South Central Ambulance Service NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this provider. It is based on a combination of information provided to us by the provider, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this provider.

Ambulance services

Patient Transport Services

Facts and data about this service

South Central Ambulance Service provides patient transport services (PTS) in Hampshire, Berkshire, Buckinghamshire, Oxfordshire, Surrey, Sussex and Milton Keynes. The service operated out of 41 stations. Some stations were shared facilities with front-line services and PTS, other stations were dedicated PTS facilities and some stations were in community settings where PTS services shared the space with other community services. The PTS service has 344 vehicles available to use across the locations.

A list of PTS teams is shown below:

Team name	Site Address	Days and hours of staff presence, where appropriate
PTS Hampshire	1-4 Woodside Road Eastleigh Hampshire	24 hours a day
	250 Ordinance Business Park, Aerodrome Road, Gosport, Hampshire	5am to midnight Monday to Friday
	6 Onslow Close, Kingsland Business Park, Basingstoke, Hampshire	5am to midnight Monday to Friday
	Botley Road, Hightown, Hampshire	24 hours a day
	Chaffey Close, Ringwood, Hampshire	24 hours a day
	Charlton Road, Andover, Hampshire	24 hours a day
	Eastern Road, Portsmouth, Hampshire	5am to midnight Monday to Saturday
	Evingar Industrial Estate, Ardglen Road, Whitchurch, Hampshire	24 hours a day
	Privett Road, Gosport, Hampshire	5am to midnight Monday to Saturday
	Testwood Lane, Totton, Hampshire	5am to midnight Monday to Saturday
	Unit 1 Downley Point, Downley Road, Havant, Hampshire	5am to midnight Monday to Saturday
PTS Milton Keynes	Milton Keynes General Hospital NHS Foundation Trust, Standing Way, Eaglestone Milton Keynes, Buckinghamshire	24 hours a day
	Whalley Drive, Bletchley, Buckinghamshire	24 hours a day
PTS Surrey & Sussex	Amis Avenue, New Haw, Surrey	6am to midnight Monday to Sunday
	Canada Avenue, Redhill, Surrey	7am to 7pm Monday to Friday
	Dorking Community Hospital, St Pauls Road West, Horsham Road, Dorking, Surrey	6am to midnight Monday to Sunday
	Ian Goodchild Centre, Knoll Road, Camberley, Surrey	6am to midnight Monday to Sunday
	Manor Farm Centre, Manor Farm Lane, Egham, Surrey	6am to midnight Monday to Sunday
	North Lane, East Preston, East Sussex	7am to 7pm Monday to Friday
	The Causeway, Worthing, West Sussex	Monday to Saturday - 7am to 8pm Sunday - 8am to 5pm
	Unit 1 Whiteknights Business Park, 10 Hammonds Drive, Eastbourne	Monday to Friday – 6.30am to 7pm Saturday - 9am to 5pm
	Unit 15, Pacific House, Sovereign Harbour Innovation Park, 1 Easter Island Place, Eastbourne	Monday to Saturday - 6am to 11pm Sunday – 7am to 10pm
PTS Thames Valley	111-112 Loverock Road, Berkshire	5am to midnight Monday to Saturday
	43 Hawthorn Road, Newbury, Berkshire	24 hours a day
	Banbury Business Park, Trinity Way, Adderbury, Oxfordshire	24 hours a day
	Broadway, Didcot, Oxfordshire	24 hours a day
	Chiltern Avenue, Amersham, Buckinghamshire	7am to 7pm Monday to Friday

	Churchill Hospital, Churchill Drive, Headington, Oxford	24 hours a day
	Evenlode Crescent, Kidlington, Oxfordshire	24 hours a day
	High Street, Chalfont St Peters, Buckinghamshire	7am to 6pm Monday to Friday
	Moreton Hall, Church Street, Maids Moreton, Buckinghamshire	7am to 6pm Monday to Friday
	Old Bracknell Lane, West Bracknell, Berkshire	24 hours a day
	Opecks Close off Wexham Park Lane, Wexham, Berkshire	24 hours a day
	Ormond Road, Wantage, Oxfordshire	7am to 4pm Monday to Friday
	SJA, Unit D2, Telford Road, Bicester	7am to 7pm Monday to Friday
	St John Ambulance, Caldecott Road, Abingdon, Oxfordshire	7am to 7pm Monday to Friday
	St Marks Road, Maidenhead, Berkshire	7am to 6pm Monday to Friday
	Stoke Mandeville Hospital - Ent 2, Lower Road, Aylesbury, Buckinghamshire	24 hours a day
	Welch Way, Witney, Oxfordshire	7am to 7pm Monday to Friday
	West End Street, High Wycombe, Buckinghamshire	24 hours a day
PTS West Sussex	Northgate, Chichester, West Sussex	7am to 7pm Monday to Friday

(Source: Routine Provider Information Request (RPIR) – Sites, vehicle tabs)

The service transported patients who were unable to use public or other transport due to their medical condition and included those who were, attending hospital outpatient clinics, being admitted or discharged from hospital wards or needed life-saving treatments such as radiotherapy, chemotherapy, or renal dialysis. From December 2018 to November 2019 PTS completed 590,058 non-emergency patient transport journeys. Including, 3,635 journeys for patients under the age of 18 which equated to 0.6% of journeys.

The journeys were booked and coordinated by dedicated contact centre staff, call handlers, planners and dispatchers, based in Eastbourne (West Sussex), Durrington (East Sussex), Dorking (Surrey), Otterbourne (Hampshire) and Bicester (Oxfordshire).

The trust employs 878 PTS staff who comprised of managers, ambulance care assistants (ACAs), contact centre staff, support and logistics staff.

The service employed hospital liaison officers in major hospitals (HLOs). HLOs linked with hospital staff to deal with patient transport bookings and queries, and to help with patient discharges from hospital.

Patient transport services was supported by a volunteer car service, members of the public who volunteer with transporting patients to routine appointments. At the time of inspection, there were 183 active voluntary car drivers working in PTS. From December 2018 to November 2019 volunteer drivers undertook a total of 85,532 journeys which equated to 15% of journeys.

The trust fulfilled contracts with 17 clinical commissioning groups across the counties it serviced.

Prior to the inspection we reviewed a range of information from and about the service. During our inspection we visited 11 PTS stations throughout the region the trust served:- New Haw, Camberley (Surrey); Eastbourne (Sussex); Totton, Eastleigh, Havant, Basingstoke (Hampshire); Reading, Newbury (Berkshire), Stoke Mandeville (Buckinghamshire); and Didcot (Oxfordshire). We visited the contact centres at Otterbourne (Hampshire) and Eastbourne (Sussex) and the SCAS training centre based at Newbury (Berkshire). We checked 23 vehicles and spoke with 11 patients and approximately 50 staff members. Staff members included contact centre staff, ambulance care assistants, managers and senior managers.

Is the service safe?

Mandatory training

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

Mandatory training completion rates

The provider set a target of 95% for the completion of mandatory training.

Provider level

A breakdown of compliance for mandatory training courses February 2019 to November 2019 for all staff in patient transport services at provider level is shown below:

Training module name	February 2019 to November 2019				
	Staff trained	Eligible staff	Completion rate	Provider target	Met (Yes/No)
Infection prevention control	816	820	99.5%	95%	Yes
Dementia awareness (inc privacy & dignity standards)	815	819	99.5%	95%	Yes
Health and safety (slips, trips and falls)	810	819	98.9%	95%	Yes
Equality and diversity	809	820	98.7%	95%	Yes
Manual handling not differentiated into people and object	808	820	98.5%	95%	Yes
Conflict resolution	736	776	94.8%	95%	No
Fire safety 2 years	753	819	91.9%	95%	No
Information governance	726	820	88.5%	95%	No

In patient transport services at provider level, the 95% target was met for five of the eight mandatory training modules for which staff were eligible. The service narrowly missed the target of 95% for conflict resolution and fire safety 2 years. The lowest completion rates were for information governance (88.5%).

(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training was delivered by a combination of e-learning and face to face training. Staff told us they completed their training within work hours and where given enough time to complete it. Staff felt the training provided was useful for performing their roles.

Systems were in place to continuously monitor training compliance. This meant senior staff could track staff's mandatory training rates and see if staff were in date, going out of date or had expired with their training. Staff were rostered the time to complete e-learning modules or attend face to face courses.

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.

Safeguarding training completion rates

The provider set a target of 95% for the completion of safeguarding training.

Provider level

A breakdown of compliance for safeguarding training courses from February 2019 to November 2019 for all staff in patient transport services at provider level is shown below:

Training module name	February 2019 to November 2019				
	Staff trained	Eligible staff	Completion rate	Provider target	Met (Yes/No)
Safeguarding adults (level 1)	810	820	98.8%	95%	Yes
Safeguarding children (level 1)	810	820	98.8%	95%	Yes
Safeguarding adults (level 2)	757	776	97.6%	95%	Yes
Safeguarding children (level 2)	756	777	97.3%	95%	Yes

In patient transport services at provider level, the 95% target was met for all four of the safeguarding training modules for which staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust had clear policies, training and reporting arrangements for safeguarding adults and children. Level 2 safeguarding was mandatory for all patient facing staff and this included clinical and non-clinical call centre staff. Staff we spoke with had completed their safeguarding training and protected work time was available for this purpose. Training included information on female genital mutilation and PREVENT, the safeguarding of people vulnerable to radicalisation.

Staff knew how to report safeguarding issues and had a high level of awareness identifying and dealing with local situations. Staff were confident in reporting and escalating safeguarding concerns. They could give us examples of when they had raised a concern. The reporting of safeguarding concerns was completed electronically on the trust's incident reporting system. Staff received acknowledgement of a referral, whether they received any subsequent feedback was dependent of the context of the safeguarding referral.

Cleanliness, infection control and hygiene

The service did not consider infection risk consistently across the PTS service. Equipment, vehicles and premises were not always visibly clean and this was not reliably monitored throughout the service.

During the inspection we checked 23 vehicles across the 10 PTS stations we visited. 21 of these vehicles were operational and being used to transport patients. The other two vehicles were off the road (VOR) and were currently not being used to transport patients. The 21 vehicles, being used

to transport patients, where either starting the day and therefore should have been cleaned down the night before or had already been used to transport patients and had returned to base before going out again to pick up patients. We found 10 of the operational vehicles we inspected visibly clean inside and outside. However, 11 of the operational vehicles and the two VOR vehicles were not.

Of the 11 operational vehicles, nine had dirty and dusty cab areas with five of these vehicles having dirty out of date hand sanitiser gels in the door wells. 10 vehicles had dirty floors in the area where patients travelled, with four of these vehicles having debris on the floor including a used glove in one vehicle and a dirty tissue in another. Five vehicles had dirty and dusty areas where the patients were transported, including dirty rails where the carry chair was kept on one vehicle. Two vehicles had tears in the seats, with one of these vehicles having a taped-up sign on the seat saying out of order. Chairs with rips or tears are no longer impervious to contamination and cannot be cleaned properly. In one vehicle, we found a used blanket left on a seat that had not been placed in a linen bag after use. In another vehicle we found an open pack of disinfectant wipes that had dried up but were still being used to clean the vehicle. This would impact on the disinfection performance of the wipe.

According to the trust's infection prevention, control and decontamination policy dated July 2018, staff were required to clean their vehicles and equipment at the end of their shifts. When discussing with staff about the cleaning of vehicles, we were told there was an expectation vehicles should be cleaned internally daily but it did not always happen due to operational reasons, such as shifts over running and there not always being time to clean vehicles at the end of the shift. We were told by staff at one station that vehicles were mopped out weekly rather than daily by the make ready team.

Staff did not complete any formal paperwork to show vehicles or equipment had been cleaned. This meant there was no record that vehicles had been cleaned down. Where cleaning had not been carried out we saw no evidence, or were told of no procedure, how this information was passed on to the team leader or to the next crew using the vehicle. Without this information there were no assurance vehicles were cleaned before use.

The PTS stations we inspected varied. Some stations shared their facilities with front-line services, others were PTS only facilities and some were in community settings where they shared the space with other community services. This meant, there were different amenities available to staff for the cleaning of vehicles. For example, some stations had dedicated areas where vehicles could be cleaned, including a power-washer for cleaning the outside of the vehicles. However, some stations and especially the stations which shared their services with the community, parked their vehicles in public car parks and had to walk their cleaning equipment through public areas (buildings and outside spaces) to get to the vehicles. We asked to see environmental risk assessments or other assessments to see if these practices posed any infection prevention and control (IPC) risks. Senior staff told us no assessments had been carried out. Therefore, if there were any IPC issues they had not been identified or considered.

In addition, lighting in one of the community car parks where the vehicles were kept was turned off at midnight. If journeys overran the vehicles were not returning to the station before the lights turned off, making it difficult to clean the vehicles at the end of a shift.

We found equipment on vehicles designed to prevent and control infections and manage any bodily fluid spillages. This included vomit bowls and bags, urine bags for men, and spill kits. Spill kits enabled staff to clean up spillages such as blood, urine and vomit safely and effectively. We saw decontamination wipes and hand sanitisers were available on vehicles. However, there was

no standardisation of equipment on vehicles and we found not all hand sanitisers were in date. Staff told us they did not use a checklist to identify if the required items were on the vehicles or consumables in date.

On two of the vehicles we inspected we saw there were tears in the seats, which could spread infection. We were told these had been reported and were waiting to be fixed. Both vehicles were still in use. Post inspection we were told to mitigate infection risks to the patients, damaged seats were not allocated to a patient when planning the journey. When damaged seats were reported a manufacturer's repair kit was provided until the vehicle could be taken out of service to facilitate the permanent repair. However, on one of the vehicles we inspected with a tear in the seat, a sign had been taped to it saying out of order. We found no evidence manufacturer's repair kits were being used to mitigate IPC risks to the patient.

Station garages were not always of a standard to keep vehicles and equipment clean. We saw areas that were dirty and equipment, which was in operation, was covered in dust. In one of the stations we also saw uncovered linen trollies with the linen covered in dust. In cleaning and store cupboards we saw old equipment, for example, a child's car seat which was dirty, being stored on the floor. We saw in one station store cupboard that the toilet cleaner was stored on the same shelf as cartons of semi-skimmed milk. Therefore, we were not assured that IPC standards were being followed throughout the PTS service.

Team leaders at each of the stations we visited, told us they completed two types of IPC audit. One audit on hygiene observation. This included hand hygiene, use of gloves, and vehicle hygiene. The second audit on the ambulance building. This included vehicle garages, storage and sluice areas. However, these were carried out on an ad hoc basis and there seemed to be no standardisation across the PTS service on how and when to carry out these audits.

However, the ambulance station offices and communal areas we inspected were visibly clean and tidy. We saw cleaning staff during our visits. There were notices in the staff room around the importance of arms being bare below the elbow and there were details on how infection could transfer. Posters displayed hand washing techniques at sink areas.

Staff were bare below the elbows and personal protective equipment (PPE) including gloves and aprons were available on vehicles for staff use. PPE is equipment used to reduce the risk of cross-infection.

Staff were provided with a trust uniform which they were expected to launder at home. Staff we spoke with about this were aware of the need to wash these separately at 60 degrees to ensure compliance with best practice guidance.

Staff told us, and we saw evidence at all of the PTS stations we visited, that vehicles were deep-cleaned every six weeks or wherever there had been a contamination risk. This practice made sure vehicles were decontaminated on a regular basis to help provide a clean and safe environment for patients using the service.

Environment and equipment

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

The PTS stations we inspected varied. Some stations shared their facilities with front-line services, others were PTS only facilities and some were in community settings where they shared the space with other community services.

All doors to trust buildings or areas required a staff pass or code to be able to access which meant only authorised people could enter the stations. Some stations had CCTV cameras which monitored certain areas for security purposes. Station bases had staff locker facilities, showers, toilets and kitchen areas available for staff to use. Facilities were clutter-free and well maintained.

Some stations had garages in which vehicles were stored when not in use. Other stations kept vehicles on forecourts either at the front or back of the premises. The stations we visited that where located in a community setting, kept their vehicles in a public car park. We were told of incidents where the vehicles had been tampered with overnight or staff had been harassed by members of the public making them feel unsafe. Staff told us there were no CCTVs in these areas. We asked to see environmental risk assessments for these areas and asked what security measures had been put in place following these incidents. However, staff working at the station did not know and we did not see that any additional security measures had been taken. Post inspection we requested risk assessments for PTS stations. However, the trust were unable to provide any. Therefore, at the time of the inspection there was no assurance the trust had oversight of the environmental risks or were addressing risks to staff and vehicles. Post inspection the trust carried out environment risk assessments for Camberley and New Haw PTS stations and provided us with the documentation.

Stations that had garages stored equipment in these areas. Storage was not always of a standard to keep equipment clean and stored appropriately. For example, wheelchairs stored at the Reading station. We saw broken equipment stored in Stoke Mandeville station which was waiting to be disposed of. It was labelled to show the equipment could not be used which is good practice and ensured damaged equipment was not being used. However, staff told us they were struggling to get this equipment removed by the trust's estates department which meant it was taking up valuable space in the garage that they felt could be used better. We saw new tyres were keep at the stations that had use of a garage. This meant tyres were always available if they needed to be changed, keeping vehicles in service and off the road for less amount of time. However, tyres were stored in an ad hoc way, resting up again garage walls and on top of each other which presented as a fire risk or increased the risk of fire spreading. They were also a trip hazard to staff and visitors. We asked staff at the stations if the storage of tyres had been risk assessed and guidance given about how they should be stored. Staff told us they did not know.

At the time of the inspection, the trust told us there was no trust-wide guidance for the storage of spare tyres. However, agreed to review how tyres were currently stored at PTS stations.

Post inspection we were shown the risk assessment from the Reading, Berkshire ambulance station which had been completed after the inspection on the 9th March 2020. The risk assessment included a list of hazards associated with the storage of tyres and the measures required to control exposure to the hazards. Although the risk assessment detailed the existing controls such as to store tyres neatly against the wall, there was no date when addition controls, for example, to limit the number of tyres stored and to store them on racking, would be completed. Therefore, it was unclear when issues found at the Reading station would be addressed and, we saw no evidence risk assessments had been carried out throughout the other PTS ambulance stations.

At the time of the inspection, the service had 344 vehicles. Since the transformation of the PTS services in 2019, there now was a fleet management team who oversaw all aspects of maintaining the fleet. Staff we spoke with at the stations told us how good it was to now have a centralised

fleet management team which gave them one point of contact and support in maintaining the vehicles. Stations still kept their own records regarding the status of their vehicles. There were wipeboards at the stations we visited, which listed the vehicle, its call sign, registration number, type, its actual base, whether it was leased, Ministry of Transport (MOT) testing and service details and whether it was operational. This gave staff a quick visual overview of their fleet.

Not all of the vehicles were owned by SCAS, some were leased from an external contractor. Maintenance of these vehicles was the responsibility of the hire company but the centralised fleet management team, station team leaders and senior operational managers maintained records so they could see vehicles were road worthy.

Records showed all vehicles were complaint with MOT testing and the vehicles were regularly serviced. There were appropriate records of insurance and tax. The service had vehicle breakdown cover for emergency assistance should the vehicle develop a fault whilst not at the station.

All keys to the vehicles were stored securely in locked cupboard and key safes when outside of the driver's possession which meant vehicles could not be used without authorisation.

Staff completed daily vehicle checks prior to the start of their shifts to make sure vehicles were road worthy. These were completed on smart phones which were allocated to each vehicle. If faults were identified, such as a dent in the body work or broken wing mirror, these would be flagged. If issues were found a defect form would be filled out and given to the team leader at the station. The team leaders would decide if the vehicle could still be used, used for specific uses only or needed taking off the road to be repaired. Staff we spoke with throughout the inspection said the timeliness for getting problems fixed was one of their biggest issues and did impact on the service offered to patients due to lack of vehicles on the road. They told us they were hoping now vehicles were being overseen by the central fleet management team, repairs would occur faster, meaning vehicles would be back on the road quicker. In addition, the fleet management team were using a new reporting tool for reporting vehicle status to help with vehicle management. However, this had only been in operation for a month prior to the inspection. Staff told us it was too early to see if these changes had impacted on getting the vehicles repaired and back on the road quicker.

Post inspection, the trust informed us that no incidents had been reported by staff relating to delays to patient's journeys due to lack of vehicles on the road since April 2019. During the inspection we did not ask staff if they incident reported patient delays due to issues with the timeliness of getting vehicle problems fixed.

We saw the trust supplied equipment to support patients being dropped off and collected from hospital settings, such as wheelchairs. The service also had access to specialise equipment that gave them easier access to people's homes. For example, the portable ramp system used for wheelchair usage. However, we were told by staff that certain specialised equipment, such as the portable ramps had to be shared with other stations. Staff gave us examples where they had rearranged patient discharges from hospital as they had to wait for equipment to be available. In addition, staff time was needed to go collect the equipment from the other station.

The trust supplied suitable equipment to safely transport bariatric patients. For example, stretchers, wheelchairs and a stair climber. All staff were trained to use the stretchers and wheelchairs. Staff had also undertaken additional training to use more sophisticated equipment when required.

Seats and seatbelts suitable for use by children and babies were available. When taking bookings for children, staff asked which specific equipment the child would require, considering their age, weight and other specific needs.

Staff were responsible for checking the levels of stock in the vehicle they would be using that day and replenishing any equipment they needed at the start of every shift. If staff required more equipment during a shift, then they would return to one of the stations to stock up. Staff told us there was no load list for vehicles which provided them with a checklist of items that should be on the vehicle or things they should check, for example, dates of consumables. This meant there was no record consumables had been checked and no way for team leaders to audit that vehicles contained the correct equipment at the start of shifts. Post inspection, the service sent us the current load list for vehicles dated June 2015 review date June 2020. The trust told us work had started by the PTS clinical governance leads, in coproduction with the staff, to review the list. Although there was a load list staff were unaware of it and therefore it was not being used to make sure vehicles were carrying the correct equipment and consumables.

Some stations kept a supply of linen, such as blankets to give to patients. At other times linen was sourced from the local hospitals if patients required it. Linen either remained with the patient upon arrival at their destination or was disposed of at the hospital as stations did not have the facilities to launder linen.

Sharps bins and bags for clinical waste were available on the vehicles. Clinical waste was generally disposed of at NHS locations as not all stations had clinical waste bins for staff to use at the stations.

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.

Patient had their individual risks assessed against the trust's standard criteria before a journey was booked. This included information on mental health issues, safeguarding, do not attempt cardio pulmonary resuscitation orders (DNACPR) and patients who were at risk of a fall. Transport could then be booked depending on the patient's requirements. For example, the number of crew or specialist equipment needed.

This information was shared with crew members via their hand-held smart phones. If crews wanted to add information regarding the patient, for example, information on how to access to a patient's property, they could add this information to the system and it was automatically shared. If vehicle crews had doubts when they arrived to pick up a patient about the suitability of the transport arranged or the patient mobility level booked, they would communicate this to the contact centre and an alternative vehicle would be sourced to ensure patients were moved safely.

Procedures were in place to support patients with additional needs. Team leaders at the PTS stations would carry out risk assessments on patients and their environments to identified risks before transport was arranged. This meant transportation risks could be mitigated before the patient was transported. This included the number of staff or specialised equipment needed to transport the patient effectively and safely.

Due to the nature of the service, clinical observations of physical indicators such as pulse, heart rate and oxygen saturation level were not undertaken during routine patient transport journeys. Staff were trained in basic life support (BLS) should a patient deteriorate during a journey. At the time of the inspection 97% of staff whom were required to have BLS had completed their training. Staff were expected to call 999 for an emergency ambulance should they identify a deteriorating

patient who needed urgent support. Staff received training in identifying the signs which indicate if a patient was becoming unwell. This was delivered through their statutory and mandatory training.

The service had a clear booking criterion which detailed the clinical risk level of patients. If patients were identified as at too high a risk of deteriorating or requiring a higher level of intervention from staff then they would be transported using the emergency services vehicles.

The smart phones had a tracking device which enabled staff in the control rooms and the PTS stations to be able to track where a staff member was. This meant the location of vehicles were known at all time if there were problems and assistance was needed.

The service risk assessed whether they could move patients sectioned under the mental health act before undertaking the work. If for example the risk was mitigated by the presence of an escort, they would convey the patient. If they needed a secure vehicle for their welfare and that of the public, the services could not offer the transport.

Staff acted if they suspected patients were at risk in other ways. We were told of staff members who checked on the welfare of their dialysis patients when they were not at home for pick-up as planned.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

The senior operational managers were responsible for reviewing staffing levels, skill mix and vacancy and sickness rates. They received weekly deficit reports from recruitment which showed the current level of staffing. Senior operational managers we spoke with told us there was an improving picture regarding staffing levels, this included the recruitment, retention and sickness levels of staff. Most of the stations we visited were fully staffed. Bank staff were used to cover sickness and staff vacancies.

Rotas and shift patterns were aligned to demand. In April 2019 the service had analysed demand across the counties. It was found that the service was under resourced and crews not in the correct place at certain times. This had led to shift arrangements being revised to meet demand. Managers told us these new arrangements were making a difference to patients and covered peak demand better. The majority of crew members we spoke with were happy with the new shift patterns. Since the transformation in 2019, staff scheduling was now completed by the scheduling department. Managers at the stations we inspected said this was working well as the scheduling team had a better oversight of the whole PTS service but still liaised with them to make sure shifts were covered to meet demand.

Tailored support was provided to staff returning to work from long term absences. We spoke with several staff members who told us how they had been supported back to work following periods of illness or maternity leave. Operational staff who became pregnant were offered work in the contact centres which meant they could continue working for the service in a safe environment and their skills were retained by the service. Staff spoke of a supportive environment which enabled them to continue working or return to work more quickly.

Senior staff told us about the successful recruitment drives the PTS service had undertaken to boost recruitment. SCAS had recently introduced an 18-month emergency care assistant

apprenticeship programme. The apprenticeship programme was opened to people who wanted a change of profession. The first 12 months was spent in the PTS service, where students learnt the fundamentals of care, compassion and communication whilst completing their apprenticeship portfolio. After 12 months, if certain qualifications had been achieved, students would be re-deployed to a frontline 999 operational team. The first cohort of students were currently working in the PTS service. PTS staff we spoke with told us it was working well and they saw it as a good way to introduce people into the ambulance service, learn vital skills and help staffing levels in the patient transport service.

Since April 2019, the contact centre had introduced better training and support for the call handlers and dispatchers when they first started working for the service and as they continued in their role. Early indicators showed this was helping with staff retention.

Ambulance care assistants

Provider level

The table below shows a summary of the staffing metrics for ambulance care assistants in patient transport services at provider level compared to the provider's targets, where applicable:

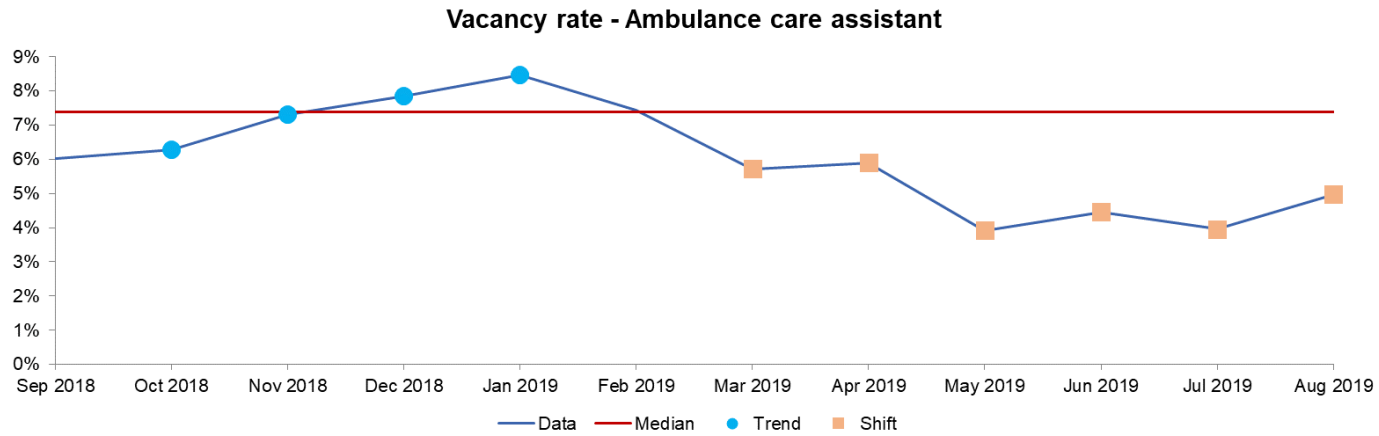
Staff group	Patient transport services annual staffing metrics September 2018 to August 2019						
					Temporary staff usage		
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		10%	12%	3.5%			
All staff	707	8%	20%	7.4%	3.5%	1.1%	96.7%
Ambulance care assistants	607	6%	20%	6.7%			

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Temporary Staff tabs)

Staffing rates for ambulance care assistants within patient transport services at provider level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

No data was provided for this staff group for bank and agency staff usage.

Vacancy rates



Monthly vacancy rates over the last 12 months for ambulance care assistants show an upward trend from October 2018 to January 2019 followed by a shift showing improvement from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

PTS call handlers / dispatchers

Provider level

The table below shows a summary of the staffing metrics for PTS call handlers / dispatchers in patient transport services at provider level compared to the provider's targets, where applicable:

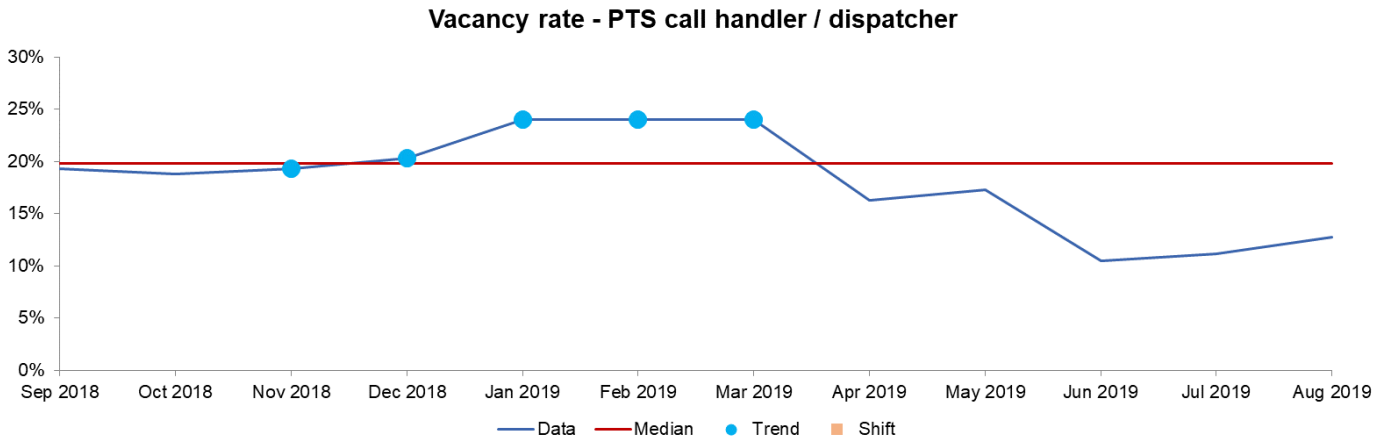
Staff group	Patient transport services annual staffing metrics September 2018 to August 2019						
					Temporary staff usage		
	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		10%	12%	3.5%			
All staff	707	8%	20%	7.4%	3.5%	1.1%	96.7%
PTS call handlers / dispatchers	100	18%	25%	11.1%			

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Temporary Staff tabs)

Staffing rates for PTS call handlers / dispatchers within patient transport services at provider level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness.

No data was provided for this staff group for bank and agency staff usage.

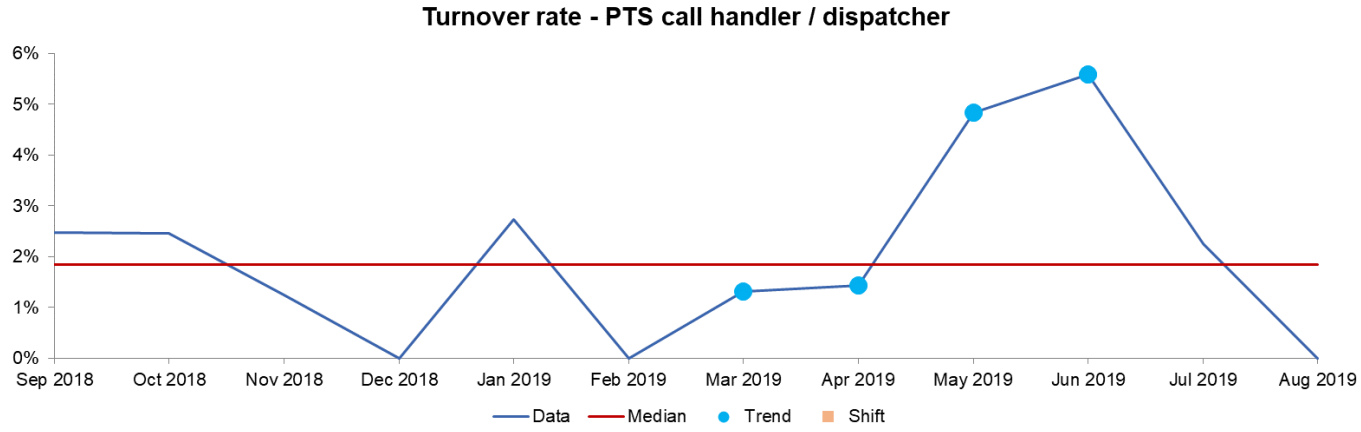
Vacancy rates



Monthly vacancy rates over the last 12 months for PTS call handler / dispatcher show an upward trend from November 2018 to March 2019. This could be an early indicator of deterioration but vacancy rates from April 2019 to August 2019 do appear to be reducing.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates



Monthly turnover rates over the last 12 months for PTS call handler / dispatcher show that while there were some months with 0% turnover an upward trend was identified from March 2019 to June 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover and sickness tab)

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 transport services used an electronic patient record system which stored patient information. Contact staff collected certain information about patients when they received a request for transport. The system could make special notes about patient's with known conditions such as patient living with dementia or with mobility issues. This would also highlight to the planning department what resources they needed to deploy. For example, staff trained in the use of patient oxygen.

The electronic patient record system interfaced with the PTS crew's smart phones. This meant when patient journeys were uploaded to the smart phones, patient information would be available to the crews making them aware of the patient's pre-existing conditions or safety risks.

Patient information was kept securely on all the information technology (IT) platforms and were password protected. This meant patient information could not be accessed by unauthorised people.

For palliative care patients using patient transport services, end of life care planning and do not attempt cardiopulmonary resuscitation information was available on the system.

Patient information was held on the computer system therefore there was no need for paper records. However, certain information such as patient discharge letters or the do not attempt to resuscitate information were carried by patients. Staff told us they checked patients had these documents before travelling but would travel alongside the patient. Staff also told us they would ensure any information was handed over safely at the patient's destination.

Medicines

The service did not use any medicines on board patient transport other than oxygen.

Patient transport services vehicles did not carry medicines for use by patients, with the exception of oxygen gas which was carried on some vehicles. Only ambulance care assistants who were trained to administer oxygen, could do so. Some patients brought and administered their own oxygen on journeys. Staff who had not been trained in the administration of oxygen could transport patients who could administer their own oxygen.

Oxygen cylinders were securely fastened to prevent the risk of injury to staff and patients on the vehicles we inspected. Medical gas cylinders were also stored safety and securely at the PTS stations, with appropriate hazard warning stickers. Cylinders were stored in a dedicated secure area that was clean, dry and well ventilated. Cylinders were stored to ensure segregation between empty and full cylinders. Oxygen cylinders we checked were in date. There were no oxygen cylinders stored at the shared-community sites we visited at New Haw or Camberley. If crews needed to replenish oxygen cylinders they did this at a local hospital where there was an agreement in place to do so.

Patients could carry their own medicines on journeys. For example, if a patient was discharged from hospital with medicines to take home. When this happened, either patients held them throughout their transfer, or alternatively if the patient was unable to do this, staff placed medicines securely in the vehicle.

Incidents

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

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.

Provider level

From December 2018 to November 2019 the provider reported no never events for patient transport services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Provider level

In accordance with the Serious Incident Framework 2015, the provider reported three serious incidents (SIs) in patient transport services, from December 2018 to November 2019.

A breakdown of the serious incidents by incident type is shown below.

Incident type	Number of incidents	Percentage of incidents
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1	33.3%
Medical equipment/ devices/disposables incident meeting SI criteria	1	33.3%
Slips/trips/falls meeting SI criteria	1	33.3%
Total	**3**	**100.0%**

(Source: Strategic Executive Information System (STEIS)

The service used an electronic reporting system for reporting incidents. All staff we spoke with were aware of how to raise an incident and could show us the electronic reporting system. Staff showed they understood what constituted an incident and told us they were encouraged to report incidents. Staff also talked about a no-blame culture and felt confident and supported to report incidents.

Incidents were investigated by the team leaders and they were given the necessary training to do so. Team leaders we spoke with could describe the investigation process and could tell us when it might be necessary to involve the senior operation manager or the area manager. Staff understood how information about incident investigation was escalated to the trust's clinical governance team.

From December 2018 to November 2109 740 incidents were rated as no harm, 589 incidents rated as low harm (minimal harm – patient required extra observation or minor treatment) and 84 rated as moderate harm (moderate harm: short term harm - patient required further treatment, or procedure).

However, during the inspection we were given examples of incidents that had been reported and how the team leaders had investigated them. Lessons learned from incidents were feedback to

staff so staff could reflect and learn how to avoid the same thing happening again. This helped to maintain the safety of the service. For example, increased incidents involving wheelchairs had led to a deep drive into the safe use of wheelchairs. From this staff training was reviewed and updated.

Staff told us information and learning from incidents was shared with them in several ways, face to face discusses, emails, through the staff 'Hot News' posters and the 'Staff Matters' newsletter. We saw posters and newsletters at all the stations we inspected.

Incidents themes and trends were discussed by the clinical governance group and any resulting action plans from these meetings would be cascaded back down to the station teams via the area managers. Post inspection we reviewed a selection of management meeting minutes and saw incidents were discussed including how the information was to be shared amongst the staff.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm.

SCAS had a duty of candour procedure which contained a set process that would be followed in the event of a notifiable safety incident. This involves a telephone call to make a verbal apology and to explain the process going forward. The patient or patient's relative will be updated with progress and provide full and honest feedback at the closure of the incident. This includes any actions and organisational learning as a result of the investigation. This includes a formal letter with an invitation to attend a face to face meeting with trust representatives.

From November to October 2019 the PTS service had been required to exercise their formal duty of candour on seven occasions.

Staff had an understanding of duty of candour such as being open and honest with patients and families when something went wrong and the need to offer an appropriate remedy or support to put matters right.

Senior staff in the PTS ensured actions from patient safety alerts were acted upon where needed and information shared with staff.

Is the service effective?

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

There were no specific National Institute of Clinical Excellence (NICE) guidelines for patient transport services. The service used guidance agreed nationally for the ambulance service which was supplemented by local standard operating procedures (SOP). Post inspection we reviewed a sample of SOPs on the transportation of adults and children. The SOP PTS 74/14 conveyance of children date of issue: August 2014, Updated: February 2016, Revision date: February 2017 was

still in operation at the time of the inspection. However, the trust told us post inspection that the SOP was being reviewed and a new version was to be issued in May 2020.

The service worked under contract to the local commissioning groups and managers ensured that the service was delivered in a way that was contractually agreed.

The service used nationally agreed assessment criteria to determine the eligibility of patients to use the service. Staff handling transport requests used specific questions and a checklist which included information on the patient's mental and physical condition to assess the patient's eligibility before agreeing to arrange transport. Patients with recognised medical conditions, for example renal dialysis and oncology patients, were exempt from the eligibility criteria.

Staff had access to guidelines and protocols through the trust's intranet site and information on their smart phone devices. Policies and guidelines were regularly reviewed by the trust to ensure best practice was followed. Changes were disseminated to staff via training and updates. Staff told us they received updates, for example changes to the equipment used for mobilising patients. We saw information was printed out in staff areas, and staff had access to a trust wide 'Hot News' and the 'Staff Matters' newsletter indicating trust wide updates.

Nutrition and hydration

Patient hydration and comfort needs were considered in planning journeys.

Journeys were planned and delivered to reflect the patient's need of hydration and nutrition and comfort breaks particularly when journey times were expected to be longer.

We observed dispatchers at the contact centre remind diabetic patients to ensure they had food with them in case of delays on the return journey from their appointments.

Vehicles carried bottled water in case patients were thirsty or needed to take tablets.

Pain relief

The service did not carry or use any pain-relieving medication.

Patient transport services did not carry any pain relief, instead relying on the patient's own medication which they could bring with them.

Response times

The service monitored and worked towards meeting agreed response times so that they could facilitate positive outcomes for patients. It used the findings to make improvements.

The trust held separate contracts with 17 different clinical commissioning groups (CCGs) across the regions it provided patient transport services. Each contract had set key performance indicators (KPIs) which the trust was expected to meet. For example, outpatient and day case transport patients do not wait more than 60 minutes after their agreed pick-up time; renal dialysis patients do not wait more than 30 minutes after their agreed pick-up time. KPI varied between CCG contracts.

Data was continuously collected and analysed by the service. Each month the information was presented at the contract review meetings where the patient transport service monitored its performance and used it to compare each region locality's achievement. Where KPIs where not met this was reviewed and discussed and an action plan put in place to raise standards.

Post inspection we were set data presented to the contract review meetings from each of the regions (Thames Valley, Hampshire, Milton Keynes, Surrey, Sussex) for January 2019 to November 2019. From the presentations we could see performance data was discussed in detail and trends over times were discussed. For example, calls not answered within the 60 second target were plotted on a graph to see if there was a specific time when call delayed occurred.

We reviewed the November 2019 KPI dashboards, which showed that many KPI were not met. For example, in the Thames Valley region on their CCG targets: 37% of KPIs were met, 42% of KPIs were nearly met, 7% of targets were significantly not met and there was 14% missing data.

We were told by senior PTs staff that a review of KPI across the regions was being carried out to ensure they reflect the service requirement, and balanced patient flow, patient experience and finance. It was felt some KPIs were outdated and no longer matched the service requirement with some contracts being awarded and KPIs set six to seven years ago. The review of KPI was in agreement with commissioners, acute hospitals and South Central Ambulance Service. Some changes to KPI had already been made. For example, the KPI for answering calls in the contact centre had been increased from 60 seconds to 90 seconds in November 2019.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Induction training for ambulance care assistants (ACA) had been reviewed and developed. All new staff had to complete a three-week induction course based at the SCAS dedicated training centre. There was a pass/fail element to week one and two, with staff not being able to progress to the next week of training unless they passed. Week one of training involved the driving standards, which was carried out by the driving standards team. Week two involved the manual lifting assessment. Week three involved the first aid at work course, and an introduction to SCAS from the chief executive. On the last day of week three ACAs would be introduced to the station where they were to be based.

Once at the station, ACAs would be given a new starter pack which continued useful information for new employees. Starter packs at each station contained standardised information but had been localised for the area where staff would be working. Local inductions included shadowing other crew members and completing competencies. Probation lasted six months, during this time performance was monitored and discussed at monthly one to ones. Senior staff we spoke with at the stations said the changes made to the induction process had reduced the dropout rate of new members of staff, helped retention and made sure staff were trained to a standardised level.

Training was seen as a vital part of patient transport service. There was an annual mandatory face to face training section for PTS staff, where staff would refresh their skills on basis life support, equipment and policies and procedures. Every 3 years staff were required to refresh their first aid

training. Staff told us about addition training sessions given to them when new pieces of equipment were introduced into the service.

Since April 2019, the contact centre had introduced better training and support for the call handlers and dispatchers when they first started working for the service and as they continued in their role. There was dedicated team of trainers who had designed a bespoke training plan which taught the skills that call handlers and dispatchers would need to carry out their role effectively and efficiently. Once the initial training had been completed and passed, new staff would shadow experienced members of staff and were mentored until they felt confident in their roles.

The training team had developed a competency framework, which defined the skills and knowledge needed to successfully perform the job roles in the contact centre. They had also developed aids for staff to reference back to if needed.

In addition, the team had developed refresher training for current staff which covered key areas such as smart phone training and telephone techniques. This programme was designed to keep contact centre staff skills up to date.

Staff we spoke with in the contact centres spoke highly of the changes made in their training and the continued support they received to carry out their roles. All said it had a positive impact on the service they were able to provide their patients as they felt more confidence in their roles.

Staff required to drive in their role completed a one week driving course by the driving standards team. Driving was continuously assessed by the station team leaders. SCAS operated a virtual points system. If staff should reach a set amount of points they would be referred back to the driving standards team for retraining.

We spoke with many staff who felt that opportunities for personal and professional progression were good within the trust. Several supervisors and managers had been promoted through a range of other positions.

Patient transport services used the volunteer drivers in the service. These were people who provided transport using their own cars, for patients who experience difficulties travelling to their appointments but were fully mobile. Before starting any voluntary work, the drivers needed to have enhanced disclosure and barring service checks (DBS) as a safeguarding measure. Their cars were checked for MOT and the correct insurance, occupational health checks and a fitness to work certificate issued. Once these were completed the driving standards department would carry out vehicle checks and driving assessments. They would then shadow other volunteer drivers until they felt confident.

Volunteer drivers were assigned a team leader who they would co-ordinate with. We were told by a team leader there was no face to face training for volunteer drivers, but all received a training booklet that included information on equality and diversity, mental capacity, dementia, safeguarding, incident reporting, information governance, infection prevention and control and personal safety and manual handling. Volunteers needed to sign to confirm their understanding.

Appraisal rates

Provider level

From November 2018 to October 2019 86% of staff within patient transport services at the provider received an appraisal compared to a provider target of 95%.

The breakdown of appraisal completion by staff group at provider level is shown below:

Staff group	November 2018 to October 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Provider target	Met (Yes/No)
Ambulance care assistant	467	521	90%	95%	No
PTS call handler / dispatcher	64	94	68%	95%	No

(Source: Post Inspection Factual Accuracy Return)

Managers supported staff to develop through regular development meetings and yearly, constructive appraisals of their work. At the beginning of each appraisal year, managers met with staff to agree their performance and development objectives for the coming year. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Managers would monitor staff performance throughout the year by having regular meetings and accompanying staff on patient journeys to assess their performance.

At the PTS stations we visited staff told us they had had an appraisal in the last year. They mostly spoke positively about the appraisal process and had found them useful in identifying training needs. Post inspection we asked for appraisal completion rates and found that 91% of PTS staff had now had an appraisal in the last year.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. However, working across PTS regions was in its infancy and still needed to be embedded.

We observed good multidisciplinary team (MDT) working in the regions. Staff worked together well to share equipment and manage vehicle shortages and senior operations managers worked together to standardise working practices. The service had recognised the need to look outside their regions to improve communications between them and improve working practices for patients, such as shared learning from incident reporting. The PTS senior operations managers from across all regions had started to have meetings, the first being in December 2019 and they had arranged to meet every four months going forward.

Since the transformation project in 2019, there was now more centralised teams, such as the fleet management team and the scheduling department. This meant there was more cross working.

We observed interactions between contact centre staff and ambulance care assistants (ACA). We saw that staff worked effectively as part of a team to resolve problems and to support patients. However, some ACAs did complain it was not always easy to get through to contact centre staff on the telephone which they found frustrating. Post inspection, the trust told us staff were encouraged to use instant messaging to contact the contact centre via their smart phones. In the event of an emergency, all contact centres had an emergency mobile number to enable efficient communication between the teams.

During the inspection, we were given details of a pilot scheme that was happening at the Stoke Mandeville station. Frontline 999 emergency crews were highlighting to PTS staff, after they had picked a patient up, if they thought the patient would require a risk assessment before they could

be discharged from hospital. This meant PTS staff could plan the risk assessment in advance and prior to discharge. The hope was by using this way of working, discharge delays could be minimised.

Senior operations managers told us they had good relationships with the care commissioner groups they held PTS contracts with and acute hospitals. They attended monthly meetings where performance was discussed and any issues highlighted and solutions found.

Staff across the regions described good working relationships with third party providers such as NHS hospitals, GPs, care homes and clinics. PTS hospital liaison officers (HLO) were working in the acute trusts to provide a key contact point for PTS and hospital staff. Their role was to help with patient discharge coordination, improve patients and hospital staff's understanding of the transport booking process and to facilitate staff training on how PTS works regarding understanding contracts and the patient eligibility criteria. During the inspection, there was a hospital awareness day at one of the acute trusts, where HLOs were on hand to liaise with hospital staff and introduce them to specialist equipment used to mobilise patients and to demonstrate the PTS on-line booking.

Health promotion

Staff gave support to patients and signposted them to other services if required.

Patient transport services identified patients requiring extra support during their initial assessment and ensured they accessed support services. The service worked with external agencies to provide services which were appropriate for the patient's needs.

Staff described how they would report on any changes to peoples' health and presentations to staff working in other services to ensure information was passed on.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion rates

The trust advised that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was provided in safeguarding level 2 training and also in day 3 of face to face training. The provider set a target of 95% for the completion of MCA and DoLS training.

Provider level

A breakdown of compliance for MCA/DoLS training courses from February 2019 to November 2019 for all staff in patient transport services at provider level is shown below:

Training module name	February 2019 to November 2019

	Staff trained	Eligible staff	Completion rate	Provider target	Met (Yes/No)
Face to face day 3*	521	725	71.9%	95%	Yes
Safeguarding adults (level 2)	757	776	97.6%	95%	Yes
Safeguarding children (level 2)	756	777	97.3%	95%	Yes

*Face to face day 3 training figures were provided by the trust on 11 February 2020, showing year to date compliance (with courses running until the end of March).

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke with understood the importance of consent when delivering care to patients. In most cases in the patient transport service this was implied consent and not documented.

Staff told us of times when patients were reluctant to travel. There were many reasons for this, including patients living with dementia who did not understand why they were being asked to travel or patients who did not want to attend a particular treatment session or appointment. Staff told us they would spoke with patients to understand the reasons for any reluctance to travel. Staff spent time engaging with patients where necessary to explain the process and offer encouragement. However, staff respected patients' decision when they did not actively consent to travel.

Staff told us they did not undertake the journey with the patient until the 'do not attempt cardiopulmonary resuscitation' form was reviewed and recorded on their smart phones.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Is the service caring?

Compassionate care

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

We found the trust delivered compassionate and caring service to patients. Feedback from patients confirmed staff treated them well and with kindness. Patients gave complimentary comments about the service and the staff using words such as helpful, wonderful caring service, friendly, happy, polite, put me at my ease.

Contact centre staff ensured information about a patient's particular needs were relayed to local crews through their smart phones. This included important information about personal preferences. Staff told us they used this information to tailor the care they delivered to the patient and to make sure patient's privacy and dignity were accounted for at all times.

When we spoke with crews they showed a genuine warmth towards their patients and were committed to providing compassionate care. We were given many examples from crew members which demonstrated this. For example,

- Operational staff would activate the safety pendant alarm service of elderly patients when

they have returned home after a lengthy time spent in hospital. They did this to make sure the alarm service knew patients were back home.

- A patient did not like the music playing in the PTS vehicle. Therefore, the crew member asked what music was played on the patient's wedding day. This was then found and played for the patient.
- Crew members told us how they made sure patients were home safe especially when they lived alone. They ensured the patient was warm, comfortable and had adequate heating, food and drink before leaving the premises. When appropriate they would make sure relatives were informed they were home
- We saw, and heard about, occasions when PTS staff had appropriately intervened to ensure patients received care and treatment.

Patients told us they often had the same drivers and really enjoyed their journeys. People said it felt like they were having a 'day out' rather than going to a hospital appointment. They talked about companionship, laughter and helpfulness from all the crews they had met.

During the inspection we saw communications from patient's praising the service they had received from volunteer's drivers. Comments included, 'the driver was so gracious, kind and gentle', 'the driver went above and beyond to make sure I got into my home safely after attending a hospital eye appointment' 'the driver shared my sense of humour and we shared a laugh and a half. We had a good old giggle'.

Results from the SCAS PTS patient survey 2019 showed that 95% of patients that responded were satisfied, above satisfied or very satisfied by the quality of service received and 92% of patients would recommend the service to family and friends. Negative feedback was mainly about vehicle comfort and long delays.

Emotional support

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

Staff understood the impact that patients' conditions may have upon their emotional wellbeing. Staff supported the patients throughout journeys as appropriate. Staff told us how they liked to ensure consistent staffing for patients who used the service regularly so that a supportive relationship could be formed.

Where necessary, staff provided emotional support to patients to minimise patient distress. The service acted to advise on or arrange other services for patients who needed them, for example social work referrals and assessments.

Feedback from patient's showed PTS staff were sensitive to their patient's well-being. Comments included, 'the driver knew when I wanted to talk or when I wanted to be quiet', 'all the drivers have been very good at their job, they make the experience of hospital treatment that little easier'

Understanding and involvement of patients and those close to them

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

Contact centre staff and PTS crews we observed dealt with the issue of eligibility for services tactfully and asked patients pertinent but polite questions to determine eligibility. Contact centre staff talked with kindness and compassion to patients who called in to book journeys. They were patient and gentle when trying to get accurate information from patients. They explained why questions needed to be asked to make sure patients received the correct service to meet their transport needs.

When delays occurred PTS staff would contact patients to update then regarding their transport. We observed dispatchers at the contact centre calling patients they apologised, explained why there was a delay, reassured patients and if needed gave patients a new expected arrival time.

During journeys operational crews asked patients about their needs and made them comfortable. They communicated with patients so they understood what was happening.

Is the service responsive?

Service delivery to meet the needs of local people

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

The patient transport service provided patient transport across Buckinghamshire, Berkshire, Hampshire, Oxfordshire and Surrey and Sussex for patients attending hospital outpatient clinics, being admitted to or discharged from hospital wards or needing life-saving treatments such as radiotherapy, chemotherapy or renal dialysis or deep vein thrombosis.

The service was commissioned separately by 17 care commissioning groups. Patient eligibility for the service varied between contracts. Each contract was individually managed and had a named person at the trust who was responsible for meetings with the commissioners to go through performance and resolve problems.

The service had hospital liaison officers in acute hospitals (HLO). Their role was to provide a key contact point for PTS and hospital staff. They dealt with bookings and queries, changes in patient appointments and problems that occurred on the day. Their aim was to ensure all patients were conveyed according to need and timeliness.

The service conducted an analysis of local demand. Staffing and resources were determined and designed around population need. Service capacity was planned to cope with differing levels and nature of demand in different localities. For example, staff shift times had been changed to make sure more staff were available at key times.

PTS team leaders were able to visit certain patients prior to booked appointments to assess their needs, such as access to property, mobility or other requirements. This ensured staff facilities and equipment were suitable for patients before their journey.

Meeting people’s individual needs

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

When healthcare professionals or patient's booked transport, the contact staff talked through people's individual needs such as mobility, vision and other factors that might affect the number of crew members and the type of vehicle allocated to their journey. This meant the correct crew, equipment and vehicle could be allocated to the patient which was appropriate to their needs and could transport them safety.

Where possible, continuity of care was encouraged for regular patients. For example, renal dialysis patients would be cohorted together or be allocated the same driver. This helped built a relationship between the service and patient. We were told by PTS staff the added benefit of this was changes in patients' health or well-being could be identified and flagged to healthcare professional involved in the patient's care.

Escorts such as family, friends, or professional staff could accompany patients where they met the eligibility criteria. However, these criteria did vary between contracts. Registered assistance dogs were allowed to travel on PTS vehicles but needed to be arranged at time of booking so other patients could be informed if necessary.

Staff could take patients' baggage, for example, if a patient had been discharged following a long stay in hospital. This was limited to one bag of property per patient according to the trust guidance. However, staff told us they would be flexible with this and could take more depending on the individual circumstance and how much room was available on the vehicle.

Patient transport services provided a service for patients with differencing medical needs, such as patients living with dementia, mental health needs, learning disabilities and end of life patients. Crews we spoke with told us they received training to support the needs of these patients but also used their experience which they had acquired whilst working in the role.

The trust had specialist equipment to cater for the needs of different patients, such as bariatric, patients with complex needs and children and babies. Patient transport service team leaders undertook pre-journey risk assessments for complex patients to ensured suitable equipment was planned and available to support the needs of the patient. This meant that the patient journeys undertaken resulted in a successful outcome rather than being aborted. PTS staff told us about the training they had received to use specialist equipment. They also told us the service was keen to pilot and assess new equipment that was being designed to help mobilise complex patients.

When necessary, relevant staff had secure access to patients' key safes, so they could enter property without patients having to get up. This was used where patients were unable to answer their door, due to mobility restrictions or other conditions. Staff told us they would always knock and call out to the patient before entering the property.

For patients where English was not their first language, staff had access to a telephone-based interpretation service 24 hours a day, seven days a week. Staff told us they did not always use formal interpretation services but would use other means of communication such as using a family member to interpret or using internet search engines to find translations. The use of a family member or internet search engines is not best practice as it is not possible to ensure accurate interpretation.

Access and flow

People could mostly access the service when they needed it, in line with national standards, and received the right care in a timely way.

The service used nationally agreed assessment criteria to determine the eligibility of patients to use the service. During the inspection we observed call handlers ensuring they completed the journey and patient details accurately. They asked patients about their particular mobility needs and access to the premises. This information was vital to reduce the number of aborted journeys and wasted appointments.

The patient transport service offered transportation for patients between 6am and 11pm, seven days per week. However, different clinical commissioning groups (CCG) required services to run between different times depending on the contract they had with the trust. Transport journeys were booked through the dedicated call handlers at the contact centres. A patient's first booking needed to be booked via the telephone either by the patient themselves or a healthcare professional. Subsequent journeys could then be booked via an online booking system. The online booking system meant patients could manage their bookings or check a journey status. Patients could also cancel bookings online if the transport was no longer required.

SCAS had produced an online booking user guide. This was a comprehensive and easy to follow guide which showed patients and healthcare professionals how to access the online booking system, make a booking and complete the equipment requirements. It also included a mobility guide which gave patients and healthcare professionals booking transport a reference to work out the number of crew or type of vehicle required to transport the patient safety. The online booking system also had an online popup chat box, where patients and healthcare professionals could chat directly to PTS support assistants if they required help using the booking system.

Between December 2018 and November 2019 50% of PTS bookings were made online. The trust did not have a target for the number of journeys booked via the system, although patients and healthcare professionals were encouraged to use the online booking system.

Call handlers did not always respond in a timely way. The service measured their KPI for patient call answering within 60 seconds, changed to 90 seconds in November 2019. Between December 2018 and November 2019, the percentage of calls answered within target was between 66% and 82%. The trust had a contract target to answer 95% of calls in the allotted time.

Allocation of patients' journeys was coordinated by planners and dispatchers working at the contact centres using a computerised allocation system. They were also responsible for liaising with operational crews, patients and appointment providers if there were delays in pick-ups or other problems such as vehicle breakdowns.

Operational crews used satellite navigation systems on their smart phones when transporting patients. This meant crews had access to the best and fastest routes to a patient's pick-up or drop off point. These systems could also point out if there were going to be delays to the journeys due to road works or accidents. These could then be relayed to the dispatch team.

Dispatchers told us part of their role was to look ahead, identify issues and work out solutions before things became a problem. For example, they told us if a delayed pick-up was going to occur they could ring the hospital and ask if appointment times could be swapped or ascertain the latest possible arrival time for the patient which meant they could still be seen. During the inspection we observed dispatchers liaising between operational crews, hospitals and patients working together to get a good outcome for patients.

Operational crew used their smart phones to talk to the contact centre. However, due to the devices not being connected to a vehicle call taking system, solo staff were unable to make or answer a call without stopping the vehicle. Some crews reported it was difficult to get through to the dispatch team when there were issues to report which could impact on collection times for the remainder of the day. Post inspection we asked for data relating to the call answering time or

missed call between operational crew and the contact centres. The trust was unable to provide this data, although we were told all call pick-up times were collected. Without this data the trust would be unable to tell if there was an actual or a perceived problem in contact centre staff answering operational staff's calls.

There was a patient charter which informed patients what was required of them when using PTS vehicles. For example, patients were told to be prepared and ready to leave two hours before their appointment time as they could be picked up anytime within this window. Patients in the Thames Valley area where given a one hour window. Patients being picked up for renal dialysis had a time window of 30 minutes. Patients were also told vehicle crews could wait 15 minutes for a patient to be ready upon collecting them. Staff told us they were flexible to patient needs, if their schedule allowed this and did not put other patients at risk. However; if they were unable to wait longer for a patient, the journey had to be aborted and would be rebooked. Trust data showed that there were 10,171 aborted journeys due to patients not being ready.

Data from the trust reported from December 2018 to November 2019 55,626 patient journeys were aborted which equated to 9.4% of total journeys. Reasons included, patients not being ready (18% of aborted journeys), alternative transport used (15% of aborted journeys), incorrect booking details (10% of aborted journeys) and patient medication not ready on discharge (3% of aborted journeys).

To reduce aborted journeys operational crews, since 2019, had been encouraged to call ahead to let patients know they were on their way. There were many benefits to this, it reduced anxiety to patients that their transport was not going to turn up but also gave the patient the opportunity to let the service know transport was no longer needed. This could free up resources and save the service money, for example, in petrol costs. If no one answered the telephone, crews would always attend the pick-up. Most crews we spoke with could see the benefits from the pre pick-up call but some commented it was hard to find the time if they were a single crew.

All data collected by the patient transport service was analysed by the trust to look for ways to improve the efficiency of the service for patients and staff.

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, including those in partner organisations.

Summary of complaints

Provider level

From November 2018 to October 2019, the provider received 459 complaints in relation to patient transport services (63% of the total complaints received by the provider).

The provider took an average of 33 working days to investigate and close these complaints. The trust's complaints policy states 'the trust would aim to provide a written response within 25 working days. If longer was required, to ensure a full investigation could be completed, the extended timescale would be sought by agreement with the complainant'.

There were 25 complaints still open at the time of reporting (5.4% of all complaints for this

service).

A breakdown of the complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of complaints
Clinical treatment	2	0.4%
Communication	18	3.9%
Other	10	2.2%
Patient care	27	5.9%
Transport	354	77.1%
Values and behaviours	48	10.5%
Total	**459**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the provider

Provider level

From November 2018 to October 2019 there were 171 compliments collected by the provider about patient transport services (11% of all compliments received provider wide).

A breakdown of compliments by team is shown below:

Team	Number of compliments	Percentage of compliments
Surrey	23	13.5%
Sussex	68	39.8%
Hampshire	25	14.6%
Buckinghamshire, Berkshire and Oxfordshire	55	32.2%
Total	**171**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The patient transport service clearly displayed information about how to raise a complaint. We saw information and leaflets in vehicles. Information on how to make a complaint was also available on the trust's website. Complaints could be made in person, by telephone, and in writing by letter or email. In addition, patients could raise concerns using the trust's feedback forms or patient experience survey.

All staff we spoke with were aware of the complaint's procedure which reflected national guidance. Staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to team leader or senior operations manager in the first instance. There was an emphasis placed on listening to the patient or relative to identify their needs and to address their concerns in a manner that improved outcomes for them, wherever possible. If concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint.

The service followed the SCAS complaints policy. The complaints policy stated that complaints would be acknowledged within three working days, and routine complaints investigated and responded to within 25 working days. Where the complaint investigation took longer than 25 working days, a holding letter was sent to the patient, explaining why the response was delayed.

The service had trained investigating officers who would carry out a thorough investigation of the complaint. This often involved talking to other organisations, such as GP surgeries or local hospital trusts. Staff indicated delays in reaching the 25 working day target to close a complaint was often due to the complexity of the investigation. Complainants were offered a face-to-face meeting or a telephone call with the senior operations managers or appropriate staff such as team leaders. At the end of the process a formal letter would be sent to the complainant which had to include how the complaint had been investigated, conclusions drawn, what action was to be taken following the complaint and next steps the complainant could take if they were not happy with the outcome.

Complaints were collated by the patient experience team where common themes were identified, and action plans put in place to minimise recurrence. It had been identified that delays to transport and staff attitudes were the main reason for complaints in PTS. We were told that the patient experience team had been working closely with PTS senior managers to address the common themes. It had identified that delays were often related to on the day bookings versus available resources and also incorrect bookings due to wrong information regarding the patient's mobility and the type of vehicle required. Poor communication was the main factor in perceived poor staff attitude.

Training had been provided to the contact centre staff in managing difficult calls and early resolution of concerns and patient dissatisfaction. PTS managers had also been working closely with stakeholders across the healthcare system to promote correct transport booking procedures.

Staff said learning from complaints and concerns was communicated to them either by their team leaders or via emails or the trust's 'Hot News' bulletins.

All staff we spoke with during the inspection were committed to providing an excellent service to their patients. Staff told us they saw learning from complaints and concerns as a vital tool to help them achieve this and drive improvement.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had undergone some restructuring of their service and management team since the transformation in 2019. Although there had been a period of instability staff were now seeing and feeling the benefits of the changes made, with stronger and more effective leadership.

There was a director of commercial services who oversaw the whole of the patient transport service. The service had a clear management structure in place with defined lines of responsibility and accountability.

The operational service was split into two groups and each group was managed by an area manager. The North group which covered the Thames Valley (Berkshire, Buckinghamshire and Oxfordshire) and Milton Keynes; and the South group which covered Hampshire, Surrey and Sussex. Each of the counties was managed by a locality manager. The locality managers managed the performance leads, customer care managers, senior operations managers and the renal managers in their county. The teams of ambulance care assistants (ACAs) based at the

individual PTS stations were managed on a day to day basis by the team leaders who were managed by the senior operations managers.

The head of the contact centre had overall responsibility for the contact centres with a locality manager managing the individual centres. The dispatchers and call handlers were managed on a day to day basis by the contact centre managers who were managed by the locality managers.

The newly formed central PTS teams; the fleet management team, the scheduling team and the continuous improvement teams had their own managers who reported directly to the director of commercial services.

During the inspection we spoke with managers throughout the PTS structure. We found managers to be knowledgeable about their roles and passionate about the team and the patients they cared for. They told us they operated an open and transparent management style.

Staff, in the main, told us their managers were visible, fair and approachable. All staff we spoke with knew who their immediate and more senior leaders were and felt able to raise concerns with them. During the inspection we saw ACAs engage with their team leaders when they needed support or advice. Contact centre staff had a system where they could put their hand up to show they needed support from their managers. We saw support was readily available. We saw several local leaders within the service had progressed through the trust which provided them with an understanding of a variety of roles.

Managers told us their role was to provide leadership which involved stepping in when there was a problem and changing it. They also encouraged staff to come forward with suggestions and empowered them to problem solve and innovate. More senior PTS managers understood the challenges to quality and sustainability to the service and could identify the actions needed to address them.

The trust had a leadership development programme which all line managers were required to attend, this included the executive directors. It consisted of three modules over six months and included areas such as personnel management, coaching, quality improvement and staff development. Managers we spoke with were complimentary about the programme, found it helpful for their role and thought it showed the trust was committed to looking after their staff.

Managers at all levels had recognised the need to work outside their own areas and regions to improve communications and working practices for patients and staff. For example, the shared learning from incident reporting, the standardisation of working practices and the better managing of resources. Managers believed with the changes made to the PTS structure since the transformation more cohesive working was now beginning to happen and would be developed further over time.

PTS staff talked highly of the trust's executive management team, especially the chief executive. We were given examples, where the chief executive had been out to the stations, met and accompanied crews on their journeys. Staff felt this gave the executive management team a real understanding of their role and issues they might face during their shifts. One newer member of staff was impressed that the chief executive had spoken individually with every new starter on their induction training. They felt this showed the organisation and the managers to be open, approachable and supportive.

Vision and strategy

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

The trusts vision was 'towards excellence – saving lives and enabling you to get the care you need' with a mission that 'we are with you when you need us, providing help and professional mobile healthcare to you and your community'.

The vision was supported by four key themes:-

- helping people access appropriate care by assessing individual needs and directing people to the most relevant service.
- dispatching emergency clinicians to treat people with life-threatening injuries or conditions and providing specialist care whilst transporting those people to the most appropriate healthcare facility.
- enabling people to stay safe and well in their own communities by providing mobile healthcare closer to home.
- supporting whole system healthcare by working with partner organisations to assess needs and plan care for local communities and individual needs.

To achieve this vision the trust had developed a strategy in 2017 which was reviewed during 2019 to ensure the trust was still relevant and up to date given the rapidly changing nature of health economy. There were six strategic themes:-

- clinical excellence – improving clinical outcomes, ensuring patient safety, and providing a positive patient experience.
- operational excellence – achieving response time performance standards, resilience and efficiency.
- effective stakeholder relationships – developing whole system solutions and seamless pathways of care.
- sound governance, value for money and a strong financial standing.
- leadership, staff engagement and a learning culture – developing the workforce, motivating and enabling our people to deliver excellence.
- a network of profitable and high quality non emergency contracts.

For the patient transport service the strategy involved, continued expansion of PTS, developing the right organisational structure for the service, modernisation of the service model, investment in staff, and using informatics and information technology to drive improvements in patient experience and service performance. Their vision for the service was 'we will be the market leading NHS provider for Patient Transport Services, delivering the highest quality of patient care'

The strategy included and was unpinned by the trust's core visions of: -

- teamwork - deliver delivering high performance through an inclusive, and collaborative approach which values diversity
- innovation – continuous improvement through empowerment of our people.

- professionalism – setting high standards and delivering what we promise.
- caring – for our patients and each other.

The trust's vision, strategy and values had been developed using a structured planning process in collaboration with staff and external partners. The trust had engaged with staff and stakeholders to seek their views on updating the vision, values and strategic priorities.

Staff we spoke with knew how their work contributed to the vision of the trust and the patient transport service and used the core values daily in their work. Although some staff had been unsettled by the transformation of the patient transport services, they knew the reasons for the changes and how it fitted into the long-term strategy of the trust and service. They were pleased the trust saw PTS as important and had a clear plan to make it a quality service for both staff and the patients it served.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

With all the changes in the patient transport service over the last 12 months, managers had worked hard to develop a positive culture in PTS. Managers told us progress was linked to action being taken in the service, such as listening and supporting their staff, looking after their well-being, better recruitment and resource planning and improving the training and development of teams.

Staff told us the culture was changing within SCAS. They felt the PTS was no longer seen as a secondary service to their front-line colleagues. This had led to staff feeling more valued, respected and supported. Staff that had transferred using the TUPE regulations to SCAS from other organisations, and had seen many changes in their working practices, but were now feeling more part of the team. Although managers recognised there was still more work to do in this area.

Staff working across PTS talked of a service working together to run an effective service for their patients. We were told of the good atmosphere in the teams, even when staff were under pressure, and how as a team, they shared the stress. Staff told us they felt proud to work for the organisation, to wear the SCAS uniform and be part of PTS. They were passionate about providing an excellent service to their patients. They spoke with pride about the plan to issue PTS epaulettes to wear on their uniforms and felt this was the trust acknowledging their service.

Staff told us they were always flexible and put the needs of the patients first, even where this meant missing a meal break. They understood the importance of their role to ensure patients got to appointments on time and how delays caused anxiety. The trust had recognised this and had introduced a reimbursement allowance when meal breaks had to be delayed due to workload.

Equality and diversity were promoted within and beyond the organisation. Staff explained that the service had made it easy for them to step down from operational duties when they needed to take on lighter duties. For example, when a member of staff became pregnant, they were immediately allocated light duties to reduce risks to mother and baby, or when staff were returning from periods of illness, or when unable to continue as vehicle crew because of injury.

Staff told us there was a health and well-being lead and we spoke with members of staff that were well-being champions. We saw staff well-being notice boards at station and were told of health and well-being days run at stations to promote support and benefits available to staff.

Managers and staff understood the importance of staff being able to raise concerns without fear of retribution. The trust had appointed a freedom to speak up guardian (FTSUG) which reflected national guidance and whom staff could talk to in confidence if they had concerns. The role of the FTSUG was created in response to recommendations made in the Francis report (2015) which found the NHS culture did not always encourage or support workers to speak up. Staff were aware of the freedom to speak up guardian role. We saw posters at the stations we inspected giving details of how to contact the speak up guardian. Most staff told us they felt confident to speak out where necessary.

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 had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Much of the governance function of the trust, including PTS, was held more centrally and was overseen by the clinical governance department and the patient safety group.

Data and information gathered from these groups was cascaded down to the senior operations managers and the contact centre managers. They worked with their teams to investigate issues and concerns and monitor performance. Information was reported back to the trust's clinical governance department and the patient safety group who would look for themes, trends and any outstanding issues.

This information would come back down to the PTS area managers and locality leads who would hold twice monthly meetings with the senior managers to review operational, quality and performance issues. These meetings had a set agenda which included, incident reporting, key performance indicators, complaints and compliments and safeguard concerns. From these meetings actions might need to be taken, such as retraining of staff, the change of a procedural or mitigation to minimise a risk. We reviewed a selection of senior management meetings and saw that issues were discussed and action plans decided upon which included who owned the action and the date of action review.

Crews and contact centre staff told us quality and performance data was cascaded down to them either by face to face meetings, the trust's 'Hot News' posters and the 'Staff Matters' newsletters.

Quality and performance data from the clinical governance department and patient safety group were reported upwards to the quality safety group and the board which ensured the board had a good oversight of the patient transport service.

Arrangements with partners and third-party providers were governed and managed effectively. Any sub-contractors had to work to the same contractual standards as SCAS PTS. The service ensured this was the case through audits and regular communication.

The service maintained positive and transparent communications with partners and commissioners about performance. We were told the locality managers met monthly with stakeholders where issues of quality and performance were discussed.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Since the transformation there was more of a focus on consistency of practice in the patient transport services which linked to improved quality and governance procedures for patients.

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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks identified in the patient transport service were placed on the PTS risk register. Risks were categorised from one to five depending on the area the risk sat in. For example, Risk 1- quality of care, patient outcome, safety experience and excellence; Risk 2 - performance; Risk 3 – Stakeholder perception and trust reputation, Risk 4 – viability/finance/estates; Risk 5 – workforce and development. PTS risk management mirrored the governance structure and formed part of the governance meetings. Risks had a date they were added, review dates, who owned the risk, severity of risk and an action plan/mitigation. We saw evidence that the risk register was reviewed monthly and action plans updated.

At the time of the inspection there were 16 risks identified on the risk register and aligned with issues staff had spoken about during the inspection or issues we had identified during the inspection. For example, maintenance for equipment and vehicles, infection control measures, estate risks and the suitability of sites for the purpose of delivering PTS services. Staff at all levels had an understanding of the PTS risks and what was on the risk register. However, the area and locality managers had more in-depth knowledge and understood the implication of risk to the service and therefore to patients and staff.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information technology systems were used effectively to monitor and improve the quality of care. The contact centre used a computer system to log patient information and used a transport logistics system to support computer-assisted route scheduling. Operational crews used smart phones which provided access to operational data including patient information. These devices had special instructions and a link to the route scheduling system for fast access. Details of daily vehicle checks, start and end journey times and other performance measures were also recorded on the smart phones. A computerised incident reporting and safeguarding system was used to collect data.

Data was taken from all these systems, analysed and used to understand performance, make decisions and used as a tool for improvements. As well as a way to assure the trust that standards and key performance indicators were being met.

Team managers had access to a range of information to support them with their management role. Senior staff had access to an easy online dashboard system which enabled them to see information. This included information on the staff's mandatory training completion and appraisal rates. This information was electronically collated, and a tracker report produced every month for team leaders and senior operations managers to be aware of their team's performance.

The trust and the patient transport service were constantly looking at ways to improve the quality of their data, whether this be through automated data collection systems or better training for staff in the collection of data.

All personal information from individuals was collected and processed according to the legal framework of the general data protection regulation (GDPR). The trust's internets pages gave patients information on how it collected, used, retained, protected and disclosed personal data.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service and its leaders had worked hard to improve engagement with the PTS staff and staff we spoke with, in the main, were positive about this.

Staff notice boards were used to communicate information to staff in a quick and accessible way. The boards were used to display such things as; good news stories, health and well-being advice, the names and images of the executive board and other key messages. There was also the 'Hot News' posters and the 'Staff Matters' newsletter. Staff told us they were well informed with developments in the trust.

The north of the PTS patch which covered Berkshire, Oxfordshire, Buckinghamshire and Milton Keynes produced a quarterly newsletter for the staff. This was a comprehensive newsletter which kept staff up to date with the happenings in the service. The newsletter included staff news, feedback from patients and updates on key performance targets. It also included highlights from staff social activities, public engagement days, updates from the staff forums and a health and well-being section.

There was a cohort of ambulance care assistants and contact centre staff who were nominated representatives who attended engagement forums. These forums were a formal way for staff to raise issues with the management team. There were agendas and forums were minuted. Recent issues raised had included, meal breaks, refurbishment of station facilities and lone worker safety. The staff engagement forums had been developed in response to the previous staff survey feedback.

The service operated a 'you said we listened' programme with the aim to enhance engagement with the staff and to see what mattered to them. For example, we saw 'you said' notices about baseball caps being issued to staff to stop sun stroke and the 'we listened' saying management would review how this could be funded to more the idea forward.

We saw suggestion boxes in the stations where staff could make proposals to management. Staff could either name themselves or make suggestions anonymously. Some ideas that had been suggested and taken forward by the service included issuing reusable water bottles to staff.

We were told of a vehicle group at Eastbourne station. These were a group of road-based staff who were asked to assist in the standardised layout of vehicles and could raise concerns or give feedback about the fleet.

The trust continued to look at ways to engage with their patients, the public and their stakeholders to raise awareness and improve the service offered to patients.

The trust used staff surveys to gather information on how staff were feeling. The heath and well-being team conducted a survey to find out what staff expect and areas that could be developed. Results showed that staff felt the trust could do more to support the staff's mental health and reduce stress. There was an eagerness for staff to support one another and staff wanted greater access to discounts, particularly around fitness. These trends had been incorporated into the health and well-being strategy.

Results from the 2018 annual national staff survey showed a good response rate from SCAS staff trust-wide at 63% which was an increase of 2% from 2017. A total of 90 questions were asked in the survey and compared to the 2017 results SCAS was significantly better on 15 questions and significantly worse on nine questions. Key improvements included quality of and the number of appraisals undertaken, staff felt they were more able to report harassment and bullying or ask for advice and there were more resources within the trust. Following the staff survey, action plans were developed trust-wide and locally for individual services. For PTS the action plan was to increase the national staff survey uptake, following the transformation period by focusing on quality, values-based appraisals and stronger staff engagement through forums and a staff newsletter. From speaking to staff at all levels and the evidence we looked at during the inspection, showed the service had taken action in these areas.

The trust held annual staff awards which recognised individuals and teams who went the extra mile to deliver care to patients. Members of staff and volunteers could be nominated by colleagues, patients and peers. Awards were presented at the annual staff awards night which was attended by the trust's board. In 2018 the patient transport service had won the SCAS award for innovation for a schedule they had put in place involving patient discharge. The schedule had been shown to improved patient discharge performance rates.

SCAS were keen to engage with patients and people who used the patient transport service. Free-post patient experience surveys were found on PTS vehicles and volunteer cars which patients could fill in. Information from these surveys were analysed every quarter by the patient experience team and results shared with the service to help make improvements.

SCAS ran community engagement forums throughout the counties it served. During the inspection we were told about a long-wait forum where patients who had experienced long waits could come and discuss the issues they faced, the problems it caused and to talk about solutions. The trust had started to pilot bi-monthly public talks in the evenings open to members of the public and stakeholders. These talks included a presentation on relevant topics and an opportunity for questions. They were proving popular and the two already held had been fully booked.

Trust and PTS representatives attended events throughout the year including schools, colleges and family fun days. Where possible a PTS vehicle and staff were provided to raise awareness of the service. We were told about PTS attending, the Emergency service day at Didcot, an employability skills event at a local school in Berkshire and hospital awareness days at the local NHS trusts.

SCAS had an active presence on social media which regular posts about the services offered and key service developments. There was a comprehensive SCAS webpage where much information on the trust could be found. This included a dedicated page for the patient transport service. This page contained details of the service, areas it covered, how to book the service, conditions of travel and how to give feedback on the service.

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. Leaders encouraged innovation and participation in research.

The service had identified key areas were changes and improvements needed to be made to drive the service forward and kept it sustainable. The trust had looked at the organised structure and reorganised, streamlined and delegated operations to ensure the most efficient use of resources. For example, the introduction of a fleet management team and scheduling department. Some changes in the reorganisation had unsettled staff. However, the benefit was beginning to be recognised and talked about positively by staff. Other changes, such as the fleet management team, were still in their infancy and needed to be embedded before the improvements to the service and hence patient care could be fully understood.

The patient transport service had identified the need to collect, monitor and analyse data better to understand performance, make decisions and improvements. Staff recognised more effective data monitoring systems would lead to improvements in patient experience and service performance.

The service recognised the need to develop the workforce to support and improve recruitment and retention. PTS had developed thorough and well thought out induction programmes for PTS crews and contact centre staff. This training was more effective at preparing staff for their roles and improving retention and the quality of service for service users.

The service was continuously developing its cross working with other organisations to improve services for patients. For example, the hospital liaison officers, whom were located in trusts, worked together with the trust to optimise the discharge process for patients.

During the inspection we were told of clinical innovation that was occurring in the service. For example, the renal team had developed a process to stop unexpected fistula bleeds for their renal patients. The process was designed so PTS staff could control the bleeding until emergency medical help could be obtained. This had been rolled out by the trust with information in a SCAS clinical memo (CG11 CM).