ERS Transition Limited

ERS Medical South

Quality Report

Unit 1
Barton Farm Industrial Estate
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Eastleigh
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Website:

Date of inspection visit: 22-29 March 2019
Date of publication: 10/06/2019

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

Ratings

Overall rating for this ambulance location	Good
Patient transport services (PTS)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

ERS Medical South is operated by ERS Transition Limited. It is an independent ambulance service in Hampshire. The service primarily serves the communities in South East London and Hampshire.

The provider has been registered with CQC as ERS Transition Ltd since October 2017.

ERS Transition Limited is registered with the CQC to carry out the regulated activity of transport services, triage and medical advice provided remotely and treatment of disease, disorder or injury.

ERS Medical South primary service is transporting non-emergency patients within South East London and Hampshire.

The service has had a registered manager in post since October 2017. At the time of the inspection, a temporary registered manager was registered with the CQC.

We inspected this service using our next phase inspection methodology. We carried out a short notice announced inspection on 22 March 2019, along with an unannounced visit to the service on 29 March 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated the service as good overall because:

- The senior leadership team had created a culture where information was used to drive improvement and gain assurance. Through this process front line staff engaged in the change process. They shared their data with partner organisations for better decision making.
- The service had a clear vision and strategy and staff were fully aware of it. The strategy and supporting objectives and plans were stretching, challenging and innovative.
- There were systems of governance in place that had been embedded and strengthened. Staff worked with other organisations to improve patient care outcomes.
- There were effective and integrated business management systems which gave senior leaders up to date information and oversight of the service.
- There were systems in place to safeguard vulnerable adults and children. Staff could identify safeguarding concerns and knew how to report them.
- Policies and procedures were in line with national guidelines and were version controlled and within date. There was an audit programme in place to monitor compliance with policies and procedures.
- The service had good oversight of the booking process and monitored drop off and pick up times and kept patients informed about delays.
- There were systems of governance at management level to monitor performance and risk. Problems were identified and addressed quickly and openly.
- The process for shared learning from complaints was embedded. Staff told us how learning from complaints was shared.

However, we also found the following:

Summary of findings

- Road staff at the Mitcham location were not aware on how to exchange their oxygen cylinders if it was out of date or empty. We raised it at inspection and followed it up formally with the service following our inspection. The service submitted evidence that they had informed all staff of the process for exchanging cylinders.
- The service did not have a system to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Good	Patient transport services were the only activity undertaken. We rated well led as outstanding because the senior leadership team had created a culture where information was used to drive improvement and gain assurance. Front-line staff were engaged in the change process. They shared their data with partner organisations for better decision making. The service had a clear vision and strategy and staff were fully aware of it. There were systems of governance in place that had been embedded and strengthened. The service had effective, integrated business management systems which gave senior leaders up to date information and oversight of the service. We rated safe, effective, caring and responsive as good because staff received mandatory training and annual competency updates. There was an effective process in place for infection prevention and control and vehicle and equipment maintenance. Policies were up to date and reflected national guidelines and staff treated patients with kindness, dignity and respect.

Good

ERS Medical South

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Detailed findings

Contents

Background to ERS Medical South

ERS Medical South is operated by ERS Transition Limited. It is an independent ambulance service in Hampshire. The service primarily serves the communities in South East London and Hampshire.

The provider has been registered with CQC as ERS Transition Ltd since October 2017.

ERS Transition Limited is registered with the CQC to carry out the regulated activity of transport services, triage and medical advice provided remotely and treatment of disease, disorder or injury. ERS Medical South primary service is transporting non-emergency patients within South East London and Hampshire. The service can transport patients detained under the Mental Health Act 2007.

The service has had a registered manager in post since October 2017. At the time of the inspection, a temporary registered manager was registered with the CQC. The organisation was in the process of recruiting a permanent registered manager.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, a CQC lead inspector,one other CQC inspector, and two specialist advisors with expertise in patient transport services. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

Facts and data about ERS Medical South

ERS Medical South operates from stations located in Eastleigh and Mitcham.

They operate a total of seven vehicles in Mitcham, two in Eastleigh and operate two mental health vehicles. They employ seven members of staff in Mitcham and two in Eastleigh. A central control room based in Leeds supports all ERS Medical, part of ERS Transition Ltd.

The service is registered to provide the following regulated activities:

- Patient transport service (PTS)

During the inspection, we visited Mitcham and Eastleigh stations. We spoke with ten staff including; medical director, patient transport drivers, dispatch and planning staff, trainers, volunteer driver and managers. During our inspection, we reviewed 10 sets of patient records. We inspected seven vehicles.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12

Detailed findings

months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity January 2018 to February 2019:

- There were 8156 patient transport journeys undertaken.
- There were 10 patient transport drivers and two administrative and clerical staff who worked at the service.

Track record on safety:

- No never events.
- Incidents: 14 no harm, two moderate and three serious harm. No deaths had been reported because of an incident.
- 16 complaints.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Good	Good	☆ Outstanding	Good
Overall	Good	Good	Good	Good	☆ Outstanding	Good

Patient transport services (PTS)

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

Information about the service

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Patient transport services (PTS)

Summary of findings

We found the following areas of good practice:

- The senior leadership team had created a culture where information was used to drive improvement and gained assurance. Through this process front line staff engaged in the change process.
- The service was rolling out a leadership development programme to all its front-line staff. It had started this programme for all senior and operational managers.
- The service had linked the hospital bed flow software with ERS dispatch. Good hospital bed flow allows for an efficient system to arrange the transportation of the patient to their residence. This software had created a seamless link between the hospital and the service. It also allowed patients to track their transport through a special "Patient View" on an accessible portal.
- All vehicles had a forward-facing vehicle camera that recorded continuously. The system captured 40 seconds of footage when triggered by an incident and this was sent by email automatically to the driver's line manager. It allowed for immediate investigations of any serious incident.

However, we also found the following:

- Road staff at the Mitcham location were not aware on how to exchange their oxygen cylinders if it was out of date or empty. We raised it at inspection and followed it up formally with the service following our inspection. The service submitted evidence that they had informed all staff of the process for exchanging cylinders.
- The service did not have a system to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty.

Are patient transport services safe?

Good

This was the first inspection of the service under our new methodology. We rated safe as **good.**

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated and shared lessons learned with the whole team at a local and national level.
- There was genuinely an open culture in which all safety concerns raised by staff and people who used the service were highly valued as being integral to learning and improvement.
- The service had an incident reporting policy. We reviewed the document and saw that it contained definitions of incidents, reporting and investigation process, and detailed different types of incidents such as clinical incidents, information governance, security incidents and transport and road traffic incidents. All staff we asked could tell us what constituted an incident.
- The service had reported 19 incidents between January 2018 and February 2019. Of these,14 incidents were risk scored as no harm, two as moderate and three as serious harm. There were no deaths reported. All moderate and serious harm incidents were investigated by a team leader in line with policy. The incident and the investigation report was peer-reviewed by the medical director. An action plan was developed for each of concerns identified. The action plan was implemented by a team leader and progress reported to the senior leadership team (SLT).
- We reviewed the process for frontline PTS crews to report an incident. The care standard manager told us the incident reporting process required staff to use a single telephone number to call the central control room based in Leeds to report incidents. All staff were aware of this number. They told us they would call dispatch to report any incidents.

- Incidents were recorded on an electronic system. When an incident was recorded, an email alert was sent to the regional manager and the head of care standards as well as to the staff member's line manager and the member of staff who had raised the incident.
- We reviewed the system and saw that incidents were colour coded red, amber, lower amber and green (RALAG rated). Incidents were allocated an investigation owner and timescales were included to ensure the investigation was completed in line with policy.
- We saw three sets of minutes from the monthly Governance and Patient Safety Committee (GaPS) meeting which showed that incidents were a regular agenda item. This was a location based committee. The head of care standards told us that learning from incidents was shared with staff through a computer business system. Individual learning from incidents was delivered by the regional manager or operations manager to the crew or individual concerned. Wider learning was shared with staff via team meetings, email and tool box talks. Individual learning from incidents was delivered by the regional manager or operations manager to the crew or individual concerned.
- During inspection we spoke with five ambulance crew members. All staff stated that they had received training in incident reporting, which was confirmed in the mandatory training records, and all could explain the incident reporting procedures.
- Managerial staff understood their legal responsibilities under the duty of candour. We saw evidence the service applied duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014 following three applicable incidents. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide them with reasonable support.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory training arrangements and policies were in place for all front-line staff, team leaders, managers and directors. Staff completed annual update training which contained 14 core elements including manual handling, basic life support, health and safety and safeguarding adults and children.
- We reviewed a spreadsheet that had staff names, where they worked, their role, date of induction training, date of provider driving test, driving qualification, clinical skill set, date of clinical skill set refresher, dates of the one day statutory and mandatory training, dates for statutory and mandatory training refresher, dates of Depravation of Liberty Safeguards (DoLS)/Mental Capacity Assessment (MCA) training and MCA consent training. The spreadsheet showed all staff training was up to date. We saw a record identifying all staff members which indicated their training compliance status, when training was due to expire and whether they were booked onto a course to receive their update training. The target set was 95% and the service exceeded this target as 98% of staff had completed their mandatory training.
- The service had adopted the Health and Safety Executive guidance on moving and handling in an ambulance. It had applied, where applicable, the same guidance to patient transport vehicles. We saw evidence of this in three personal files of staff who had undertaken driver training and manual handling.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it**
- The service had a safeguarding policy. We reviewed the policy and saw that it was version controlled and within review date. The policy referred to the intercollegiate document, Safeguarding children and young people: roles and competencies for health care staff (2019). It also contained information on how to safeguard those in vulnerable circumstances; for example, those with learning difficulties or complex needs and children under 16 accessing services without requirement of parental consent.

Patient transport services (PTS)

- The service had a safeguarding and a deputy safeguarding lead in post. The medical director was the safeguarding lead. Both had completed safeguarding level four training. In addition, the head of care standards had trained to level four safeguarding.
- Patient transport service (PTS) staff were trained in safeguarding adults and children level two. They received safeguarding update training every three years and an annual refresher as part of their mandatory training. The average safeguarding training rate for staff was 98% across both sites.
- There were processes in place to support frontline staff to report a safeguarding concern. The service provided staff with a single phone number to use to contact the ERS control room located in Leeds to make a safeguarding referral.
- When a safeguarding referral was recorded on the system the regional manager and the head of care standards were alerted via email. This meant that they could assess the type of referral that had been reported and whether any immediate action was required.
- We reviewed the computer system and saw that there were drop down boxes which had to be completed as part of the safeguarding referral. If any were answered "no" the system automatically generated an action plan which the person allocated to investigate had to complete before the referral could be closed. We reviewed three safeguarding incidents which were recorded using the online system. Information included the nature of the incident and actions taken for example completing a safeguarding referral to the local authority. To raise awareness of staff, the outcome of each safeguarding incident was shared with them monthly.
- Staff we spoke with demonstrated a good understanding of safeguarding concerns. Staff knew how to make a safeguarding alert. As part of their training, they identified and dealt with concerning situations at the locations they attended, particularly homes and care homes.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- The service had an infection control policy, which addressed all relevant aspects of infection prevention and control including environmental cleaning and laundering of uniforms. Paper copies of this were displayed on the wall at the Eastleigh and Mitcham bases. We reviewed the document and saw that it was version controlled and within review date.
- Staff were aware of how to maintain cleanliness and to reduce the risk of the spread of infection. Staff explained how they would clean their vehicle if a patient was unwell and we noted spill kits were available in all vehicles we inspected to enable staff to safety deal with spillages of body fluids.
- We were told 12 weekly deep cleans took place and these were undertaken at the Mitcham location. The deep clean schedule was not available for us to review during our inspection to confirm that these deep cleans had been completed. However, staff did confirm these were undertaken. The completed schedules were sent to us after the inspection.
- The service had a total of seven vehicles: three in Mitcham, two in Eastleigh and two mental health vehicles. As part of our inspection, we looked at three vehicles in Mitcham and two vehicles in Eastleigh. These were all uncluttered and visibly clean. All the vehicles inspected contained hand sanitising gel and sterile wipes which were in date.
- They all had clinical waste bags and staff were aware of how to dispose of this waste. We noted the clinical waste bins at Mitcham and Eastleigh were locked.
- Short sleeve uniforms were provided by the service and designed to be washed at high temperatures. These uniform assisted staff to adhere to the arms bare below the elbow protocol. Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infections between patients and staff. We saw staff use them.
- Staff received infection prevention and control training as part of their annual mandatory training update. Data provided by the service showed that staff training compliance was 100%.
- We saw that monthly infection prevention control audits were completed by the head of care standards at both sub stations we inspected. Data showed that in the

most recent audit in February 2019, compliance was 100%. Compliance in January 2019 was 98%. The head of quality told us that where there was non-compliance, an action plan was completed and allocated to a manager for delivery.

- The ambulance station at Mitcham had a designated area for mops and cleaning products. The registered location at Eastleigh also had a designated area for mops and cleaning products. Mops were colour coded and mop checks were undertaken in line with their policy. We reviewed records which showed that the check had been completed consistently from 2 January 2019. Previous records had been archived.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- There were seven ambulances used for patient transport.
- All the ambulances we inspected had four seats with seat belts and space for a wheelchair. The vehicles were also fitted with a hydraulic ramp to help with patient access to the vehicles.
- All work was allocated and managed from the Eastleigh station with staff only visiting the Mitcham location to collect consumables or bring their vehicle for a deep clean. The vehicles were parked at the staff member's home overnight and when not in use and were checked before each shift. To ensure the security of the vehicle, each ambulance had an alarm system.
- The staff were responsible for checking their vehicle prior to starting their shift. We reviewed the checklists and saw that vehicle and equipment checks were carried out daily and the forms had been completed correctly.
- We saw details of road tax, fleet insurance and, where applicable, MOT testing for the vehicles.
- The service had 24-hour breakdown cover for the vehicles. During our inspection one of the ambulances had a puncture and we saw the problem was dealt with in a timely manner and the vehicle was back on the road. No patient had their journey cancelled or delayed as the other drivers covered the journeys.
- All staff we spoke with reported that faults on the ambulances were repaired quickly and managers were responsive to any concerns raised by staff about vehicles.
- Each vehicle carried a first aid kit, high visibility jacket, wheelchair, first aid box, vomit and urine bowls and blankets. Each vehicle had a resuscitation bag that included oxygen and masks both paediatric and adults for use in the event of an emergencies. All ambulances carried a defibrillator which had been serviced and staff were aware of how to use it. The service did not use radios. There was a personal digital assistant (PDA) in the vehicles for communication. A PDA is a small electronic device that is used for storing, and organising information. The vehicles could be tracked using the PDA.
- All vehicles carried oxygen and staff were trained to use. We noted all cylinders were in date. However, staff gave us various answers when asked how they would exchange their cylinder if it was out of date or empty. Staff were unclear on the process for exchanging cylinders. They were also unclear whether medical gasses were stored at Mitcham or Eastleigh. The inspectors visited Eastleigh and saw medical gasses were stored and managed safely at that location. The Mitcham base only stored consumables and no medical gases.
- Both stations had an area where staff could leave broken equipment. Staff placed a red label on the equipment to indicate that it was not in working order and could not be used. We observed that all equipment in this area was clearly labelled.
- Equipment servicing was provided by an external supplier. All the equipment we checked was within service date. We checked the equipment service schedule and saw that all equipment service checks were up to date.
- We checked 10 consumable items. All were within expiration date. We checked 10 pieces of clinical equipment. All were within the manufacturer's recommended expiry date. There was equipment available that was suitable for different patient groups including bariatric patients and children.
- All vehicles had a satellite navigation system and a vehicle tracker system so dispatch could identify the

location of the vehicles. The vehicles had a dash cam system that emailed a video clip of a vehicle incident to the driver's line manager allowing immediate action to be taken.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- There was a triage system in place so that only appropriate patients were accepted by the dispatch team. Staff we spoke with described assessing patient needs by reviewing information provided by the control room, seeking additional clinical advice if required, speaking with the patient, carer, and / or staff, and conducting their own clinical observations.
- There was evidence on the patient record forms reviewed during inspection, showing staff had assessed risk and provided patient transportation in a way that aimed to ensure safety. For example, if a risk was identified, crews requested the support of additional staff, obtained additional equipment, adapted the number of patients transported at one time, or made the decision not to convey the patient if the risk was too high.
- Managers and staff, we spoke with told us if a patient became ill while being transported crews would deal with the patient using their skills in accordance with their qualifications and training. If the patient was obviously seriously unwell an emergency NHS ambulance would be contacted to attend.
- The service had a specialised vehicle to transport bariatric patients (severely or morbidly obese). Staff told us that there was a specific risk assessment form that was completed when transporting a bariatric patient to keep patients and the staff transporting them safe.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service used an electronic system to generate the staff rota which involved allocating crews to available vehicles. A new shift pattern consisting of a seven-week rolling rota of 10-hour shifts had been implemented. A senior manager told us that this work pattern had been successfully established in other areas of the business.
- At the time of our inspection there were no road crew vacancies. If there were gaps in the rota, these were filled by offering additional shifts to existing staff. If a shift could not be covered, team leaders and senior managers, who had front line training PTS training stepped in. We looked at four rotas and found there were no unfilled shifts.
- The provider scheduled floating crews on duty each day to deal with unexpected demand or to support emergency cover due to illness or family emergency.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- Crews received job information via a PDA before conveying the patient. Staff told us that they received information about the patient's name, date of birth, and if they required any equipment.
- Transport bookings were made through a central control room based in Leeds. Staff recorded information provided on an electronic system. The system had required fields to be completed before the booking could be confirmed. This included information about the booking, to assess eligibility, patient's mobility and additional relevant information. Staff received this information on their tablet. Staff told us that the information provided was accurate since a new system had been introduced by the central control room. If the information provided about the patient was not accurate staff told us they would contact the control room to update the record with additional information. This would be used to decide whether to complete the transfer or not. Staff told us since this system had been introduced, delays were reduced.
- Staff said they would transfer patient paper notes in a sealed bag with the patient. They were aware they could not access these due to data protection. Records were not shared with other providers.

Patient transport services (PTS)

- Patient record forms (PRFs) were completed by staff for patients. We reviewed 10 PRFs and saw that they were completed appropriately and contained patient details, patient observation and pain assessments.
- The PRFs were audited monthly. We saw that the patient record audits had been completed every month by the head of care standards dating back to February 2018. We reviewed three audits completed in September 2018, November 2018 and January 2019. In each audit all PRFs completed during the month were reviewed. We saw that for each month no issues or concerns were identified.
- We saw that there was information displayed in staff areas providing guidance on methods of ensuring security of confidential information. For example, password protection and maintaining a clear desk.
- The provider used a computer based system for recording patient records. During inspection five records were checked and all had been completed correctly.
- Patient records were audited and were discussed at the monthly Governance and Patient Safety Committee (GaPS) meeting. This was a location based committee. The results of the last audit in January 2019 highlighted an overall compliance rate of 95% to the standard. The service had set a standard of 90% compliance.

Medicines

- **The service followed best practice when giving, recording and storing medicines.**
- At the time of the inspection, with the exception of oxygen, the provider did not store controlled drugs or any medicines including prescription only medicine (POM), pharmacy only (P) medicines and general sale lists (GSL) medicines.
- The service had a protocol in place to support oxygen administration. Staff followed the protocol on administering and recording and storing of oxygen.
- We inspected the records of three patients and found all had received oxygen based on the protocol.
- Medical gases were available at Eastleigh only. They were stored in cages in accordance with the British Compressed Gases Association Code of Practice 44: the storage of gas cylinders. Full and empty cylinders were kept separate and were clearly marked. Oxygen piping in ambulances we inspected, had been serviced and were in date. At Eastleigh staff were aware how to obtain replacement oxygen. Road staff at the Mitcham location were not aware on how to exchange their oxygen cylinders if it was out of date or empty. We raised it at inspection and followed it up formally with the service following our inspection. The service submitted evidence that they had informed all staff of the process for exchanging cylinders.

Are patient transport services effective?

Good

This was the first inspection of the service under our new methodology. We rated effective as **good.**

Evidence-based care and treatment

- **People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and technologies. This was monitored to ensure consistency of practice.**
- Staff had up to date guidance available to them on how to provide evidence based care and treatment. The following polices were reviewed and they all followed Joint Royal Ambulance Colleges Liaison Committee (JRCALC) guidance; safeguarding, oxygen administration, Control of Substances Hazardous to Health (COSHH) and end of life care. For example, senior staff told us staff followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines when administering oxygen. There was a local policy in place on how to administer, record and store oxygen. We inspected the records of three patients and found they all had received oxygen based on the protocol.
- We saw evidence managers discussed local polices and pathways which included the scope of practice for every clinical grade. Managers told us they were undertaking a review to align the clinical grades with standardised training.
- Staff valued the access they had to a specialised mental health trained member of staff if needed. A member of staff was always on call Monday to Friday 12 hours per day to provide advice and guidance.

Patient transport services (PTS)

Response times/patient outcomes

- **Information about people's care and treatment, and their outcomes, was routinely collected and monitored.**
- The regional manager told us the monthly Mission Performance Review meeting included key performance indicators (KPIs). KPIs were not separately audited but crews were time stamped on the running sheets to show when activities were completed.
- KPIs were recorded for every patient journey undertaken. These KPIs were reviewed by management. The provider had two key performance indicators (KPIs) from the main commissioning provider which were; 90% of patients were to be collected within a maximum of three-hour response time from time of booking to the patient being picked up on the ward and 98% of patients would travel no longer than 1 hour 30 minutes on transport for any given transfer.
- The KPI for patients to be collected within a maximum of three-hour response time from time of booking to the patient being picked up on the ward had a target of 98%. The data for December showed 98% achieved this KPI, January 99% achieved it and February 99% achieved it.
- The KPI for patients would travel no longer than 1 hour 30 minutes on transport for any given transfer from the main commissioning provider had a target of 98%. The data for December 2018 showed 99% achieved this KPI, January 2019 99% achieved it, and February 2019 98% achieved it.
- Managers told us that due to the limited KPI information collected no corporate and wider benchmarking was carried out, however, we saw evidence the data was discussed at local and regional governance meetings.

Competent staff

- **The service made sure staff were competent for their roles.** All staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was provided to meet these needs. Managers regularly appraised staff's work performance. Managers held regular supervision meetings with staff to provide support and monitor the effectiveness or the service.
- All staff that we spoke with reported they had received a comprehensive induction at the start of their employment which had lasted at least four to five days, depending on the nature of their role and start date.
- Staff reported they received annual training which included assessments of knowledge and practical competence. They told us training updates would be automatically scheduled and notified two to three weeks in advance.
- We reviewed five staff training files. These all demonstrated that staff had undertaken comprehensive inductions and mandatory and statutory training. For example, induction training included basic life support, health and safety, fire safety, infection control, and manual handling.
- Managers also told us they wanted to ensure all staff knew and worked to the company values before commencing appraisals.
- The provider had a training and continuing professional development (CPD) prospectus for staff to refer to. This included; the training team, mandatory e-learning, annual core update day, mental health uplift course, non-clinical staff courses, education and training staff courses, management training courses, commercial training, training administration process, training hub equipment list and feedback.
- The provider had a performance development and review plan. A blank plan was reviewed. It contained key performance areas to consider.
- The performance development and review plan was supported by a personal development review plan with individual SMART (specific, measurable, achievable, relevant, time-bound) objectives, achieving personal qualities, reflections, future objectives and development and a staff rating was reviewed before signing off by the individual and their manager.
- In performance quality the performance areas included; job knowledge, quality of work, adaptability, team work, dependability and attitude. In safety the areas considered included; attendance/punctuality, customer

focussed, care of equipment, initiative/innovation, continuous improvement and technical skills. Staff identified personal strengths and development opportunities and they devised a plan with their line manager.

- The provider had a personal training and development policy. There were 23 areas covered including training plans, workplace activity observations records and training compliance audits/targets. The document had an owner, who the author was, version control, when the document became active and when it was due for review. During inspection the policy document was reviewed and found to contain extensive information for staff to refer to in relation to their training and development needs.
- We saw evidence the provider recorded the driving licence details of the staff on a software package designed to meet the needs of the organisation. The system recorded staff names, date of birth, driving licence details, date licence expired, date when the licence was checked and the date when the next check needed to be carried out. The system set up an automatic alert to inform managers when the checks were due.
- During inspection we saw evidence of a computer based system linked to front facing cameras in the provider's ambulances. The cameras were activated when the vehicle exceeded a certain speed. The camera footage was stored on a computer hard drive. The system also recorded harsh breaking and over revving of the engine. This information was used by the operations managers to identify any drivers whose driving standards were below what was expected.
- There were no systems to make sure local healthcare providers were informed in cases where a staff member was suspended from duty. Such a system would prevent local health care providers to subsequently employ anyone who had been suspended. The absence of a system could result in a suspended member of staff being employed locally by another ambulance service provider.
- Managers we spoke with told us there was a process set up for appraising staff and we saw evidence of this. The appraisal process had been rolled out to senior managers. They had all completed the accompanying training. The senior managers had begun the process of training team leaders. In 2019, the focus was to have all team leaders to appraise front line staff. At the time of inspection in March 2019, 59% of front line staff had been appraised and they were on target to meet this by December 2019. Managers told us this was because the company priority had been to ensure all staff had been on an induction course and had received statutory and mandatory training. Staff appraisals would follow that.
- Two of six staff we spoke with told us that they had appraisals where their performance was reviewed. Staff told us that they could approach managers if there was something they wished to discuss in relation to their role.

Multidisciplinary working

- **Staff in different roles worked together as a team to benefit patients'.**
- Staff supported each other to make sure patients had no gaps in their care. Team leaders across the two stations held a morning call to discuss the needs of the day and coordinate the daily workload across the different locations.
- There was a member of staff located at two NHS trusts. These staff worked with the staff at the trust to coordinate discharges and ensure that patients were waiting in the correct areas to be collected by the ambulance crews.
- There was evidence that coordination with other providers was achieved through the booking in system which ensured pre-alerting and capacity issues were highlighted to PTS crews.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** The service followed the policy and procedures that was in place when a patient could not give consent.
- The provider had a Deprivation of Liberty Safeguards (DoLS) policy which contained related documents and

legal references, an introduction, policy statements, responsibilities, levels of restriction and restraint, ERS medical responsibilities and death of a person subject to a DoLS order.

- During inspection the policy document was reviewed and found to contain extensive information for staff to refer to in relation to dealing with patients who could be subject to a DoLS order.
- The provider training data had evidence that all PTS staff were all up to date in relation to training in the Mental Capacity Act (MCA) including consent.
- Staff we spoke with confirmed they had received training in consent and Mental Capacity Act. Staff files showed that staff had received training on consent, Mental Capacity Act, and Deprivation of Liberty Safeguards.
- Staff reported they would seek consent from patients, if they had capacity, before conveying them and if a patient did not consent they would not convey them. If the patient lacked capacity to consent or staff were unsure of if they had capacity, staff would obtain an assessment from staff in the hospital. Only as a last resort, would they make a best interests decision and record this. Best interest decisions were undertaken with the on call operational manager.
- They told us that on such occasions ERS staff would ask staff working with the patient to speak with them and further explain the rationale for transport in the hope the patient would consent. Staff said that such decisions would be documented on the running sheet. If consent was not obtained the ERS control would be contacted and advice sought. Staff gave us examples of how they executed the advice given to them by the control centre.
- Staff told us they did not complete a specific form detailing whether the patient had consented and whether staff had completed a Mental Capacity Act assessment. They could explain the assessment process from the training they had received.

Are patient transport services caring?

Good

This was the first inspection of the service under our new methodology. We rated caring as **good.**

Compassionate care

- **Staff cared for patients with compassion.** We reviewed three cards sent by family members who confirmed staff treated patients with compassion and kindness. Patients confirmed they were treated with compassion and kindness.
- Staff we spoke with told us about how they maintained patient dignity during long distance transfers. The crews ensured at least one female member of crew was present when transporting a female patient. If the crew were male and female they would switch roles; for example, if a patient needed to use the toilet so that patient's dignity was preserved.
- Staff told us they would ensure a patient was comfortable, warm and would ask what they could do to make the patient more comfortable; for example, adjusting the patient's head position if transported on a stretcher. Staff told us they would offer patients drinks and if the hospital had sent the patient with a packed lunch they assisted to them, if required, eat and drink at a time which suited them.
- We saw a letter of thanks from staff at a local nursing home in relation to a delay in preparing the room for a patient who had been discharged from the hospital. The crew remained with the patient in the day room to ensure their comfort.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.** Staff we spoke with described providing emotional support by listening to patients and responding in a calm and empathic manner. Staff had received customer care training to assist with positive communication with patients.

Patient transport services (PTS)

- Staff told us sometimes older patients would get very nervous so they offered their hand to them. Staff told us this reassured patient. One member of staff explained how they 'sensed' what was needed. Patients told us staff provided them with reassurance.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment**. Staff told us they would explain to the patient they were going home and keep patients informed about the journey. One patient told us how on a previous long journey, they were told how long the journey would take and were asked they should let staff know when they want to have a comfort break.
- Staff explained how they would phone a relative who was waiting for the arrival of the patient to inform them of their progress.

Are patient transport services responsive to people's needs?

Good

This was the first inspection of the service under our new methodology. We rated effective as **good.**

Service planning and delivery to meet the needs of local people

- **Services were planned and delivered to meet local needs.**
- The service was planned and managed in line with the commissioning agreement in place with the clinical commissioning group (CCG). Managers told us the planning of the service was done through the contract agreements between themselves and commissioners. The service had regular meetings with commissioners to review progress against the contract and to raise and address any issues or concerns. Services were delivered to meet local needs. The service had appointed a hospital liaison assistant based at two NHS trusts to support the safe discharge of patients and to avoid delays for patients leaving the hospital. There had been instances where patient pick-ups were booked just before or after lunch. Once staff arrived onto the ward, they found either the food had just arrived or the patient had just finished their dinner and had to be accommodated with time to use the facilities. In both situations, staff had to wait for them. Staff shared this feedback with the operations manager. As a result, no pick-ups were scheduled one hour before or after dinner.
- During inspection we saw examples of how additional resources as contingency were set up to meet unexpected demand.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Crews were made aware of patients with complex needs through the booking in process. We saw examples of information being shared about patients with learning disabilities, dementia, older people with complex needs and those requiring access to translation.
- There was evidence that all PTS staff had received training in dementia, equality diversity, bariatric patients and paediatric care.
- All staff we spoke could described the steps they would take to support patients with visual or hearing difficulties. They said they would use writing, gesture or verbal explanation.
- Staff had undertaken training in equality and diversity as part of the induction. Staff described being able to access interpreters if required. We saw that there was information about how to request an interpreter displayed in staff areas for ease of access. Staff reported that family members might accompany patients and interpret for them additionally some patients used interpreting devices on their own mobile phones.
- All PTS ambulances carried visual communication aids. Staff told us this was important for patients who were unable to verbally communicate. They gave examples on how they had used the aids.

Access and flow

- People could access the service when they needed it. Managers told us the resourcing levels were agreed with the providers requesting PTS through a service level agreement.

- Due to the nature of the contractual arrangements the provider did not have control over the number of bookings.
- There was a service level agreement with each provider.
- The provider had the ability to track where the PTS ambulances were. We saw evidence of crew members that had provided information and updates about their location and availability to control room staff.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- During the inspection we reviewed the provider's complaints policy. The policy contained related documents and legal references, an introduction, policy statements, responsibilities, definitions, complaints management with key steps, complaint referenced to an incident with key steps, comment and / or concern and compliments. The policy document had a flow chart which explained how a complaint would be investigated.
- The document had an owner, a review date and a version control number.
- Managers told us the procedure for making complaints was through a link on the ERS website or through a phone call to the ERS 24-hour HQ control room in Leeds. The information would be recorded on a computer based business support system overseen by the patient experience coordinator. The system generated an email to the operations manager of the site where the complaint originated from. They had five days to investigate it. The complaint was then routed to the technical lead who had 14 days to complete the investigation before it went back to the patient experience coordinator for quality assurance. The patient experience coordinator drafted a response to the complainant.
- If the complainant was unhappy and wished to appeal the outcome of the investigation this was done through the head of care.
- During the inspection the computer system for recording and investigating complaints was reviewed. The complaints were colour coded to identify at what stage the investigation was at linked to the KPIs. Any completed investigations were archived on the computer system. We reviewed three responses and they were all recorded and completed in time.
- We saw minutes from the monthly Governance and Patient Safety Committee meeting which showed that complaints were an agenda item and had been discussed. This was a location based committee. There was evidence each incident had a reference, event type, region, location, event date, owner, work flow status and submission date. The minutes showed there had been three complaints made in November 2018 three made in December 2018 and one made in January 2019.
- Any wider learning in relation to complaints was shared with staff through a computer system which they could all access. Any individual or crew learning was delivered to staff by the Operations Managers or Regional Manager.
- Staff we spoke with told us if a patient asked to make a complaint they would provide them with the service telephone number.
- The provider had a Whistle blowing (Raising concerns at work) Freedom to speak up policy. The document had an owner, a review date and a version control number. There were 11 areas of information that staff could refer to for them to raise issues at work and inform them of the investigation process.
- To support the policy the provider had a raising a concern(s) report form. The report form had various areas for the person raising the concern to fill in. The information could be anonymous. Once completed the form was sent to the regional manager to investigate.

Are patient transport services well-led?

Outstanding ☆

This was the first inspection of the service under our new methodology. We rated well-led as **outstanding.**

Leadership of service

- **Managers at all levels in the organisation had the right skills and abilities to run a service providing high-quality sustainable care.**

- The corporate leadership consisted of the managing director, group finance director, head of care, head of HR and training, an executive director and a medical director and are based at Leeds. The managing director visited this location every 14 days,
- ERS Medical South had clearly defined managerial and supervisory roles. The regional manager had overall responsibility for Eastleigh and Mitcham. They had operational responsibility for the operations managers. The operations managers were responsible for supervising and managing the team leaders. The team leaders were responsible for the supervision of the lead drivers and road crews. We saw that there was information about the organisational structure and senior management team displayed in staff areas.
- The regional manager had regional responsibility for HR administration and financial administration.
- During inspection we saw evidence that the corporate leadership team and regional leaders had enhanced their visibility by attending regular staff meetings and visiting the two stations. They shared their vision and their values. They also shared their new performance management framework highlighting to staff "what they were doing, we were also doing."
- During the inspection we reviewed the provider's Company Directors Fit and Proper Persons policy which contained references to related documents and legal references, an introduction, policy statements, responsibilities, definitions, requirements of the Health Social Care Act Regulations 2008 Fit and Proper Person, unfit person test, and management and monitoring. We saw three examples of how this was applied and reviewed.
- Managers told us the purpose of the policy was to define a single process in which the provider would manage and meet the requirements of CQC regulated activity, specifically under the Health and Social Care Act 2008 (regulated activities) Regulations 2014 Regulation 5 Fit and Proper Persons: Directors. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- The directors were closely involved with the local management structure at ERS South. Staff told us that the directors were visible and had attended staff meetings informing them about various aspects of the business including finance. Staff felt the directors were open, transparent and accessible. Staff reported that local managers were approachable and would listen and respond to feedback about the organisation.
- There was a commitment to support and develop staff. In 2017, all directors attended a leadership development programme. In 2018, the programme was rolled out to managers and team leaders. There were plans in place to have all front-line staff attend the programme over 2019-2020.

Vision and strategy for this service

- **The strategy and supporting objectives and plans were stretching, challenging and innovative, whilst remaining achievable**. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to a system wide collaboration and leadership.
- The provider`s vision is to "be recognised as the leading provider of health care transport services in the UK by 2022."The local leadership team identified six objectives to achieve this vision. These were as follows:

1. Improve on performance standards and reduce variation.
2. Deliver excellence in leadership and development.
3. Continually review and improve our quality and clinical effectiveness.
4. Improve satisfaction and experience for all stakeholders.
5. Develop and promote a world-class training model for pre-hospital care.
6. Increase recruitment and retention.

- The providers vision was underpinned by seven values which were; integrity, compassion, respect, professionalism, patient focus, innovation and working in partnership. The senior leadership team (SLT) trained and equipped front line staff and kept them engaged and highly motivated. The SLT spent time communicating the message of values and purpose throughout the organisation.
- During inspection we saw that the provider's vision, values and business vision were displayed on posters in

various prominent places around each of the stations. At Eastleigh there was a screen in the foyer which played a presentation of the provider's vision, values and business vision on a continuous loop. This could be watched by staff and visitors.

- Staff we spoke with told us that the service vision, objective and values and five-year plan had been communicated at a recent staff meeting. They said minutes from the meeting were available to all staff, so those not in attendance were kept informed. We saw evidence of this during the inspection.
- We saw evidence the provider's vision and values were included in the appraisal system and in the monthly National Governance and Performance Review.
- The location had identified key pressures, risks, goals and plans for PTS including how they increased their market share and achieved economy of scale. For example, they recognised the NHS cost pressure would also impact them. They ensured they invested in business management systems to help run an efficient and cost-effective healthcare transport operations.
- Staff that work away from main bases or who were lone workers engaged with strategy, vision and values using social media, conference calls, and access to HR systems remotely.

Governance, risk management and quality measurement

- The organisation had the processes to manage current and future performance. Performance and risk issues were escalated to the appropriate committee and the board through clear structures and processes.
- All clinical incidents were reviewed by the medical director and the local quality assurance manager. For example, the SMT received an action plan for all incidents. The progress on the action plan developed depended on the recording of the incident: Progress on all incidents colour coded as red was weekly. Incidents recorded as amber were reported every two weeks and lower amber was monthly. The medical director ensured greater scrutiny of the implementation process.
- Every day, there was daily control call amongst operations managers. There were weekly operational meetings where the team leaders reported to the operations manager. Once a month, the operation managers reported to the directors at the monthly regional governance and performance reviews. There were also monthly business governance and performance reviews where regional directors reported to the executive directors. There was also a monthly executive committee meeting that reviewed the current business situation. We saw examples of how issues were escalated upwards and how decisions were cascaded downwards.
- We saw evidence the Governance and Performance Review Committee (GaPR) met monthly on a regional basis. The scope of the meeting was all patient care, quality and clinical issues arising from and related to CQC regulated activities within the registered locations and pertaining to ERS Medical, its subsidiary companies and business activities in the UK.
- The core GaPR committee members for each GaPR location were the registered manager; health and safety advisor / manager; care quality manager; site operations managers within the location region; regional clinical trainer and other senior managers, heads of department and business unit managers who could be invited attend on an as required basis. The minutes of these meetings were always reviewed by the medical director. They would attend these meetings at least three times a year as it gave them assurance on how governance was being managed at a local level.
- We saw evidence the provider held monthly board meetings. The minutes for the meetings held in December 2018, January 2019 and February 2019 were reviewed. The meetings had a set agenda with recorded minutes and actions with owners and completion dates. This fed into the national Governance and Performance Review (GaPR) meeting.
- In March 2019, the corporate leadership undertook a review of the key areas of performance where improvements could be made. The information was shared with staff via a power point presentation.
- The provider held local monthly governance meetings. The minutes for the meetings held in December 2018, January 2019 and February 2019 were reviewed. The meetings had a set agenda with recorded minutes and actions with owners and completion dates. The minutes

of these meetings were reviewed by the medical director. During the local unannounced visits, they undertook, the medical director sought assurances from front line staff on the actions undertaken.

- During inspection there was evidence of weekly team leader meetings and monthly staff meetings. If anyone could not attend the minutes were copied and held in folders in each station for staff to read.
- Managers told us that the governance meetings were audio recorded and the recordings were stored on a hard drive along with the minutes of the meeting. The recordings were made and kept ensuring transparency and so there could be no dispute over what had been discussed.
- We reviewed staff files for all employees who had been recruited since registration. We saw evidence of identification, references, and job applications. Managers told us that interview documentation was recorded and held at ERS headquarters. Managers told us that staff were asked about health conditions that could affect their performance or restrict which duties they could perform as part of the interview process. They told us that staff did not undertake a separate occupational health questionnaire or interview.
- We reviewed information for five staff and this showed that all staff had Disclosure and Barring Services checks within the past three years. We inspected the records of five members of staff and they all had appropriate checks done.
- We reviewed a sample of records for five operational employees and found all had been offered the option to receive hepatitis B immunisations free of charge and their decision recorded whether they took up the offer.
- We reviewed information for five PTS staff employees and saw that driving licence checks had been completed within 12 months of the inspection. Managers told us checks were carried out yearly and that when an update was due a reminder was sent to staff and results were checked by managers.
- Driving licence checks provided information about driving penalties and points and identified whether drivers were low, medium or high risk. Decisions about whether staff could drive or not were based on what the contract with other providers specified, the driver risk assessment, and the nature of any driving offence.
- During inspection we saw evidence of a risk register with five risks identified. Each had a date when it was added to the register, with a risk rating, a review date and who the owner was. There was evidence the risk register had been discussed at the Governance and Performance Review (GaPR) meetings. Individual risk owners were responsible for devising actions to mitigate the risk. The managing director reviewed the risk register and undertook assurances for the follow-up.
- Managers told us they received alerts from external organisations relating to medical devices and health and safety. We saw an example of a safety alert relating to wheelchairs. This was displayed in the Mitcham base. The medical director reviewed these alerts and through their local visits sought assurances that action had been taken.
- There was good oversight of staff training and competencies. The service had an online HR system that tracked staff training compliance. At the time of inspection 98% of staff had completed mandatory training and 100% of staff were up to date with their annual update training. There was a monthly audit programme in place. We saw audit compliance were always above the set standard.

Culture within the service

- Leaders had an inspiring shared purpose, and they strove to deliver and motivate staff to succeed. Leaders believed that success was driven by leaders at the front line. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- The service had a transparent culture that was customer focussed. Senior leadership team (SLT) were honest and open with facts and focussed on strategies that had been agreed. As a result, the middle management team became more positive and confident and developed a sense of ownership. This resulted in front line staff wanting to be part of the brand.
- All managerial and operational staff we spoke with described the culture at both sites as positive. All the

staff we spoke with said since the buyout of the business, the culture had changed for the better. They were kept informed regularly of significant issues in the company and the leaders were open and visible.

- We saw evidence that change in the organisation was managed through staff consultation, keeping the staff informed through forums and by leaders delivering key messages face-to-face with staff.
- Delivery of organisational change was done by appointing action owners with timescales for completion and holding them to account by the managing director through the governance meetings.

Information management

- **There was a holistic understanding of performance. Performance information was used to hold management and staff to account.**
- The service focussed on technology for a dual purpose: improvement and assurance. The medical director told us the service saw it as two sides of the same coin. As a result, the central call centre in Leeds was made the central hub for all locations. They introduced new technology that worked for people who worked on the front line. For example, hand held devices for recording of incidents, safeguarding concerns and others. By this subtle shift, the SLT found front line staff embracing IT and the change it brought.
- There were clear and robust service performance measures. These were reported and monitored. The service ensured accuracy of the KPI data through regular monitoring and testing of the system. The tracking system resulted in an information system which enabled effective performance management.
- The senior leadership team (SLT) had access to reliable, timely and relevant information. Timely access to such information provided the SLT with the necessary assurance. For example, we saw how by clicking a few icons, the SLT could query a wide range of information such as percentage of staff who had an appraisal done to the last time a vehicle was deep cleaned and the gaps identified in that process.

Public and staff engagement

- **The service proactively engaged and involved all staff and ensured that the voices of all staff were heard and acted on to shape services and culture.**
- The regional manager told us ERS staff attended contract review meetings to discuss with commissioners what was going well and not so well. ERS conducted on board patient surveys, however, the response rate was approximately 2%. As a result, they consulted patients and their relatives to identify ways to increase the response rate. The service recently (February 2019) launched a new on-line survey.
- The service initiated a top down leadership development programme and this was started with the senior leaders in 2017 followed by middle managers and was now being given for all front-line staff to access across other locations.
- Managers we spoke with told us staff engagement was more open and transparent since the ERS 'takeover'. The provider mission performance had been shared with operational teams on site. The head of performance and the ERS managing director had done roadshows in each region in 2018 for team leaders to deliver the provider's vision and mission statement.
- The service undertook staff survey across the ERS Transition. There was evidence of other engagement with staff through team briefings for team leaders and quarterly staff meetings, the minutes of which were reviewed during inspection. For example, front-line staff were encouraged to share ideas that would improve service. Two such ideas from staff included the change to the service by avoiding any pick-ups around lunch time and the appointment of local liaison. Staff told us they felt empowered to make suggestions and positively impact the service.
- Managers told us the managing director had given directions to managers to be very visible to staff. Managers told us the provider's values were the result of engagement with staff and linked to their PDR. For example, a target was set that by the end of 2018, all senior staff and by the end of 2019, all front-line staff had to be appraised. The service met the target for all senior staff. At the end of March 2019, we found 59% of front line staff had been appraised.

- The managing director told us the provider had started publishing a quarterly newsletter for staff called "In Touch." The most recent issue (Spring 2019) was reviewed during inspection and it contained information about performance and plans.
- There was evidence that patient feedback was discussed at the monthly regional governance meetings.
- Staff told us that they received prizes as recognition for times when they went 'above and beyond' their role.
- We saw information displayed on a staff notice board about an employee assistance programme which staff could access for emotional support.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- **The service fully embedded a systematic approach to improvement and made patient experience pivotal for staff to learn and enhance the performance of the organisation.**
- The provider had invested in business management systems to support various parts of their business. Managers told us they had been involved in the design to ensure the systems were appropriate for the services provided.
- We saw evidence the systems produced accurate real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making.
- Managers we spoke with told us that the business was sustainable because the provider had several contracts with NHS trusts.

Outstanding practice and areas for improvement

Outstanding practice

- The senior leadership team had created a culture where information was used to drive improvement and gain assurance resulting in front line staff engaging in the change process. For example, staff told us how their ideas had been implemented to improve the quality of service.
- The service was rolling out a leadership development programme to all its front-line staff. It had started this programme for all senior and operational managers.
- The service had linked the hospital bed flow software with ERS dispatch. Good hospital bed flow allows for an efficient system to arrange the transportation of the patient to their residence. This software had created a seamless link between the hospital and the service. It also allowed patients to track their transport through a special "Patient View" on an accessible portal.
- All vehicles had a forward-facing vehicle camera that recorded continuously. The system captured 40 seconds of footage when triggered by an incident and this was sent by email automatically to the driver's line manager within minutes. It allowed for immediate investigations of any serious incident.

Areas for improvement

Action the hospital SHOULD take to improve

- The service should have a system in place to ensure local healthcare providers were informed in cases where a staff member was suspended from duty.