectives and values and understood how they related to their role. During our discussions, staff demonstrated enthusiasm and passion for the service, and this was reflected in feedback from patients and NHS contract managers.

The SMT demonstrated a strong commitment to working ethically across the region and prioritised the needs of NHS services first and foremost.

The SMT empowered crews to work with NHS colleagues in their areas of work, enabling them to contribute to the performance of the service within their control. This was part of a values-driven work ethic that encouraged crews to advocate for their own success.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients and proactively sought opportunities for joint working and continuous improvement. The service promoted equality and diversity in daily work and provided personalised opportunities for career development. The service had an open culture where patients, their families, and staff could raise concerns without fear and in which senior staff genuinely wanted to understand challenges.

The SMT promoted an ethos of professionalism, empowerment, and accountability in care delivery and staff represented this by wearing clean, professional uniforms and ID badges at all times whilst on duty. Staff had a palpable sense of pride in their work during our inspection and the senior team went to great lengths to ensure they supported everyone in the team to maintain a good work/life balance. For example, managers arranged for wellbeing activities to support staff struggling with mental health challenges or pressures, provided substantive financial support to staff experiencing difficulties, and incentivised new staff to achieve personal goals, such as passing their driving test.

The senior team coordinated counselling with contracting NHS trusts for staff who were involved in stressful instances, such as the death of a patient. The service extended this to staff who were experiencing difficulties in their personal lives. This was part of an overarching culture of compassionate support for staff that reflected the value in the organisation.

The senior team issued certificates of commendation to staff who performed beyond their responsibilities and exceeded patient expectations.

Mentors formally introduced new staff to the organisational culture during the induction process for new staff. While the culture had key markers, such as work ethics and organisational values, the service empowered each member of the team to be themselves at work. The SMT demonstrably valued diversity and new staff completed human rights and equality training.

There was an embedded, demonstrable focus on collaborative working between ambulance crews and the operations and administration teams. Joint working, empowerment for communication, and a motivated team meant staff across all roles worked well together for the benefit of patients.

Staff told us they liked working for the provider and said they felt supported by a helpful office team.

Staff spoke positively of the provider's response to suggestions and feedback and said the working culture encouraged them to raise concerns and suggestions in a supportive environment that respected differences of opinion and used them to drive change.

The 2022 staff survey results demonstrated around 50% satisfaction with organisation, training, and communication. Following the survey, the SMT worked extensively with colleagues across the organisation to develop and implement a comprehensive programme of improvement. Managers worked with mentors and the rest of the team to identify areas for improvement, including why they had been unaware of areas of dissatisfaction until the survey took place. This led to significantly improved communication between the senior team and the ambulance care team, including more consistently visible leadership for staff working in remote areas. Staff who noted they were happy with the organisation spoke highly of the work and leadership, including the support of the senior team and options for support.

Feedback from contracting services reflected very high levels of satisfaction with the working culture. A contract manager recently referred to staff as, "Extremely helpful, positive, professional and friendly despite the difficulties we faced" following a challenging shift. Another service manager noted staff has "worked above and beyond their role" during an emergency.

Each patient transport contract had specific targets and response times. When crews joined a specific area or contract, the senior team empowered them to take ownership of performance and influence work locally. This was part of a wider strategy to engage staff in their work more deeply.

Governance

Leaders operated highly effective governance processes, throughout the service and with partner organisations. Governance was measured quantitatively and qualitatively, and the service had substantial evidence of improvement and assurance as a result. 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 registered manager led comprehensive, performance- and safety-focused monthly operational review meetings that included incidents, complaints, and the key performance indicators of each individual NHS contract. The team included recruitment, training, and other staffing areas as well as vehicle cleaning and maintenance planning. Some NHS trusts were interested in such governance as part of contract monitoring and the SMT worked to provide appropriate levels of information to aid good governance and joint working.

The SMT led the governance model and supplemented it with external input from services such as occupational health and a mental health and wellbeing advisor to address specific challenges.The SMT used a daily '10 at 10' governance model to keep continuous oversight of the service, including monitoring incidents, staffing pressures, and feedback from NHS contractors. The system meant senior staff were responsive to service, patient, and staff needs across the wide geographic operational area.

The service worked with contracting NHS trusts to carry out governance audits at a frequency dictated by the individual contract. These processes worked in tandem with the provider's own governance system and meant the SMT had a sound understanding of the competing requirements and pressures on the service.

The registered manager planned a rolling programme of audits up to 1 year in advance. This ensured regulatory and legislative requirements were always met.

The head of care, quality, and compliance, head of quality, general manager, planning coordinator, and 3 other staff formed the operations team. They met bi-monthly and reviewed challenges, issues, and successes across the whole service. The team worked proactively to identify opportunities for improvement. For example, to establish a better understanding of emerging operational pressures each day, the team introduced a daily 10am whole-team meeting that reviewed planned transport across each NHS contract.

Transporting patients who received end of life care had presented a series of challenges to staff. The head of care, quality, and compliance worked with NHS colleagues to establish protocols within the governance system to ensure staff had clear details of processes to follow if a patient died during a journey.

Management of risk, issues, and performance

Leaders and teams used systems to manage, assess, and improve performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Risk management was holistic, and the service had extensive, tested plans to cope with unexpected events. Staff contributed to decision-making to support consistent quality of care.

The head of care, quality, and compliance used a 6 monthly quality report to monitor and manage risk, quality, and performance. This included monitoring of the various key performance indicators for each NHS contract, a review of incident trends, safety track record, and audit outcomes. Staff performance, measured by continued education and development, was a key aspect of quality in the service and the head of care, quality, and compliance embedded this throughout quality assurance processes. This was reflected in feedback from commissioners, trusts, and patients, which was consistently positive and focused on staff professionalism and competence.

Staff used a comprehensive auditing and management system to ensure vehicles and standards of practice were consistently maintained. Managers and mentors carried out regular audits of vehicle cleaning standards, benchmarking audit findings against the checklists staff completed daily. The service used this as a quality assurance system to check routine cleaning policies and procedures were effective.

The senior team used a risk management scoring system that enabled staff to implement control measures when using specialist equipment on vehicles and when transferring patients to or from a vehicle. A risk assessment was in place for each risk and the senior team updated these when manufacturer or national guidance changed, or after an incident.

The operations team reviewed risks daily as part of an approach to continuity and ensure known risks were managed in line with service needs. For example, there was a lack of new vehicles available for purchase after the lifting of pandemic restrictions and this was a key risk for several months as routine patient transport resumed with a significant backlog.

The risk management system was designed to work flexibility and agilely with the equivalent systems in NHS trusts that contracted PTS. This meant the service managed internal and external risks, provided assurance of standards of practice, and met the requirements of contracting organisations to keep patients and staff safe.

The SMT used a risk register to log, track, and manage risks. At the time of our inspection there were 8 active risks. Each risk had a named responsible member of staff and evidence of regular updates and mitigation. Unsafe or inappropriate discharges were a key recurring risk in the service and the senior team used learning from specific incidents to update policies and procedures.

Business continuity action plans reflected the nature of the service, including vehicles and crews operating in remote or distant locations. Plans were in place to support crews and patients in the event of vehicle breakdown, road accidents, and severe weather. A disaster recovery team were trained to maintain essential services by working with NHS partners to identify the patients in most need.

The provider maintained a lone working policy to support staff in the event of single crew working although this was rare and there were no such contracts in place at the time of our inspection. Crews who worked alone on previous transport contracts provided feedback when they felt this was inappropriate for patient needs or their own safety and the SMT acted on this with commissioning managers.

The SMT monitored incidents in other PTS services as a strategy to avoid risk. For example, a patient had experienced harm during an accident in another service. The registered manager reviewed moving and handling policies as a result to identify any need for changes in policy, training, or practice. This reflected a high standard of practice in risk avoidance and meant the service was swift to act on new or previously unidentified risks.

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

New staff signed a data protection commitment that reflected the flexible working nature of the service, including providing care for the patients of different NHS trusts. This formed part of wider information governance and security training. Information security and confidentiality policies reflected NHS requirements and were a contractual element of each transport arrangement.

A named data protection officer monitored the provider's compliance with national standards set by the Information Commissioner's Office.

The service shared the data protection policy with trusts contracting its services and worked with them to make modifications to meet specific contractual needs.

Ambulance crews accessed data specific to individual trusts using an electronic log. Such logs provided an audit trail of access, which the SMT monitored through a secure business management system.

Staff used a data protection policy and an information governance policy to guide their handling of personal data and information. Mandatory training included the policies and senior staff monitored how staff managed confidential information during the course of their work. The service had no data breaches or information-related incidents in the previous 12 months.

Crews handled a range of personal information, including from formal transport records and verbal information from NHS transport control centres. Training included information protection and governance based on the type of data being handled, including hard copy and digital material.

Engagement

Leaders and staff actively and extensively engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. This approach demonstrably led to high quality care.

The service encouraged feedback from each journey. Each vehicle was equipped with a poster that encouraged patients and anyone accompanying them to provide feedback using a QR code. Ambulance crews carried hard copy comment cards in addition to this and patients also provided feedback by letter, e-mail, and telephone. Feedback was consistently good, and patients frequently agreed that crews were polite and professional and that they felt safe and cared for.

The service received frequent written compliments from patients and the SMT contacted individual members of staff where they were named in positive feedback.

The organisation had completed a leadership restructure in the months before our inspection. This restructure followed results of the staff survey and led to a better structure that supported staff development and provided more rapid support for staff experiencing challenges. An external specialist organisation carried out a consultation with the SMT and helped shape effective leadership strategies. This embedded an evidence-based leadership model that produced demonstrable results that results in significantly improved staff satisfaction.

The service engaged with NHS trusts to ensure their commissioning and patients' needs were met. The SMT was readily available for ad-hoc discussions and feedback in addition to formal governance or operational meetings. This led to effective lines of communication and meant the service maintained an up-to-date awareness of feedback and acted quickly on compliments and complaints.

The service had built an extensive range of positive feedback from NHS teams, patients, and their relatives. Recent feedback from an NHS manager complimented an ambulance crew who they said, "…Went above and beyond to ensure a patient was taken home after a lengthy wait even after their shift ended." Another senior person from a contracting trust wrote to the service and said crews, "…never say no, we don't know what we'd do without them." A patient who had used the service wrote to the head of care, quality, and compliance and noted, "What a success story! From the bottom of my heart, I thank you so much."

The SMT implemented a range of changes and improvements to the service in response to staff survey results from early 2023. The provider had completed a period of restructure and was expanding, and the survey results highlighted a need for improvements in rostering, assessment feedback, and the mentoring system.

The senior team carried out a rolling programme of 1-to-1 welfare calls with all ambulance care assistants (ACAs) following the results of the staff survey. The team increased these for any staff who needed more support and ACAs we spoke with described the system in very positive terms.

The service developed good working relationships with discharge teams at hospital sites to ensure booked transport was safe and appropriate. This followed instances of unsafe discharges in which crews were expected to care for patients above the scope of their role, training, and the contract. Staff said relationships following such instances improved because they led to discussions of clear boundaries and expectations, which embedded greater assurance of care quality.

The SMT introduced a 'grassroots ownership' model of staffing across the ACA team. This approach empowered staff to make decisions and take the initiative during their work to provide care to patients that reflected individual needs and the circumstances of the shift. It enabled staff to develop their abilities and reduced the reliance on contacting a manager for decision-making. The SMT carried out a staff turnover analysis to identify opportunities for retention. This was part of work the team conducted to act on staff survey outcomes and resulted in improved incentives, such as better recognition of staff who undertook higher acuity work.

The SMT acted on staff survey feedback to substantially increase their visibility across each geographic area. They implemented a continuous programme of accompanying ACAs during their work, meeting patients and NHS colleagues. This helped the senior team build relationships with staff who worked long distances from head office who would otherwise not be seen frequently.

The SMT held periodic open forums where staff from any area could drop in to talk about their work or the service. This was good practice for engagement and led to improvements in care. For example, feedback from staff using this process led the SMT to increase crew numbers for patients transported from a dialysis unit, who typically needed higher levels of support during the journey.

Learning, continuous improvement and innovation

All staff were demonstrably committed to continually learning and improving services through inquisitive working, professional development, and research. They had an advanced understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The combination of strong values, work ethic, and a culture that supported new ideas and challenge let to a professional environment that facilitated innovation. All staff we spoke with were determined and motivated and demonstrated a clear understanding of their respective region(s) of work. A senior member of staff described this as "curiosity that seeks constant improvement."

Services that contracted the provider rated the team highly. This had led to a recent extension of a contract for patients being discharged from hospital. The contracting trust noted this was due to an "exceptional level of service" by the provider.

Good

Patient transport services

The service had adapted risk management systems to reflect the diverse range of care provided, including an innovative approach to dynamic risk assessment led by crews who had undertaken specialist training. This meant a member of staff carried out a specific, individualised risk assessment before transporting each patient. Using the expected patient eligibility criteria set by each NHS trust, staff checked the needs of each patient, including issues such as reduced mobility, to ensure they could be safely transported and were within the acceptable risk limitations of each contract. This was a new system developed to address risks caused by inappropriate or unsafe discharges. The approach reduced the risk of aborted journeys because it meant staff could adapt the service to meet individual needs. For example, patients sometimes presented with mobility needs different to their discharge documentation. The risk assessment carried out by staff meant they did not automatically need to decline a transport and instead could work with the patient to make it safe.

Staff demonstrated continual learning in ensuring good safeguarding standards for patients with complex needs whose care was the responsibility of multiple organisations. There were a significant number of examples where staff worked beyond their expected role to make sure patients were safe, despite pressures and challenges from other organisations in the care system. Such actions had led to improvements such as securing new social worker support for a patient with previously unknown vulnerabilities and another patient receiving more appropriate home care.

The SMT understood staffing and retention challenges across their areas of operation. They recognised many new recruits were keen to gain experience in the sector before moving on to other roles. To provide such individuals with a useful experience, the team targeted recruitment of university students to complement the ACA team outside of teaching semesters. This supported increased capacity, helped generate flexible hours, and embedded the organisation's work and reputation in the wider health economy. In addition to the university programme, the SMT restructured the scheduling ethos to reflect the gig economy trend, which enabled trained and qualified staff to work flexibly around their other commitments. This led to a significant increase in staff morale and satisfaction.

The SMT developed, tested, and implemented safeguarding practices that reflected the specific vulnerabilities of patients. ACAs were usually with patients for short periods of time during transport and overall care was managed by other organisations. The safeguarding process enabled staff to act rapidly on information or observations of concern and had led to a series of instances in which other organisations acted to improve the safety and care of patients with previously unknown vulnerabilities.