

ERS Transition Limited

ERS Medical West Midlands

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?

Requires Improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

We carried out an inspection of ERS Medical West Midlands using our comprehensive methodology on the 6 December 2022. Care Quality Commission had not previously inspected the service. We rated it as good overall because it was good in safe, caring, responsive and well led.

Our rating of this location was good. We rated it as good because:


- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and assessed patients' food and drink requirements. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and we heard examples of staff being promoted. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.

However:

- The service did not always meet agreed response times. However, the service had implemented an improvement plan and some key performance indicators had improved.
- Staff did not always feel respected, supported and valued by leaders. There appeared to be some disconnect between the operational road crew and the control room staff.
- There were no specific team meetings for all staff and leaders had paused staff ambassador meetings due to ambassadors leaving. However, the registered manager hoped these meetings would resume shortly as leaders had recruited new ambassadors.
- Not all staff had received a yearly performance development plan, although managers were working towards this and had made some good progress.
- Responsibilities such as who was responsible for discharging duty of candour was not explicit between third party providers.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	We rated it as good overall. See overall summary above for details.

Summary of findings

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Summary of this inspection

Background to ERS Medical West Midlands

ERS Medical West Midlands is operated by ERS Transition Limited, it is an independent ambulance service providing non-emergency patient transport services (NEPTS) and a high dependency patient transport service. The service transported both adults and children. The service had a Care Quality Commission (CQC) registered manager who had been in post since July 2022.

The main unit, including the control room operated in Stoke on Trent. The service also operates additional ambulance bases at locations in Stafford, Burntwood and Burton in Staffordshire.

The service is registered to provide the following regulated activities:

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

How we carried out this inspection

During the inspection we visited the Stoke and Stafford locations. We also visited a hospital site where patients were being transported. We spoke with 21 staff including managers, relationship managers, team leaders, fleet assistants, control room staff and operational road crew. We spoke with 6 patients and 1 relative. We observed 2 patient journeys and reviewed 8 patient records.

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

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

- The service must ensure that they continue to improve patient waiting times for transport, including transport times for renal patients and that consideration is given to best practice guidance (Regulation 17).

Action the service **SHOULD** take to improve:

- The service should ensure leaders are more visible to operational road crew staff and consider how they can ensure engagement with staff is effective.
- The service should ensure there are appropriate staff forums for all staff to be able to contribute, participate and share any relevant information.
- The service should ensure all staff are up to date with their yearly performance development plan.
- The service should consider what actions are needed to address any disconnect between the operational road crew and control room staff.

Summary of this inspection

- The service should consider where responsibilities in relation to discharging duty of candour are recorded and agreed with third party providers both for oversight of services and to assess, monitor and improve the quality and safety of the services they are providing.






Our findings

Overview of ratings

Our ratings for this location are:

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

Patient transport services

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

Are Patient transport services safe?

Good 

This was the first inspection of the service. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff.

The training year ran from April 2022 to March 2023, arrangements were in place for those staff who were not up to date to complete the training by March 2023.

Staff received mandatory training. Staff at ERS Medical West Midlands followed the statutory and mandatory training programme based on the UK core skills training framework. The programme included the following modules: -

- Conflict Resolution
- Data Security Awareness
- Equality, Diversity and Human Rights
- Fire Safety
- Health, Safety & Welfare
- Infection Prevention and Control
- Moving and Handling
- Preventing Radicalisation (Prevent)
- Resuscitation
- Safeguarding Children and Adults

The programme was classroom based and covered a full day of annual updates.

Training requirements were ambulance care assistants completed basic life support, emergency care assistants completed immediate life support (ILS) and paramedics completed advanced life support (ALS).

Patient transport services

Leaders told us when they took over the current contract, paramedics had not been trained with the correct continuing professional development (CPD) and a training programme had been implemented to support them. At the time of the inspection leaders told us all paramedics had received their ILS training and would be receiving their ALS within the next training year.

Leaders provided us with mandatory training figures broken down into clinical and handling staff. This showed 68% of clinical and handling staff had completed the required mandatory training (159 out of 235); ERS Medical West Midlands target rate was 100%. The training year at ERS ran from 1 April 2022 until 31 March 2023. Leaders told us how 100% of staff had received statutory/mandatory training in the last calendar year. Leaders provided us with planned training schedules for the remaining months from January to March 2023.

We reviewed the annual update slides and found they contained information for staff on learning disability and autism. New starters and office staff also completed an NHS programme Oliver McGowan mandatory training on learning disability and autism e-learning.

The annual update training slides did not contain any information specific to dementia; however, leaders told us this was covered within the care certificate awareness of mental health, dementia and learning disability. Following the inspection, leaders showed us they had since updated their training slides to include information on dementia and a dementia awareness short film.

The mandatory training was comprehensive and met the needs of patients and staff. Staff felt the training they received met their needs and was good. Training was via face to face and online.

Managers monitored mandatory training and alerted staff when they needed to update their training. The human resource (HR) staff monitored staff training compliance levels and were able to share this information as required. Leaders discussed mandatory training levels at operational governance meetings named mission performance reviews.

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.

Staff received training specific for their role on how to recognise and report abuse. ERS Medical West Midlands requirements were that office staff received level 1 adult and child safeguarding training, road staff level 2 and that safeguarding training was included in the mandatory training programme. The registered manager was trained to level 3 in safeguarding.

Level 3 safeguarding children and adults training was provided via the e-learning NHS portal for all paramedics, and was classroom delivered to all business's senior operations managers. Eight paramedics out of 20 had not yet evidenced to ERS Medical West Midlands they had completed their level 3 safeguarding training; however, 2 of these were leaving the business and 1 was on long term sick leave. Leaders told us they had contacted all paramedics and given them until early January 2023 to complete this.

Level 4 children and adults safeguarding training was provided to the ERS Transition Limited safeguarding team of which there were 5 staff in total. We reviewed the annual update slides for staff and noted safeguarding was included, including how staff should report any safeguarding concerns. The name of the safeguarding lead was displayed in the main entrance of the building.

Patient transport services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff understood what to do if they had a safeguarding concern and were able to give an example of when they had safeguarded a patient. There was a specific telephone number staff could call to raise safeguarding concerns. The contact numbers for reporting safeguarding concerns were displayed in staff areas.

We reviewed the quality and governance report dated October 2022 and noted there was a total of 6 safeguarding referrals made by staff in the month of October 2022. The report shared a description, location, reason for the referrals and a category; safeguarding trends were also documented in a chart.

A safeguarding adult at risk and children's policy was in place. The policy was in date and contained links to safeguarding legislation and guidance; it also described types of abuse and identified individual responsibilities. We reviewed the providers last 3 patient safety committee meeting minutes and noted leaders discussed safeguarding incidents at locations.

Leaders ensured staff had up to date disclosure and barring service (DBS) checks. Leaders kept a record of when staff DBS checks and identification badges expired. When staff had not yet completed a DBS check, a DBS risk assessment was completed and control measures were put into place, such as not working alone. This was then signed by the chief operating officer and the director of HR and training with a clear date for review.

We reviewed the due diligence records for the taxi service and noted staff driving the taxis were trained to level 1 in safeguarding and had enhanced DBS checks. It also noted the local authority inducted all staff.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were clean, tidy and well maintained. We looked at 7 vehicles and found them to be visibly clean. Contractors came into clean areas, such as the control room Monday to Friday.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed the vehicle deep clean reports of 5 vehicles and saw these were comprehensive and contained before and after swabbing results.

Leaders completed infection control audits. We reviewed the most recent audit from December 2022 and found there was a 94% compliance rate. Leaders had identified actions as a result; these included asking the on-site cleaner to keep housekeeping forms and ensuring staff refilled hand sanitisers.

There was an infection prevention and control policy in place, the policy was version controlled and in date. The policy contained links to external guidance and contained information for staff on the spread of infection.

The service had an infection control lead staff could contact for infection control matters. Staff were responsible for the laundering of their own uniforms at a high temperature. Staff told us how they needed to record on their personal digital assistants if the vehicle was clean.

Patient transport services

Staff followed infection control principles including the use of personal protective equipment (PPE). We accompanied the ambulance crew on 2 patient journeys and noted staff always wore the correct PPE. There was sufficient stock of PPE at the base and on vehicles.

There was enough hand gel available on vehicles and in the main reception area of the base. An electronic screen was on display in the reception area which displayed updated information for staff and visitors, such as COVID-19 guidance. We reviewed the staff annual update slides and saw trainers covered infection control. The road crew's new starter induction programme and annual statutory and mandatory training also included information on Infection prevention control.

Staff cleaned equipment after patient contact. Staff cleaned vehicles between patients. The location had its own facilities for cleaning the outside of vehicles. We observed an ambulance fleet assistant cleaning vehicles to a high standard.

There were 5 levels of cleaning in relation to vehicles which included a pre shift check, after patient clean and an enhanced clean. The service also arranged for the regular deep cleaning of vehicles from an external contractor.

Environment and equipment

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

The design of the environment followed national guidance. The Stoke location was based on an industrial unit providing control room facilities for the co-ordination of ambulance resources and an ambulance base; there were also 3 additional ambulance bases. The locations did not have patient access as staff provided all patient care remotely during transfers. The garage areas were large, in good repair and very suitable. There were adequate facilities for both clinical waste and sharps and used pharmacy waste; this was segregated and secure. There was a policy in place for infection prevention control, environment management.

Staff carried out daily safety checks of specialist equipment. Leaders provided us with a service report completed by an engineering company. The reports showed if equipment had passed or failed, what tests were carried out, and if there were any recommendations. The equipment checked included wheelchairs, carry chairs, fire extinguishers, transfer boards, scoops and ventilators. Staff ensured that they kept stores locked.

Staff took vehicles to an external company for tyre changes and kept a record of this. Staff took faulty equipment was out of service and clearly labelled it to show why it needed repair. An external company completed any repairs.

Leaders ensured vehicle information was recorded on an electronic system. The system contained details such as when the MOT, road tax and service was due and how many miles the vehicle had completed. All vehicles were up to date with their service, MOT and road tax. Service check sheets were available to view on the day of the inspection.

Leaders completed a fleet compliance audit. The audit looked at areas such as if the vehicle pack contained a valid insurance certificate, if ramps and sidesteps were in good working order and if staff secured vehicle keys when not in use. The most recent audit results for September 2022 showed a 100% compliance rate.

Leaders provided evidence of vehicle health checks. Checks were colour coded and demonstrated staff completed vehicle checks such as checks on doors, tyres, latches and straps, driving control and hazard warning lamps.

Patient transport services

The service had enough suitable equipment to help them to safely care for patients. We looked at 7 vehicles, including 2 high dependency vehicles and found there was enough suitable equipment available. Child car seats were available if required.

Defibrillators were available, we reviewed the contents within 3 bags kept in the medicines room and found 2 paediatric electrodes were out of date in April 2022. We raised this at the time, and this was resolved immediately.

Leaders told us how certain vehicles had satellite navigation systems in place. However, in other vehicles staff could collect one from the base or choose to use their own.

Staff disposed of clinical waste safely. Arrangements were in place for the appropriate disposal of waste. An external company collected this on a weekly basis, there was sufficient clinical waste containers available at the base.

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 knew how to respond promptly to any sudden deterioration in a patient's health. Staff told us they would telephone 999 if there was a sudden deterioration in a patient's health. The service employed paramedics for high dependency patients requiring transfer, these patients had their observations monitored and other relevant information taken and recorded on a clinical report form.

We reviewed the slides from the annual update course provided to staff and noted it contained information on the deteriorating patient. There was a policy in place for patients who deteriorated in transit which contained links to external guidance and detailed the actions the crew should take.

Processes were in place for when a patient did not open the door when they arrived to collect them. Staff told us they would first check through any windows and doors to see if they could see the patient or if patients had provided the details, they would access using the property using the key safe. If staff were unable to ascertain why the patient was not answering they would contact the number given on the booking. If there was no answer on this number, the staff would contact the control room who would follow this up with the ward.

We reviewed the care to care policy which detailed the actions crew should take if a patient did not answer the door. The policy also stated crew could ring 999 if they have any concerns.

Staff completed risk assessments for each patient. Staff working in the control room asked pertinent questions around risk including if the patient had any COVID-19 symptoms, mobility, access, if they had any health issues, if the patient had dementia or was diabetic.

Control room staff inputted patient information onto the electronic system. Staff accessed patient information including any risk via a personal digital assistant which detailed the jobs staff needed to complete. Staff told us how they completed dynamic risk assessments when they collected the patient.

Patient transport services

Dynamic risk assessments were in place, including on patients with complex needs and patient handling. There was a dynamic bariatric and complex patient risk assessment document in place. The risk assessment contained a flow chart for staff to refer to, this supported staff to determine if a risk assessment was required, for example if the patient had a high body mass index or weight. The risk assessment had a weight conversion chart and asked questions such as how the patient usually mobilised, details of any equipment and if the patients' medical condition was time critical.

Staff told us they would sometimes arrive at a property and find risks, such as those around access to the property had not been correctly assessed. Staff gave examples of having to move sofas when they arrived at a property. Staff in the control room relied on the person making the booking to communicate any risks. When risks were identified home visits could be arranged and completed by staff prior to the patient journey.

We reviewed the safer person handling and dynamic risk assessments policy and found it included information for staff on areas such as dynamic risk assessments, escort and mobility types, bariatric and complex needs patient handling and wheelchairs. Health and safety risk assessments were also in place when needed; for example; there was a health and safety risk assessment in place for the use of a wheelchair including the loading, securing and unloading from a vehicle.

Leaders told us they only conveyed mental health patients that were the lowest risk, there was a risk matrix in place around this, in addition to a policy named mental health services. Leaders told us patients with a mental health condition who were not eligible for patient transport were signposted in the direction of a secure transport provider.

Staff shared key information to keep patients safe when handing over their care to others. We observed a patient handover and found key information was handed over appropriately. Patient clinical report forms had a section for staff to record patient handover following arrival at the hospital and a signature. The record form also contained details of the patients presenting complaint, past medical history and, if a cardiac arrest had been witnessed as well as details of the patients presenting complaint.

Staffing

The service had enough staff with the right qualifications, skills, training and experiences to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough staff to keep patients safe. The service had 100% actual versus planned staffing in the month previous to the inspection in November 2022. This was made up of full time, bank and third-party staffing. Additional hours and resources over and above the required amount were also utilised with staff volunteering for overtime. There was an on-call system in place which was disseminated to the local trust. There were no concerns around staffing levels on the day of the inspection.

Paramedics were used on the high dependency contract. We observed two patient journeys and found skill mix was adequate. Staff had the right qualifications, for example, the FREC3 qualification. There was a mandatory training schedule in place.

Staff told us they did not always find it easy to find the time to take their breaks. Meal breaks for crews were not planned in advance. This was due to the impact on allocated work and changes in completion times for journeys due to real time, on the day circumstances. Guidance around breaks and working hours was included in the ERS Transition Limited staff handbook.

Patient transport services

Leaders told us planning of work was completed with an appropriate allowance to allow for meal breaks within a suggested window. Staff told us the control room oversaw allocating breaks and they did not feel they always knew what they were facing out on the road.

The service had low vacancy rates. The service operated 2 contracts, 1 contract had 2 full time and 1 part time paramedic vacancies which any shortfalls were covered by utilising bank staff and third-party recruitment. The second contract had 6 full time ambulance care assistant vacancies.

The service utilised bank staff and staff additional voluntary overtime to address any gaps in staffing. The control room had 1 full time vacancy covered by bank staff and staff doing overtime and if required used agency on an as needed basis. These positions were out to advert for recruitment.

The service had high turnover rates. The current staff turnover rates for the region were 27%. This included 140 total leavers over the year, 28% of the 140 staff left under exceptions so were not included in the turnover rate.

Leaders monitored the reasons for leaving the business these included retirement, ill health, failed probation, conduct and performance through a HR process, leaving for a new role, ill health and not transferring or starting after a job offer and personal reasons.

The service offered exit interviews when staff left the business, the main reason for leaving (36%) included leaving for a new role. Retention was reported on in the monthly quality and governance report.

The service monitored sickness rates. Staff sickness rates for November 2022 was 314 days averaging 1 sickness day per person for the month. This was in relation to 311 staff. Leaders told us at the time of the inspection they did not use many agency staff utilising instead their own bank staff. Agency staff were only utilised on an as needed basis occasionally in the control room. Sickness rates were reported on in the quality and governance report.

Records

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

Patient notes were comprehensive, and staff could access them easily. We reviewed 8 patient records forms. All records were legible, written in black ink, and were completed appropriately. ERS Medical West Midlands had provided staff with a toolbox talk on how a patient report form should be completed. We observed a patient journey and found patient records and personal information was kept secure.

Leaders completed audits on patient report forms. Results from November 2022 showed 93%. The audit found patient details were missing on 3 occasions. The audit showed a discussion had taken place with the relevant paramedics around this and feedback would also be given to third party providers that this needed to be completed.

Control room staff recorded if a patient had a ResPECT form in place prior to the patients' journey. Information on do not resuscitate orders was provided to staff in the care to care policy.

Records were stored securely. Patient records were stored in a room that required staff to use facial recognition to enter. Staff used their personal digital assistants to access patient information allocated to them via the control room; these were kept securely.

Patient transport services

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Controlled drugs (CD's) were licenced correctly and stored securely and ERS Medical West Midlands provided paramedics with personal issue CD administration books. Medicine management policies were in place which included the management of controlled drugs and medicines management make ready and other medicines processes.

Medicines were recorded correctly when used and patient clinical records were audited. Staff recorded batch numbers, medicine and clinicians' names. Paramedics bags were stored securely in lockers, each bag was tagged to show if it had been opened.

Leaders carried out weekly and monthly medicines inspection audits. We reviewed the results for November and December 2022 and found these were 100% compliant. We also reviewed the bi -annual internal HUB audit from June 2022, this also showed 100% compliance rates.

Staff stored and managed all medicines and prescribing documents safely. Medicines were kept securely in a room which required facial recognition to access and only the agreed staff could access this. There was a controlled drugs officer in place.

Staff monitored and recorded the room and fridge temperatures where medicines were stored these were within the required range. Processes were in place to discard of any unused medicines. Medical gases were in date and stored securely in locked cages. Empty and full cylinders were separated.

Staff completed medicines records accurately and kept them up to date. Paramedics were able to record any allergies and drug administration on the patient report form/clinical record. This included if cannulation was required, drug amount, dose, route and time. Leaders told us paramedics working from a third-party contract supplied their own medicines.

Staff learned from safety alerts and incidents to improve practice. Quality and governance teams were responsible for signing up, monitoring and where necessary communicating safety alerts and recalls across the business. The service was signed up to receive alerts and updates from Medicines and Healthcare products Regulatory Agency, The Central Alerting System, National Institute for Health and Care Excellence (NICE) and the Health and Safety Executive e bulletin service.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff knew to report any incidents to incident reporting lines which was well publicised within the building. There was an incident reporting and investigation policy in place, this was version controlled and in date. Incidents at the service were recorded on an electronic incident reporting system.

Patient transport services

Third party providers who undertook work on behalf of the service were required to report any incidents; they were given specific information on how to do this and provided with the relevant contact numbers. Third party providers had reported 11 incidents since the region began operations, these included care quality, health and safety and safeguarding incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw evidence of learning as a result of incident trends and that as a result ERS Medical Transition Limited had taken several actions including raising a health and safety regarding the safe loading, unloading and transporting of patients in a wheelchair, completing a health and safety risk assessment and updating policies and procedures. This was also shared with the training team to address as part of the initial training and annual update manual handling training.

Leaders shared a second example of learning regarding the use of hospital porter chairs. ERS Transition Limited had taken several actions including issuing a toolbox talk to staff to highlight the issues and risk to patient safety; policies were also updated as a result. We spoke with staff who knew about this incident. We saw an incident feedback record several staff had signed in October 2022.

The quality and governance team worked alongside the regional and national operation leads to review incidents and identify trends across the incident reporting system. Any local trends were reported within a regional quality and governance report monthly. The report was reviewed as part of the governance and performance review committee meetings. Additionally, they were also reviewed from an organisational perspective through the senior leadership's monthly performance reviews and the quality and governance reports. Incidents were also discussed at patient safety committee meetings.

Staff understanding around the duty of candour was varied. The provider arranged for Care Quality Commission (CQC) awareness training for registered managers and supporting operational teams; we reviewed the training slides and saw it covered duty of candour in relation to CQC regulations.

Managers investigated incidents. We noted leaders completed a root cause analysis report when an incident occurred relating to a third-party provider working in behalf of ERS Medical West Midlands. The report contained a full chronology of events, the root cause, lessons learnt, recommendations, an action plan and a distribution list for shared learning.

Quality and governance reports detailed incidents that had been recorded on the electronic recording system as well as the time incidents took to be raised, incident types, location incident breakdown and regional incident breakdowns. The report also had details of incidents that had happened, root causes and lesson event feedback.

Managers supported staff after an incident. Staff were able to give an example of managers checking on their welfare following an incident which happened on a patient journey. We reviewed an incident report from the electronic recording system which showed a welfare check of the crew had taken place and support had been offered.

Are Patient transport services effective?

Requires Improvement 

This was the first inspection of the service. We rated it as requires improvement.

Evidence-based care and treatment

Patient transport services

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed up to date policies and procedures. Policies were up to date and version controlled with links to related policies, legislation and external guidance such as National Institute for Health and Care Excellence guidelines and the Health and Social Care Act 2008. A policies and procedures road map was available on the HR system, staff knew where to access them. The road map was included in the ERS Transition Limited staff handbook.

ERS Medical West Midlands had a care to care policy in place. The policy set out to establish and define actions, responsibilities and standards required when patients were receiving care treatment and transportation. The policy including information from booking the patient journey to arrival at the destination.

The service had clear eligibility criteria in place. This included a list of 23 questions; however, if the patient was travelling for renal or cancer treatment, they were automatically eligible. There was a specific policy in place for renal patient services. The policy included information such as eligibility, safe working practices, hospital-based staff and useful hints and tips.

Staff assessed patient's needs and eligibility against protocols to provide care and transport. For example, if a patient was under the age of 18 years an escort was required to travel with them.

Nutrition and hydration

Staff provided patients with water on journeys if needed.

Staff did not provide food to patients due to the type of service. However, single use water bottles were available if a patient needed a drink. Patient report forms had a section for paramedics to record any fluid administration and allergies.

The ERS Transition Limited care to care policy detailed how on longer journeys the hydration needs of the patient must be considered in a more dynamic manner based on their needs, but as a baseline considered hourly and immediately if requested by the patient. It also notes how consideration should be given to patient's hydration needs for the taking of medicines and to quench thirst.

Response times and patient outcomes

The service monitored, agreed response times so that they could facilitate good outcomes for patients, however they did not always meet the targets set.

The service had key performance (KPI) measures in place. We reviewed the monthly analysis for 14 KPI's from August, September and October 2022 and found service performance varied in relation to meeting the targets set. For example, results showed the service did not meet the targets set in 9 out of the 14 instances and partially met them in 2.

The number of patient journeys over 3 months were August 13,308, September 12,903 and October 13,109.

Patient transport services

Trends in complaints showed most were related to perceived lateness and service delivery issues such as late collections and waiting too long to be picked up post appointment or on discharge or issues with calls and bookings. Leaders spoke of the system pressures they faced daily; governance meeting minutes reflected this. Leaders spoke of how on the day bookings created the greatest challenge.

Patient transport was not always in line with good practice guidance issued by Kidney Care UK, standards for dialysis treatment 2019. Renal patients we spoke with spoke about the length of time taken to get home following dialysis, late collections and poor route planning which meant they had to travel long distances to collect or drop off other patients. Staff also spoke of picking up and dropping off patients late for appointments.

Patients told us how after having dialysis they just wanted to get home; one patient gave the example of being out of the house from 10.45am to 9pm at night. Another patient told us how if they were late for dialysis, they felt they needed to knock time off their treatment.

Leaders told us how renal patients were captured in the special category of their KPI's, however this was not specific to renal patients as it also covered other patient groups who had regular bookings.

We reviewed the comments from the most recent onboard ambulance surveys, comments included waiting from 10.15am to 3.15pm for transport, transport waiting times being too long going home, journeys not being planned very good with a 15-minute journey taking 2 hours. Good practice guidance shows that for renal patients transport to and from dialysis is one of the most important issues affecting patient's quality of life.

Minutes from meetings with commissioners dated November 2022 noted how most concerns raised tended to be time related and this was a concern as it could lead to harm from waiting or potential readmission to hospital.

Leaders discussed KPI's in monthly clinical quality review meetings were held with the local integrated care board. We reviewed the minutes from November 2022 and saw improvements had been discussed alongside what had been done to create improvements and what could be done to further improve. Many KPI's showed some level improvement over the last few months, however some had also declined. Leaders told us improvements were a result of an improvement plan previously implemented.

Leaders recently completed (November 2022) a volume and trend analysis against the tender data and operations solution designs to ascertain the current position of resource requirements. The analysis found they were resourcing the contract beyond levels budgeted for in their tender solutions. Key reasons included an increase in mileage per patient journey, increased volume of patients going to Birmingham and surroundings, pre-planned journeys decreased, cancelled and aborted journeys increased, more complex stretcher patient activity and made ready delays on outward journeys represented 38% of the total outward journeys.

Leaders told us that differing priorities on the day can apply given the situation across system partners and that ERS Medical West Midlands were not always able to control items that effected delays and any subsequent knock off effects throughout any given day.

Third party providers monitored their own response times. Due diligence for a third-party contract noted how ERS Medical West Midlands would be able to access information on patient journey times if required via a spreadsheet. In relation to the third-party taxi service utilised by the service, the company had a system in place that recorded the taxi arrivals, departures and drop off times.

Patient transport services

ERS Medical West Midlands participated in relevant quality and safety improvement initiatives. Leaders told us bench marking was achieved through audits conducted across the business. This process allowed the service to produce evidence of improvements through associated action plans with this information being fed into the company's one report. The reports were produced monthly for each separate region and this set the bench marking and comparison for all regions.

Leaders completed audits to improve outcomes and identified actions when compliance was not met. We noted audits had been completed in areas such as infection control, medicines, documentation and fleet. Audits were also reported on in monthly quality reports which were shared with the local integrated care board.

Competent staff

The service made sure staff were competent for their roles. However, managers were not always up to date with staff performance development plans.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The First Response Emergency Care (FREC3) training course was provided to all new starters and those staff who completed this received annual updates based on FREC3 update requirements as well as their statutory requirements. Staff who came over to ERS Medical West Midlands in 2021 on their previous terms and conditions had the opportunity to complete this if places were available. Leaders told us they aimed to move staff over the length of the contract from their current level of qualification onto the FREC3 certificates. Scoop stretcher training was carried out in the manual handling section of the new starter and annual update training.

Leaders told us they had 18 paramedics working on their high dependency contract and 19 ambulance care assistants / high dependency staff all of which had a current emergency response driving qualification. They also advised the paramedics completed their blue light driving as part of their initial training and The Health and Care Professions Council (HCPC) registration. The 19 ambulance care assistants / high dependency staff employed on the contract had relevant emergency response driving qualifications.

Due diligence information noted how all third-party taxi drivers were required to have their BTEC NVQ Level 2 certificate in road passenger vehicle driving.

Staff received annual update training to support in their understanding of specific groups such as those with autism or a learning disability. They also provided staff with information around ResPECT forms and when they would be accepted.

Managers gave all new staff a full induction tailored to their role before they started work. All new starters completed ERS new starter induction training days. Inductions included subjects such as manual handling including bariatric awareness and scoop stretchers, basic life support, safeguarding, oxygen therapy and information governance. Staff were signed off as competent by an assessor. Practical assessments included assessment and treatment of illness such as asthma, anaphylaxis and anatomy and physiology. Staff induction training was being undertaken on the day of the inspection.

We heard examples of ERS Medical West Midlands promoting staff. We met with several staff who had been given the opportunity to develop by taking on more senior roles within the organisation.

Patient transport services

Managers had not completed all staff's personal development plans. On the day of the inspection we were provided with a list of 60 staff who still needed to complete their performance development plan (PDP). Out of the 60 staff it was noted 4 staff had refused, 1 staff was unable to complete, and 2 staff were on maternity leave. Meeting minutes from December 2022 showed 100% of managers had completed their PDP and staff completion rates were 71% and overall, 85%. The minutes specified PDP's needed to be completed and staff could do a paperwork manual one if needed.

The PDP's once completed, were recorded on the HR electronic system. We reviewed a sample of 6 completed plans and saw they included a manager's assessment, self-assessment, a section on how staff felt they could improve and if staff had any goals and training needs.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Each region at ERS had a clinical trainer/associate trainer to provide a clinical focal point and oversee and manage training under the direction of the director and HR training.

There was a training prospectus in place which set out useful information for staff such as mandatory e-learning, training equipment lists and details of the training team. Training was reported on within the quality and governance report which was shared with the integrated care board.

Managers provided staff with bite size training information which was named "toolbox talks". We noted toolbox talks displayed in the break room.

Staff previously held ambassador meetings; however, these had not taken place since July 2022. Staff did not have specific team meetings; however, ERS Medical West Midlands had recruited staff ambassadors who held monthly meetings with leaders in attendance. The role of the ambassador was to work as a liaison for colleagues and peers across the site to the wider group. However, leaders told us the last ambassadors' meeting was held in July 2022 due to long term sick leave or the ambassadors leaving the business. The company had recruited 2 new applicants and hoped to restart the meetings in the new year.

Multidisciplinary working

All those responsible for delivering care worked together to benefit patients.

Staff held regular meetings to discuss and improve the service. Staff from within all areas of the organisation worked to assess, plan and deliver patient care. Managers had regular meetings with third party providers.

ERS Medical West Midlands had a relationship manager based at the local trust. The relationship manager visited different hospitals and attended any meetings including trust bed meetings and renal handovers. ERS Medical West Midlands had hospital liaison workers based at the hospital five days a week. We received consistently positive feedback regarding this service from patients. The service had regular meetings with those who commissioned the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Patient transport services

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed the annual update slides and noted consent and the Mental Capacity Act 2005 were a topic. Training slides detailed the 5 principles of the Mental Capacity Act including how capacity was tested. Staff understood the concept of assessing a patient's mental capacity to make a decision.

Leaders completed records audits enabled them to monitor if staff were meeting legal requirements and following national guidance around consent. We observed a patient journey with a patient who was unable to communicate, and found staff acted in their best interests at all times.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent and the status of patient's mental capacity were included on patient report forms. We reviewed 8 completed patient report forms and saw staff gained and recorded consent each time. We observed 2 patient journeys and found staff gained consent.

We reviewed a copy of a complaint and noted a third-party consent form had been gained to authorise a complainant to act on behalf of a family member. The complaint response contained an apology, explained what to do if they had further comments or concerns and explained they had the right to ask the Health Service Ombudsman to investigate the complaint. It also contained the details of the CQC and the NHS complaints advocacy service.

Information on consent and mental capacity were also detailed within the ERS Transition Limited care to care policy. Eligibility criteria also included questions around patients' capacity which may impact on their ability to consent, such as the patient's level of communication and if they were living with dementia.

Are Patient transport services caring?

Good 

This was the first inspection of the service. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff ensuring that patient's privacy and dignity was maintained throughout. Patients we spoke with also told us staff respected their privacy and dignity.

Patients told us staff were both respectful and considerate; that new staff introduced themselves as well as introducing any new patients using the service.

We observed staff taking the time to interact with people who used the service and those close to them in a respectful and considerate way. We observed a staff member holding a patient's hand and involving them in interactions.

Patient transport services

Patients said staff treated them well and with kindness. We reviewed the quality and governance report for October 2022 and noted patient compliments were recorded. Compliments included how staff were wonderful and how compassion was maintained.

Staff followed policy to keep patients care and treatment confidential. For example, staff used personal digital assistants for patient records. Details of what staff should do if there was a breach or loss of patient information was recorded in the care to care policy.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were able to give examples of responding appropriately when patients had died in their care. Patients were complimentary of the service and spoke highly of the ambulance crews.

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. One patient's feedback spoke about staff showing a human approach with a level of considered humour made the patient experience a good one. Staff told us how they enjoyed their role as they were able to work with the patients.

Understanding and involvement of patients and those close to them

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

Staff talked with patients, families and carers in a way they could understand. We observed 2 patient journeys and found staff communicated well with all the patients.

We observed staff were exceptionally compassionate towards the patients. One patient's feedback spoke of good communication and verbal contact from staff.

There was a care to care policy in place. The purpose of the policy was to give guidance to staff on the level of care expected.

Patients and their families could give feedback on the service and their treatment. Road crew were able to offer patients the opportunity to complete on board ambulance surveys to give feedback on the service they had received.

Patients gave varied feedback about the service. We reviewed the results of the ERS Medical West Midlands patient survey results for October and November 2022. Patient comments included the staff being very friendly, being patient as they did not have their own transport and going above and beyond. Any negative feedback was mainly in response to the times patients had waited for transport.

Results for November 2022 showed 100% of patients at Tollgate and 37 % of patients covered by Campbell Road felt they received a very good experience of the service.

Patient transport services

Are Patient transport services responsive?

Good 

This was the first inspection of the service. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The service provided non-emergency and high dependency transfers between locations such as hospitals, patients' homes and care establishments. ERS Medical West Midlands provided a regular service to patients attending hospital for dialysis.

ERS Medical West Midlands were in the process of going out to tender to provide resilience to the emergency department through rapid discharging and improved discharging capabilities during winter. The aim was to provide a rapid transfer out of the emergency department avoiding long stays in hospital for patients that could return home, to provide discharges within a 5 mile transfer radius when vehicles were not moving emergency department patients and any other discharges should vehicles remain underutilised.

Facilities and premises were appropriate for the services being delivered. We visited the base in Stoke on Trent and Stafford and found they had sufficient facilities including garage areas, a control room, car parks, toilets and crew room with secure rooms for crew personal digital assistants, phones and medicines. All the facilities were well-presented and in good repair.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had high dependency vehicles to care for patients during high dependency patient transfers; ambulances were able to accommodate both wheelchair and stretcher patients.

Vehicle harnesses and chairs were available including those for safely transporting children. Control room staff identified any patient support required at the booking stage. The service also employed planners to plan the patients' journey. Staff told us how they could accommodate assistance dogs if needed and gave an example of when this had happened.

Meeting people's individual needs

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

Staff taking bookings asked a series of questions which identified if a patient had any complex needs. There was an end of life care and respect policy in place which included information on the priorities of care for the dying person, frameworks and quality statements.

Patient transport services

Vehicle packs containing limited communication tools were made up to store on vehicles. We reviewed a copy of the vehicle pack and found it contained a pain assessment tool with a nonverbal option to determine how the patient was feeling, it also contained a language identifier form.

The ERS on board ambulance survey had a nonverbal option to identify how patients felt about their experience of the service. We observed a patient transport journey with a patient who was non-communicative and saw staff spent time engaging with them to ensure they remained included.

ERS Medical West Midlands had access to a telephone translation service, with interpreters who could dial out to a third party if needed. We reviewed the interpreting language list which contained a comprehensive list of languages. However, staff we spoke with were not aware of this as they told us they would access the trusts interpreter services if needed.

Patient escorts could be planned if needed. Leaders told us unless there was an absolute necessity for the patient to be escorted, they would ask for all escorts to make their own way to the hospital. The policy was that patients who lacked capacity around their care needs would be transported with either a booked escort or a double crewed vehicle.

The needs of bariatric and complex patients were considered within ERS Transition Limited policies and risk assessments. Inductions included subjects such as bariatric awareness. There was equipment in place to support bariatric patients.

Leaders told us although they aimed to provide continuity of staff for regular patients this was not always possible due to the nature of the business.

We noted training slides had information on conflict resolution such as how to avoid conflict and the attitude and behaviour cycle. Staff were able to tell what they would do if a patient was being abusive such as using communication skills, considering if the patient was anxious or if required to contact the control room for advice.

Access and flow

People could access the service when they needed it, in line with national standards, however they did not always receive the right care in a timely way.

Staff in the control room managed bookings for the non-emergency patient transport service, both on behalf of and by patients. Patient bookings could be made by patients, relatives or staff at the hospital. For the high dependency contract bookings were taken at a separate location.

Leaders told us they aimed to have 90% of their journeys planned. If a patient was not ready when the staff went to collect them the process was, they would go onto the missed list and would be rescheduled for a later time.

Staff at the hospital could contact ERS Medical West Midlands via the telephone to book a patient journey. They also had the option of using an online portal to do this.

Managers monitored waiting times. There were clear key performance indicators (KPI's) in place which were monitored. However, ERS Medical West Midlands did not always meet KPI's and patients could experience delays waiting for transport, feedback from staff and patients supported this. Specific staff were employed to plan patient journeys with the aim to minimise the length of time people had to wait for their transport.

Patient transport services

Managers worked to keep the number of cancelled journeys to a minimum. ERS Medical West Midlands employed planners to plan patient journeys. Leaders monitored cancelled and aborted journeys. Data from October 2022 showed there were 2,920 cancelled journeys and 1,006 journeys were aborted. Systems were in place, for control room staff to track patients' journeys. Staff were allocated jobs onto their personal digital assistant.

Managers made sure they were rearranged as soon as possible and within national targets and guidance. Patient journeys were able to be rescheduled by staff in the control room when required.

There were 3 hospital liaison workers and a relationship manager who were based at the local hospital on weekdays. This service helped to support people to transfer between services and acted as a point of contact for staff and patients at the hospital.

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. Information on how to complain were available for patients on vehicles and in the base reception area. Patients told us they would raise a complaint with ambulance staff if they wanted to. Onboard ambulance surveys also contained contact details where patients could raise if they were unhappy about something as well as if they wanted to thank the staff who cared for them.

Staff understood the policy on complaints and knew how to handle them. There was a complaints, comments, concerns and complaints management policy in place which included key staff responsibilities, steps, flow and timescales.

Managers investigated complaints and identified themes. Leaders reported on complaints within the quality and governance reports. The report for October 2022 showed there was 52 complaints recorded for the West Midlands from September to October 2022. From the 52 complaints 28 were still under investigation, 4 were not upheld, 13 were partially upheld and 8 were fully upheld. Leaders also monitored and reported on the average time in days to report, service types and who was reporting.

Leaders reported on lessons learned from complaints; for example, identified learning included crews to remain professional, updating patients about delays and ensuring patients were planned to the correct vehicles.

Trends in complaints were monitored and reports showed most were related to perceived lateness and service delivery issues, such as late collections and waiting too long to be picked up post appointment or on discharge or issues with calls and bookings. Governance meeting minutes showed complaints were discussed.

Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed the service one report and noted there was evidence of a complaint root cause and lessons learnt; for example, call agents needing to seek guidance from their managers and control staff should have updated patients with delays. Complaint findings were used as learning for staff and for ongoing monitoring.

Are Patient transport services well-led?

Patient transport services

Good 

This was the first inspection of the service. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, operational road crew did not always feel leaders were visible.

There was a clear leadership structure in place. The company also had a chief executive officer (CEO), a quality and governance director, a head of human resources (HR), a head of operations, a communications director and a medical director in place. The senior operations manager for ERS Medical West Midlands was also the Care Quality Commission (CQC) registered manager.

Leaders understood the challenges to quality and sustainability and had identified actions to address them. For example, leaders had completed a volume and trend analysis to ascertain the current position of resource requirements. Leaders had identified they could provide resilience to the emergency department through rapid discharging and improved discharging capabilities during the winter. Other challenges identified included on the day bookings and pressures on the health and social care system.

Registered managers and supporting operations teams were provided with CQC awareness training. We reviewed the training slides and found them to contain relevant information on regulation, inspection and legislation. We saw that the senior leadership for ERS Transition limited had hosted roadshows to enable them to meet with colleagues and share important updates such as company updates, vision, employee benefits and to offer staff the opportunity to meet the senior leadership team.

Operational road crew did not always feel leaders were visible, they told us they did not see a lot of the managers. The manager of the control room was highly visible as they were based in the same room as the staff. There were photographs and roles of key staff, such as HR and safeguarding leads were displayed in the main reception area.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The vision for 2025 was to grow a profitable patient focussed business in order to be recognised as a leading provider of health and social care services in the UK by 2025.

There was an ERS Transition limited medical strategy in place for 2022. The purpose of the service was to provide a reliable, caring service that put people at the heart of everything they did. The strategy included information on reshape, values and measures of success and growth. It also contained a business model, landscape and trends and had an opportunity and growth plan.

Patient transport services

ERS Medical West Midlands displayed its values clearly around the base in staff areas. Values were also incorporated into staff performance development plans and policies, ERS values were collaborative, accountable, respectful and excellence. We observed staff displaying behaviour consistent with the company's values on the day of the inspection.

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Staff told us they enjoyed their jobs as they enjoyed working with the patients. Leaders shared examples of staff recognition when staff had demonstrated company values.

Staff had access to benefits such as a free sausage roll and coffee each month, colleagues were also able to earn points which they could save and redeem. We reviewed a letter from the manager that congratulated a member of staff for winning the employee recognition scheme and saw they had thanked them for their hard work.

Leaders were able to share examples of when they had promoted equality and diversity in the workplace. The company had an equality and diversity lead in place who was also the HR lead. There were mental health first aiders in post who could provide support to staff in relation to their mental health.

There were mechanisms in place to aid staff in their continuing professional development. However, not all staff had completed this at the time of the inspection. We spoke with staff who had been given the opportunity to progress to more senior roles. Staff also had the opportunity to complete their first response emergency care (FREC3) qualification.

We observed cooperative, supportive and appreciative relationships amongst staff and observed operational road crew staff working together collaboratively. The company had an occupational health service available to staff.

Staff commented how they did not feel appreciated, were just a number and how they did not feel listened too.

There was some disconnect between the operational road staff and the control room; road crew did not always feel that staff in the control room understood the pressures they faced when completing patient journeys. We heard how one staff member felt bullied and belittled by control room staff, other staff told us how they did not feel controllers understood their role and that they felt there was a *"them and us"* culture.

Governance

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

All levels of governance and management functioned effectively and interacted with each other appropriately. There was a governance structure in place.

Senior operations managers held weekly meetings. These meetings were also attended by the senior leadership team as a mandatory requirement for the first meeting of each month and then as required. Senior leadership meetings were held weekly.

Patient transport services

Governance and performance review meetings were held monthly and chaired by the regions senior operations manager and supported by services such as HR, training and quality and governance.

Patient safety committee meetings were held on a quarterly basis, meeting minutes showed important information such as safeguarding was discussed.

Senior leadership team performance review meetings were held monthly, where senior managers reviewed all aspects of the business and submitted the slides to the chief executive officer.

Leaders discussed key performance indicators (KPI's) in monthly clinical quality review meetings with the local integrated care board. Minutes from November 2022 showed improvements had been discussed, and what further improvements could be made.

Leaders had recently completed a volume and trend analysis against the tender data and operations solution designs to ascertain the current position of resource requirements.

Staff at all levels were clear about their roles and understood who they were accountable for and to whom. Policies were in place and accessible to staff. All policies were up to date and version controlled. A policies and procedures road map were available on the electronic system. Policies and procedures were reviewed either annually or on change of process, risk, post incident or industry standard.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction. Leaders ensured they undertook due diligence with third party suppliers.

Leaders told us when a third-party provider was registered with CQC they would support them in discharging duty of candour. They also advised they would request evidence that they had discharged this duty and record this on the incident reporting system. Third party suppliers were only used on an as and when needed basis so no fixed service level agreements were in place. This meant that it was not officially recorded who was responsible for discharging duty of candour if an incident was to occur.

In relation to non-registered providers such as taxi companies ERS Medical West Midlands took and held the regulatory responsibility to make the statutory notifications to CQC and to discharge the duty of candour to the relevant person for the incident.

Management of risk, issues and performance

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

There was a systematic programme of clinical and internal audit in place to monitor quality, operational processes. Leaders completed audits and had identified actions when compliance was not met. We saw audits were completed in areas such as infection control, medicines, documentation and fleet. Audits were also reported on in monthly quality reports which were shared with commissioners.

Patient transport services

Risk assessments were reviewed annually or on a change of process, risk, post incident or industry standard. We saw evidence that actions had been taken when a risk had been identified including the updating of policies and procedures to reflect this.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. We reviewed the risk register and saw it was colour coded, contained the date of the last review and detailed the controls in place, at the time of the inspection there was 7 risks recorded. Risk registers were discussed in governance meetings such as the patient safety committee.

Potential risks were taken into account when planning services. For example, work had been carried out by the senior leadership team comparing the activity and acuity of patients using data provided for the bid model against actual data occurring in 2022. Areas looked at included mobilities, distance travelled with a view of identifying risks. Leaders shared extreme weather alerts hot and cold with staff and placed them in the crew rooms.

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.

The service monitored response times in relation to transport. This information was shared with the commissioners and used as part of the quality improvement data.

Systems were in place to collect reliable data and analyse it. The service collected electronic information to enable them to monitor quality and performance. Patient paper records were stored securely. Policies and procedures were in place for the retention of records.

Staff used their personal digital assistants (PDA's) to access patient information allocated to them via the control room; PDA's were kept securely, and staff needed to log into the device to use it.

The ERS Transition Limited staff handbook contained information for staff on IT security and internet use.

Vehicle information was recorded on an electronic system. The system contained details such as when the MOT, road tax and service was due and how many miles the vehicle had completed. All vehicles were up to date with their service, MOT and road tax. The service used an external service to complete staff driving licence checks including if they had any points on their driving license and when staff photo cards were due to expire.

Engagement

Leaders did not always engage effectively with staff. They collaborated with partner organisations to help improve services for patients. Actions had been put into place to increase response rates in relation to patient surveys.

Most organisational road crew told us they did not feel respected, supported and valued by the management team.

Patient transport services

There were no specific team meetings for all staff, only staff ambassador meetings. At the time of the inspection staff ambassador meetings had been paused due to staff leaving the business. New ambassadors had since been recruited and it was hoped that meetings would resume in the new year.

At the time of the inspection there was not any arrangements in place for the management team to accompany the road crew on the occasional patient journey. This meant the leadership team did not get to spend time engaging and working alongside road-based staff and patients. Following the inspection leaders told us they would look at putting something in place to enable this to happen in the future.

The company shared important information with staff in its newsletter InTouch such as COVID-19, updates on marketing and communications, training updates, information on employee assistance programmes alongside competitions where staff could win vouchers.

The company had a freedom to speak up guardian in place. Posters displaying the name of the freedom to speak up guardian were displayed in the main reception areas; however, staff did not always know who this was. This information was not on display in the crew room at the time of the inspection.

Leaders held regular meetings with third party providers, commissioners and were well represented at the local hospitals where they had a relationship manager and liaison officers.

The last annual staff survey was completed in 2021, leaders told us the next survey was in the process of being completed. It was not clear from the information provided if the results were ERS West Midlands specific; therefore, we were unable to use this information within this report.

Patient experience surveys were recorded and reported on. The surveys were available from the ERS base and on patient vehicles. Patients were able to take the survey with them and return using the pre-paid service. They could also access the survey remotely on the company website. Results from November and December 2022 varied across sites.

Governance meeting minutes from December 2022 noted how patient feedback surveys were a concern and were decreasing month by month from 160 in August 2022 to 54 in October 2022. Actions to increase response included to encourage engagement, remind staff of the benefits of completion and that it was something they were expected to do as part of their role.

Learning, continuous improvement and innovation

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

ERS Medical West Midlands participated in relevant quality and safety improvement initiatives. Leaders told us benchmarking was achieved through audits conducted across the business. This process allowed the service to produce evidence of improvements through associated action plans with this information being fed into the companies one report. The reports were produced monthly for each separate region and this set the benchmarking and comparison for all regions.

Leaders and staff strived for continuous learning, improvement. The service offered the opportunity for staff to complete the FREC 3 course.

Patient transport services

The provider arranged for CQC awareness training for registered managers and supporting operational teams; the training covered CQC regulations and areas such as CQC notifications.

ERS provided paramedics with personal issue CD administration books.

The senior leadership team hosted roadshows to enable them to meet with colleagues and share important updates such as company updates, vision, employee benefits and to offer staff the opportunity to meet the senior leadership team.

Leaders had implemented an improvement plan eight months prior to the inspection in relation to key performance indicators. As a result, some KPI's had shown improvement over the last few months.