Emergency Response Systems Ltd

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Quality Report

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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Emergency Response Systems is operated by Emergency Response Systems Ltd. The service provides a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 15 – 16 January and 18 – 19 January 2018.

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?

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

The main service provided by this service was patient transport services.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were excellent governance and reporting systems and arrangements which enabled decision making.
- Feedback from both patients and local hospitals was overwhelming positive about the service provided by Emergency Response Systems.
- The service had received no formal complaints in the previous 12 months.
- Safety incidents were managed well.
- There were good standards of cleanliness and hygiene both at the ambulance base and on ambulances and staff had a good understanding of their role regarding infection control.

However, we also found the following issues that the service provider needs to improve:

- There was no person in the organisation trained to Level 4 safeguarding for children and young people.

Professor Edward Baker

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)		Emergency Response Systems Ltd primarily provided non-emergency patient transport services. The service was well led with experienced and capable leaders who drove improvements in the service with a focus on the best possible care. Leaders promoted a positive staff culture and encouraged staff development to deliver the high quality and treatment for all patients. There were effective systems to ensure patients received safe and high-quality care and treatment at all times.

Emergency Response Systems Ltd

Detailed findings

Services we looked at
Patient transport services (PTS);

Detailed findings

Contents

Background to Emergency Response Systems Ltd

Emergency Response Systems is operated by Emergency Response Systems Ltd. The service opened in July 2016. It is an independent ambulance service with headquarters based in Gloucester. The service primarily serves the communities of the North East of England having taken over a company in April 2017, which was the operational base. At the time of the inspection the company did not have contracts with NHS providers, but provided an ad-hoc service on demand of local trusts.

We inspected both the headquarters and operational base using our comprehensive inspection methodology. We carried out the announced part of the inspection on 15, 16, 18 and 19 January 2018.

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?

The service has had a registered manager in post since May 2011.

At the time of the inspection the service was working with three local NHS trusts and two NHS ambulance services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,and a specialist advisor who was an advanced paramedic. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Facts and data about Emergency Response Systems Ltd

During the inspection, we visited the service at the Unit 3, Manor Farm Office, Gloucestershire address on 15 and 16 January 2018. The provider had submitted an application for the service's new location, under which this report is now published.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the head office, and the ambulance base. We spoke with 11 staff including patient transport drivers and management. We spoke with three patients and one relative.

Detailed findings

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC

Thirty-one patient transport drivers worked at the service. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (December 2016 to December 2017):

-The service reported no never events.

-The service reported two serious clinical 2017.

-The service reported no patient harm incidents 2017.

-The service reported no complaints.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by Emergency Response Systems Ltd was patient transport services.

Summary of findings

We found the following areas of good practice:

- There were effective governance and reporting systems which enabled decision making.
- Feedback from both patients and local hospitals was consistently positive about the service provided by Emergency Response Systems.
- The service had received no formal complaints in the previous 12 months.
- Safety incidents were managed well, with staff understanding their role in safety reporting, and learning was shared.
- There were good standards of cleanliness and hygiene both at the ambulance base and on ambulances. Staff had a good understanding of their role regarding infection control.

However, we found the following issue that the service provider needs to improve:

- There was no person in the organisation trained to Level 4 safeguarding for children and young people.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- Safety systems, processes and practices kept patients safe. The service managed patient safety incidents well. Managers encouraged staff to report incidents and staff we spoke to told us that they understood their responsibilities to raise concerns, record safety incidents, concerns and near misses. The service held a database for all incidents. All staff signed a document to state that they had read the relevant documents and this was stored as part of their electronic staff record, and managers were able to run reports to show that staff were compliant.
- Between December 2016 and December 2017, the provider reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Incidents were reported and captured effectively. There had been two serious incidents requiring investigation between November 2016 and November 2017 which we reviewed. These included an assault on a member of staff and a potential safeguarding concern. Incidents were entered onto a reporting system, and a manager assigned to review. We saw that a root cause analysis took place, an action plan developed and duty of candour was considered. Learning points had been shared with staff.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour was introduced in November 2014. This Regulation requires organisations to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm that falls into defined thresholds.
- Staff we spoke with were aware of their responsibilities regarding duty of candour. They were aware of the regulation and how and when it would be used. They understood the importance of being open and transparent with patients when things go wrong.
- Frontline staff were told about changes in policy or procedure through a series of quality updates. These were emailed to staff individually and we saw copies printed and displayed in the ambulance station. Staff we spoke to were aware of the adverse incident reporting and investigation policy. They could tell us what they would do should an incident occur and this was in line with the policy.
- Front-line staff were able to report incidents 24-hours a day by calling managers. There was also a log at the ambulance base where staff arriving back at the ambulance base out of hours could log any issues which was picked up and actioned by managers the following day. We saw that this log was checked on a daily basis. Staff we spoke to told us that they could always speak to a manager if required at any time of the day or night.

Mandatory training

- Staff received effective training in safety systems, processes and practices. The service provided mandatory training in key skills to all staff and made sure everyone completed it. All staff were up to date with their required mandatory training, or planned to be completed by April 2018. Staff we spoke to explained how they managed their updates and that reminders were provided, if necessary, by their managers via emails and face to face conversations.
- Mandatory training included a safeguarding update (including mental health awareness and equality diversity and human rights), infection control, consent, duty of care, conflict resolution and fire safety. The content of the yearly mandatory training was changed depending on the needs of the service. Mandatory training records showed at the time of the inspection 76% of staff had completed dementia awareness, 83% had completed duty of care training, 69% had completed information governance training, and 66% had completed infection control training. All staff had completed a practical handling and moving training. We saw that managers had plans to ensure that staff had completed their mandatory e-learning by the time of their annual review.
- The delivery of annual mandatory training was effective. Annual mandatory training package for all subjects, including adult and paediatric first aid and safeguarding was condensed into a one-day course. We were assured by staff we spoke to that the quality of information was delivered in such a way that crews were able to practice

and update essential skills to deliver high quality service. Staff told us that they were able to access electronic learning and training packages either at the ambulance base or remotely from their homes.
- Compliance against mandatory training requirements was monitored in reports and monitored centrally. Non-compliance with training was acted upon locally and we saw plans held at the managers to address and staff who were due their required training by the end of the financial year.

Safeguarding

- There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm. Staff had received training in the safeguarding of adults and children. Staff understood the different forms of abuse and could recognise the potential signs of abuse. Staff we spoke with knew how to report safeguarding concerns and where to seek additional advice when necessary. Staff were confident in recognising a safeguarding concern and the action they would take to ensure the patient's safety. Staff could provide us with examples of situations where a patient was at risk or there were concerns with their welfare and how they responded to ensure the patient was safe and the concern reported.
- There was an effective system in place for front line staff to report safeguarding incidents. We saw contact details for the local safeguarding team were on display for staff to use if necessary.
- Staff received effective training in safety systems, processes and practices. At the time of the inspection 79% of staff had received training in safeguarding for adults levels 2 and 3, and plans were in place to ensure the remaining staff completed their training by the time of their annual review. The service had a system to identify which staff required training and dates by when training modules needed to be complete. These were reviewed by managers on a regular basis.
- Oversight of safeguarding concerns was led by a senior manager. We were told the manager would feedback to staff following a referral.
- At the time of the inspection there was not a member of staff who was trained to level 4 safeguarding for children and young people due to a recent resignation. Roles and competencies for child safeguarding training are outlined in 'Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT Third edition: March 2014, which states that I n the case of independent ambulance providers, there should be a minimum of one level 4, a named professional. A senior manager assured us that they were identifying a suitable training session for relevant managers to attend.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were well maintained and there were systems to prevent and protect people from infection. Standards were maintained through a series of daily, weekly and monthly checks. Ambulances were subject to weekly inspection and infection control checks to ensure staff were following correct procedures.
- Ambulances were also subject to a monthly deep clean, as well as ad hoc deep cleans where required. We could see this was being completed by evidence on the computer log and condition of the vehicles.
- All vehicles we inspected were visibly clean and free from contamination. We carried out checks on four vehicles and found ripped and frayed seats on one vehicle. We raised this with managers who were aware of this and had a plan to replace the seats with seats from another ambulance that was not in use.
- There was a clear understanding by staff of their roles regarding infection control. We found that staff followed the service's infection control policies. For example, staff told us the service encouraged single use cleaning products and colour coded mops and we could see this was being followed.
- Personal protective equipment was readily available for staff to use and we saw vehicles were stocked with hand sanitiser, gloves, hard surface wipes, labelled pump bottles of bacterial cleaner and spill kits. Staff could describe how and when they would use this equipment and understood the importance of handwashing over the use of anti-bacterial gel. We saw that ample stocks of cleaning materials were safely stored at the ambulance base.
- We observed staff carrying out good infection control practice. We saw staff use hand gel where available in the hospitals where they picked up or dropped patients off. They also used plastic gloves when moving patients from a hospital bed to the ambulance stretcher and vice versa. The crew members used disinfectant wipes to clean each stretcher after use.

- Clinical waste was securely managed. Waste was managed to ensure it was appropriately segregated, stored and disposed. We observed good waste management at the ambulance base and on vehicles. Staff bagged and binned clinical waste appropriately. An approved waste management company collected clinical waste regularly.
- Staff were issued with two sets of uniform, which they were responsible for cleaning. At the time of the inspection new uniforms were being rolled out to front line staff.
- We noted that there was no exchange programme for mop heads at the ambulance base, and the service was not able to evidence when mop heads had been changed. We brought this to the attention of the manager at the ambulance base and this was immediately rectified.

Environment and equipment

- The maintenance and use of equipment was arranged to keep people safe. Regular vehicle services were undertaken and crew members carried out daily vehicle checks. Faults were reported to vehicle manufacturers and tyre centres the service had contracts with. Compliance with MOT testing and vehicle servicing scheduling was prompt. We could see records of recent and upcoming servicing and MOTs. This was through an online system which could be accessed by all managers and a paper system at the ambulance base.
- The provider held a central record of all vehicles including their lease, servicing and MOT dates. This information was monitored centrally to ensure vehicles were sent for servicing well ahead of these dates to ensure they were not off the road unnecessarily. Crews inspected their vehicles at the start and end of each day and logged any faults. The station manager took the decision to remove vehicles from use based on the information reported. Staff reported that spare equipment was always available at the ambulance base if required.
- An external company was contracted to maintain and service's medical devices in accordance with manufacturer's guidelines. We saw records showing equipment such as the trollies in the ambulances had been serviced by an external company.
- The station environment was purpose built. Where staff used motor oils and other engine fluids we found safety information displayed. This meant staff would be aware of potential health issues when using them or what personal protective equipment to use.
- There were processes to ensure the security of vehicles. All vehicle keys were stored in a locked key safe with coded access by crews and managers only. The code to the key safe was changed on a regular basis.
- The service managed the replenishment of vehicles, equipment and supplies. We inspected a storage area for the service where we saw staff uniforms and various consumable items. All items were in date. Consumables included personal protective equipment such as gloves, gowns and face masks. Suitable equipment was available for both adults and children.

Medicines

- Medicines were safely managed and medicines were administered in line with the provider's policy. The service only stored and administered oxygen.
- Staff did not store or administer controlled medicines. No emergency medication was carried on the ambulances and staff did not administer medication.
- Oxygen cylinders were stored safely and securely on the ambulances and all cylinders we inspected were in date and safely secured. Medical gases were stored in a secured location in the garage of the ambulance base.
- Each ambulance was equipped with oxygen which staff could administer to patients if it had already been prescribed by a doctor. Staff were not allowed to alter the flow rate of the oxygen and could not administer more than four litres in line with company policy. Staff we spoke with explained how they would administer oxygen in line with the policy.

Records

- The service kept records of each patient transported. Patient journey data was entered onto an electronic system, and paper records were securely stored at the ambulance base and at head office.
- The service was aware if patients had up-to-date Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. Although the service did not keep patient records, we saw that this information was requested at the time of booking and kept on ambulance journey sheets.

Patient transport services (PTS)

Assessing and responding to patient risk

- Risks to people who used services were assessed, and their safety was monitored and maintained. All staff working on the ambulances were trained in basic first aid and basic life support which gave them initial skills to notice if a patient was deteriorating and when to call emergency help.
- Staff we spoke to could describe how to identify and respond to patients whose health deteriorated in their care. They told us they maintained constant conversation and observations of patients as a way of assessing risk.
- Staff were able to tell us how they would deal with violent or aggressive patients, although these situations were rare. Managers confirmed that staff were briefed in advanced on any concerns regarding patients, including the risks of violent and aggressive behaviour.

Staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. The service was fully resourced at the time of the inspection. Managers told us recruitment was not a challenge. All ambulance staff were on zero-hour contracts and staff we spoke to told us that this worked well as they still got regular hours, but it allowed them flexibility.
- Managers told us that they had never had to cancel a shift for an NHS trust, and that on occasion a manager with appropriate skills and qualifications had driven an ambulance to ensure a shift was not cancelled.
- Staff were adequately supported out of office hours and some of the staff covered shifts throughout a 24-hour period. Staff never worked alone at night. All staff we spoke with told us they were always able to contact the operational manager out of hours when working late or on nights.
- Disclosure and Barring Service (DBS) checks were completed for all employed staff to ensure they were safe to work with patients. Records were held on the electronic staffing records and alerts were flagged to inform managers if any staff were due to renew their DBS. We saw evidence this was complete for all staff and records were maintained.

Response to major incidents

- The business continuity plan for the service formed part of the strategic plan. The service had identified the risks in relation to these aspects of the service and set out what the potential impact on the organisation would be and identified what resources would be needed for the recovery of each aspect of the business. The service could extend staff shifts to deal with seasonal fluctuations in demand, including the impact of severe weather.
- Staff were made aware of the business continuity plan as part of their induction process, and managers were able to access the plan remotely

Are patient transport services effective?

Evidence-based care and treatment

- Policies and procedures were based on relevant and current evidence-based guidance, standards, best practice and legislation. This included the National Institute for Health and Care Excellence (NICE) guidance and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- Staff who worked remotely had easy access to all relevant guidelines and protocols they needed to do their job. Policies were located at the ambulance base and were easily accessible to staff. Policies included safeguarding, infection control, DNACPR, incident reporting and lone working. Staff could not remotely access electronic polices and updates whilst out on the road, although we saw that the service was in the process of rolling out hand held devices that ambulance staff could use which would give them access to policies remotely.

Assessment and planning of care

- Suitable equipment was available to patients. There were stretcher vehicles, wheelchair assisted vehicles, seated ambulances, and bariatric vehicles, depending upon the patients' individual need.
- The service relied on local acute hospitals to provide them with sufficient information to effectively plan for patients' care. The booking form allowed for the recording of any special notes such as whether a family member would accompany a patient. This assisted in the planning of care for service users.

- Staff reported they were given adequate information to allow them to appropriately deliver care, often provided by hospital staff. This allowed crews to plan the care for their patients.
- Pre-booked transport was planned and arranged at least one day in advance. The operations manager used an electronic system to plan and allocate the most appropriate resources to each patient based on the information provided.

Response times and patient outcomes

- The service did not monitor the number of journeys it undertook, response times and patient time on vehicles. Ambulances were booked out to hospitals for shifts and then were used as required by the hospitals to complete patient journeys.

Competent staff

- All staff were required to have an annual personal development review where training and development needs were identified. In the 12 months prior to the inspection, 80% of driving staff had received an annual review, but the service had plans to ensure that all reviews would be completed by the end of March 2018.
- Staff were encouraged and supported with training and to take responsibility for their own continuing professional development. Each member of staff had an individual learning plan which was updated as part of the annual review process. Learning plans covered short, medium and long-term goals. Managers and staff co-created relevant targets to achieve and these were reviewed. The service encouraged staff to undertake professional development.
- All staff were given an induction training. We spoke with staff about the induction programme and training provided. They told us it had prepared them well for the realities of the job, and told us that the quality of training had improved over the last 12 months.
- The provider assured themselves that staff were competent to drive by carrying out driving licence checks on all full and part time directly employed employees driving their vehicles. This check involved accessing the Driver and Vehicle Licensing Agency database to obtain up to date information on driver records and any endorsements that may have existed. Licences were also checked manually during the induction process to ensure they were valid.
- Staff were suitably trained and assessed to carry out driving duties safely. All relevant staff had completed a suitable ambulance driving training during 2017.
- The organisation used a web-based system and dashboard to monitor training and education of staff. It also contained details of driving licencing and DBS checks.

Coordination with other providers

- Care was delivered in a co-ordinated way by ensuring relationships were built with other providers of healthcare. The senior managers held regular meetings with hospital trusts where Emergency Response Systems were working in partnership. This enabled feedback to be shared, and ideas to be discussed.
- Other providers were consistently positive about the relationship they maintained with Emergency Response Systems.

Multi-disciplinary working

- The culture within Emergency Response Systems helped promote multidisciplinary team working. Staff at the ambulance base had an excellent working relationship with the base manager and staff we spoke told us that they could raise any issue.
- Staff also told us about the excellent working relationships they had with staff at the local hospitals they worked with and we saw this in practice. Nursing staff praised the quality of the service provided by ambulance crews and told us that crews were responsive to the hospital and patient needs., One manager told us that crews “could not be more helpful”.

Access to information

- Because of the nature of the service provided, ambulance crews were not provided information about the patients they transported in advance of each shift, to support the delivery of effective care.
- Staff we spoke with told us hospital staff made them aware of any special requirements. For example, they were alerted if a patient was living with dementia. We saw staff taking basic handovers from nurses and checking details, including medicines and DNACPR information.
- Staff and managers told us if they needed guidance, they called the manager at the ambulance base who would look up the relevant policy or guidance for them.

Patient transport services (PTS)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the importance of gaining consent in line with legislation and guidance, set out in the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
- Staff told us they had received training in the Mental Capacity Act 2005 and on consent, and that this training had been useful. Training was undertaken as part of staff induction and then as part of the mandatory training cycle.
- Staff told us if they had a patient who they suspected may be experiencing a mental health crisis, they would either call 999 in line with deteriorating patient guidance, or take the patient to a nearby hospital. However, staff could not recall any situation where this had happened.

Are patient transport services caring?

Compassionate care

- Staff understood and respected the personal, cultural and social needs of patients and treated them with compassion and kindness.
- Staff took the time to interact with people who used the services in a respectful and considerate way. We saw staff interact with patients and relatives in a positive, respectful and compassionate manner. They introduced themselves to each patient and we saw that staff were sensitive to patients' individual needs
- Staff showed sensitive and supportive attitudes towards patients and relatives. We saw crews greet patients in waiting areas and enquire after their health and wellbeing whilst escorting them to vehicles, clinics and patient homes.
- Staff we spoke with told us they would raise concerns about disrespectful or abusive behaviour or attitudes displayed by other staff, and explained this would not be in line with the core values or objectives.
- Staff ensured patients' dignity was maintained travelling to and from their vehicle. We observed crews providing compassionate care towards the patients they were assisting off and onto vehicles. Crews explained clearly to patients what they were going to do and did not rush patients to get on and off the vehicles. Patients were clothed and covered appropriately. We saw that crews kept umbrellas in the ambulances to help keep patients dry when getting on and off the vehicles.
- Staff responded in a compassionate way when people experienced physical pain, discomfort or emotional distress., Where patients were in discomfort, we saw staff alerted clinical staff once the patients arrived at their destination. However, staff were unable to administer any form of pain relief.
- We also saw patients were reassured by ambulance staff to allay fears.

Understanding and involvement of patients and those close to them

- Staff recognised when people needed additional support to help them understand and be involved in their care and treatment.
- Staff communicated with people so that they understood their care. We spoke to a patient who said she that crews "bent over backwards to help", and that they were "so helpful". We observed that crews were friendly with patients making sure that they were comfortable during their journeys.

Emotional support

- Staff understood the impact that a person's care, treatment or condition could have on their wellbeing and on those close to them, both emotionally and socially. We saw one patient who was concerned about being alone was constantly reassured by ambulance staff in a calming manner during their journey. Ambulance staff kept patients updated with transport details, and showing interest in the patient's care and wellbeing. One patient was returned back to hospital as they could not access the patients home. Once back at the hospital they contacted the patient's relatives and then returned the patient when they could gain access to their home. The crew took time to explain to the patient what was happening and included them in decisions that were being made.
- Patients who used services and those close to them received the support they needed to cope emotionally with their care. We spoke with two patients who had been transported to a local hospital. Both patients were very positive about the staff they had met. Their comments included, "staff could not be more helpful, and staff "…bend over backwards to help"

Patient transport services (PTS)

Supporting people to manage their own health

- Crews encouraged patients to be as independent as possible and provided support where required. We saw crew members enabling and encouraging patients to move independently, providing support and advice where appropriate

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- Patient transport services planned were aimed to meet the needs of people. At the time of the inspection the service did not have contracts with the hospitals they worked with. Each shift was booked on an ad-hoc basis. This meant that the service provided crews to hospitals as they were required. The service also offered a service whereby patients could book and pay for an ambulance privately. We were assured that the service had always been able to provide a service for people if booked in advance.
- There was regular engagement with clinical commissioning groups and other organisations to try to improve the service provided by ERS. This was done through meetings in person.

Meeting people's individual needs

- Services were planned delivered in a way that took account of the needs of different people. Ambulance staff showed us patient journeys were accompanied by booking details which highlighted any specific conditions such as dementia, learning disability, physical disability. Staff used this information to ensure the comfort of such patients.
- Staff told us their training equipped them to work with patients with learning disabilities and dementia. They told us that this meant that they felt confident transporting patients with these needs.
- Staff could access interpreting services for patients whose first language was not English. Language line was available for staff to use as a telephone service. We also saw that laminated picture cards were available to ambulance crews to help interpret.

Access and flow

- People were able to access the patient transport service by phone, email, or through the service's website. The service could be accessed during working hours from Monday to Friday. Calls were taken at the Gloucester office.
- The service took action to ensure resources were where they needed to be at the time required. Vehicles were allocated by the service depending ad hoc requests from local hospitals and private patient journeys.

Learning from complaints and concerns

- Data submitted for 2017 showed the service had not received any formal complaints. The service had a complaint policy and staff we spoke with knew how to access it. Staff were encouraged to resolve issues if and when they arose, and knew that they should advise a patient or carer how to formally complain to the service provider.
- People we spoke to who used the service knew how to make a complaint or raise concerns, and they told us they were encouraged to do so. We saw feedback leaflets were available on all vehicles with information on how to make a complaint., They also encouraged patients to use social media to provide feedback.

Are patient transport services well-led?

Leadership of service

- The managing director had overall responsibility for the quality, safety and sustainability of the patient transport service. The registered manager was the director who maintained oversight of operations.
- The service had recently appointed a regional manager to assist with the service's change management. They were involved in board meetings and decision-making. The regional manager was based at the ambulance base in Preston, and supported the base manager. They provided a link between the operational site and head office. All senior managers demonstrated a good understanding of the requirements of their role.
- Leaders and managers had the capacity, capability, and experience to lead services effectively. We saw that leaders had long service histories within the ambulance service and military service. The registered manager had been in post from 25 May 2011.

Patient transport services (PTS)

- Leaders understood the challenges to good quality care. Identified issues included the restructure of the organisation in April 2017, when they took over another ambulance service. The managing director described these issues during the inspection and we heard these spoken about across the organisation. The senior managers had focused on improving the quality of the service provided and engaging with local stakeholders. Senior managers recognised that their next challenge was staff engagement, and had discussed having regular staff meetings.
- Staff spoke highly of the ambulance base manager. We were told that they were always available at the ambulance base during working hours, and available by phone out of hours. The manager was described as 'reliable… always able to help out', and ''amazing… he knows everything"

Vision and strategy for this this core service

- Emergency Response Systems had a vision, strategy, and set of values which supported the overall company vision. The vision was to "build a platinum level multi-tier ambulance service covering a national footprint". Their mission was "to deliver safe, effective and responsive care to all our patients. Ensuring the human rights of all our stakeholders are considered".
- The senior management team set out their new strategic plan in October 2017. Senior managers told us that there had been no staff engagement with the plan. Staff we spoke with did not know about or feel engaged with the company's overall strategic direction. However, staff at all levels understood what the pressures and risks were for providing safe patient transport services.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There were arrangements for identifying, recording and managing risks, which included meetings and risk registers. The service had a corporate risk register and we saw how risks were identified and how control measures were put in place to mitigate them. We saw risks were reviewed by the senior leadership team and managers told us their 'worry lists' were reflected on the register.
- As part of the HSCA 2008 (regulated activities) Regulations 2014, providers are required to demonstrate how individuals who hold eligible roles are of good character to hold that role. We saw DBS checks in place for all director level roles.
- There was a programme of clinical and internal audit. We were shown an 'audit overview' which showed regular audits were undertaken at the ambulance base and head office including infection prevention control and vehicle safety. Information from the audits completed was monitored by senior management and used to improve performance. We saw that a previous audit had identified an immediate need to improve mandatory training and this had been rectified through remedial action. However, a lack of patient records prevented the organisation from auditing services and identifying where improvements or innovation could be made.
- Senior managers were clear about their roles and understood what they were accountable for. The clinical governance lead was the managing director, and governance issues were minuted at board meetings.
- The service undertook regular 'key lines of enquiry' audits against the five Care Quality Commission's domains of safe, effective, caring, responsive and well led. The service judged themselves as good to outstanding in all domains. Results of audits were shared at management meetings.

Culture within the service

- Most ambulance staff we spoke with felt respected and valued and felt that local management demonstrated openness and honesty.
- We saw that the leadership culture encouraged candour, openness and honesty. However, staff we spoke to told us that they did not know the senior managers, and were much more likely to engage with local management. This was mainly due to geography and the responsiveness of the local manager who staff told us could resolve issues on their behalf. Staff told us that they rarely needed to speak to senior managers.

Public and staff engagement

- Patient feedback analysis from December 2017 included responses from 41 patients. Patients were asked to rate five statements regarding their care including: the ambulance staff were reassuring; I felt safe whilst in the care of the ambulance staff; and I understood the

explanation of the care and treatment provided. All patients responded that they either agreed or strongly agreed with all five statements. When patients were asked if they were happy with the service overall, 71% strongly agreed, and 29% agreed.

- Ambulance staff we spoke with told us that they did not feel engaged with. Senior managers acknowledged that the transition to the new company had been unsettling for staff and planned to hold staff forums to improve staff engagement. However, they also told us they had excellent relationships with their local management at the ambulance base.

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

- Emergency Response Systems has implemented a flexible computer aided dispatch, compliance, booking and governance system to help co-ordinate the flow of people and resources in a health and social care setting. It had also earned the Armed Forces Covenant Gold Award, as an exemplar within their market sector, advocating support to Defence People issues to partner organisations, suppliers and customers with tangible positive results.
- The service demonstrated many IT tools it had introduced to support a governance system, and was in the process of rolling out hand held devices to all ambulance crews to improve efficiency across its services.
- All staff we spoke with were focused on continually improving the quality of care. Senior managers met with hospital representatives and listened to patient experience to assess and monitor the impact on quality and sustainability in order to improve.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure there is a member of staff who is trained to level 4 in safeguarding.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment At the time of the inspection there was not a member of staff who was trained to level 4 safeguarding for children and young people due to a recent resignation. Roles and competencies for child safeguarding training are outlined in 'Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT Third edition: March 2014, which states that in the case of independent ambulance providers, there should be a minimum of one level 4, a named professional.