Ms. Judith Appleton

Wealden Ambulance Services

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Wealden Ambulance Services is operated by Ms Judith Appleton. The service provides a patient transport service.

We inspected this service using our focused inspection methodology. We carried out the announced part of the inspection, giving 48 hours' notice on 10 December 2020.

To get to the heart of patients' experiences of care and treatment, we normally ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? During this focused inspection we focused on part of the domain of safe and the whole domain of well led.

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

Following this inspection, we suspended the registration of this service for eight weeks, to allow the service to make necessary improvements. We found that:

- There was very little improvement since our last inspection in January 2020
- The inspection action plan submitted to CQC had not been updated or used to drive improvement. Therefore, there was little progress made on the must do and should do actions identified on our January 2020 inspection
- Staff training was not always undertaken. Staff did not receive training to the standard needed to enable them to meet the needs of those they cared for. An example of this included (but was not limited to) providing a service to patients detained under the Mental Health Act.
- Safeguarding training, systems and processes did not protect people from the risk of abuse. Safeguarding notifications were not submitted to CQC
- There were no systems or processes to monitor governance, risk or monitor quality in the service
- There was insufficient leadership in the organisation.

However:

- It was clear from our interactions with staff there was a commitment to improve the service.

Name of signatory

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	We found the following issues that the service provider needs to improve: • There was very little improvement since our last inspection in January 2020. • The inspection action plan submitted to CQC had not been updated or used to drive improvement. Therefore, there was little progress made on the must do and should do actions identified on our January 2020 inspection • Staff training was not always undertaken. Staff did not receive training to the standard needed to enable them to meet the needs of those they cared for. An example of this included (but was not limited to) providing a service to patients detained under the Mental Health Act • Safeguarding training, systems and processes did not protect people from the risk of abuse. Safeguarding notifications were not submitted to CQC • There were no systems or processes to monitor governance, risk or monitor quality in the service • There was insufficient leadership in the organisation. However, we found the following areas of good practice: • It was clear from our interactions with staff on the day of inspection there was a commitment to improve the service.

Summary of findings

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Summary of this inspection

Background to Wealden Ambulance Services

Wealden Ambulance Services is operated by Ms Judith Appleton. The service opened in 2017. It is an independent ambulance service in Battle, East Sussex. The service primarily serves the communities of East Sussex.

The managing director was the responsible individual.

The team that inspected the service comprised of a CQC inspection manager, one CQC inspector and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the registered location. We spoke with six staff including; patient transport drivers and management.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice before the most recent inspection which took place in January 2020.

At the previous inspection in January 2020 we found issues with the key questions of Safe and Well Led. The provider was issued with a list of actions they must and should take following the inspection

Activity (January 2020 to October 2020)

- There were 1,487 patient transport journeys undertaken between January and October 2020. 275 journeys for the local NHS Ambulance Trust, 691 patients discharged from accident and emergency departments, 376 inter-hospital transfers, 96 patients for social services and 49 patients sectioned under the mental health act.

The service employed 14 members of staff including a paramedic and patient transport staff. The accountable officer for controlled drugs (CDs) was the registered paramedic.

Track record on safety

The service reported no incidents between January and October 2020.

Complaints

The service told us they had received no complaints between January and October 2020.

Summary of this inspection

How we carried out this inspection

This inspection found there was very little improvement since our last inspection in January 2020. The post inspection action plan submitted to CQC had not been updated or used to drive improvement.

Staff did not receive training to the standard needed to enable them to meet the needs of those they cared for. This included including safeguarding where people were not protected from the risk of abuse.

There was insufficient leadership and no systems or processes to monitor governance, risk or monitor quality.

Areas for improvement

Action the provider MUST take to meet the regulations:

- The provider must ensure all staff receive training of a national accredited standard to enable them to meet the needs of those they cared for. Regulation 12 Safe care and treatment
- The provider must ensure safeguarding training, systems & processes protect people from the risk of abuse. Regulation 13 Safeguarding service users from abuse and improper treatment
- The provider must ensure there are systems or processes to monitor governance, risk or monitor quality in the service. Regulation 17 Good governance

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided some mandatory training in key skills to all staff but did not ensure everyone completed it. The service allowed staff to care for patients without training and when their training had expired.

The service had a training manager who was developing a training programme for staff. However, the training programme was not accredited to meet any national standards. The training manager had a Safety Training Award (STA) Level 3 qualification in Education and Training. This meant that although the training manager was qualified the training they delivered was not accredited to meet any national standards.

Mandatory training included: safeguarding adults, safeguarding children, Mental Capacity Act (basic understanding), infection prevention and control and health and safety awareness, which was delivered online. Basic life support, moving and handling, medical gases management and do not attempt cardiopulmonary resuscitation (DNACPR) training was delivered face to face.

The training manager also completed driving assessments with staff although they did not have a qualification to do so. The service did not provide training on mental health, learning disability, autism, dementia or end of life care.

The managing director provided care without completing mandatory training. The managing director who worked as part of the service, could not show they had ever completed any mandatory training. During the inspection, the training lead confirmed they had offered the managing director several dates to attend training, but the managing director had consistently refused to attend training. The managing director told us they regularly transported patients and the last patient transfer they had undertaken was on the 27 November 2020.

The provider could not be sure the staff transporting patients were trained to do so. Records we viewed on the day of inspection showed the provider kept a record of staff attendance at the training provide. However, staff we allowed to continue working when their training had expired and before completing training.

There was a spreadsheet to monitor training attendance. Records showed five out of 14 staff had not completed or were overdue their mandatory training, one staff member had completed first aid training, eight out of the 14 members of staff who required medical gases training had completed it.

Safeguarding

Inadequate

Patient transport services

Staff did not understand how to protect patients from abuse and the service did not work well with other agencies to do so. Staff had not received training on how to recognise and report abuse and they did not know how to apply it.

The service had an education lead who was developing a safeguarding training programme for staff, but the training programme was not accredited or recognised to meet the required standard.

We could not be confident staff had received safeguarding training to the required standard. The training lead told us safeguarding adults and children training was provided to level 2 but the training was not accredited. Staff did not hold the level of knowledge required to understand their safeguarding responsibilities.

Staff did not always make safeguarding referrals when it was appropriate. We reviewed one patient record during the inspection and the information recorded about the patient should have led to a safeguarding referral being made. Staff told us they did not make a safeguarding referral as the patient was detained under the Mental Health Act and making the safeguarding referral was the responsibility of the mental health team. This was incorrect and staff should have made a safeguarding referral.

Staff accessed safeguarding advice the training lead who had been trained to level 3 in adult and child safeguarding. Staff also get safeguarding advice from a member of staff at the local NHS ambulance trust who was trained to level 4 in adult and child safeguarding. Staff we spoke to on the day of the inspection knew how to get safeguarding advice.

Staff were unaware that when a safeguarding referral of abuse or allegations of abuse was made, a statutory notification must be sent to the Care Quality Commission. We had not received any notifications for the period January 2020 to October 2021.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient and did not remove or minimise risks.

Staff were not aware of, or prepared for, the risks that might occur during a journey. The service did not have acceptance criteria, either inclusion or exclusion. and accepted all patients for transportation. The service did not complete any risk assessments before transporting a patient.

Staff told us they made their own judgements about the safety of the patient journey when they met the patient and used their “common sense” to decide if it was safe to proceed. They told us they would refuse to transport a patient if they felt the risk was too high.

The service had a Deteriorating Patient Policy. It was reviewed and updated every three years. The next review was due in June 2023. The policy stated all staff should have a minimum of a first aid certificate in addition to basic life support training. Records seen on the day on inspection showed only one member of staff out of the 14 employed had a first aid certificate. The policy stated the team managers were responsible for auditing this policy and procedures to help safeguard patients and crew however the service did not do any audits against this policy in the 12 months before the inspection.

Patient transport records showed one example where staff were alerted to a situation that required an urgent convey to hospital. Staff called 999 for assistance from the local NHS ambulance trust. The staff did not have access to handheld devices and used their own personal mobile phones.

Inadequate

Patient transport services

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, not all staff had been trained to use medical gases.

The service had recently employed a paramedic who was the clinical lead for medicines. The paramedic had suspended the use of all medicines (excluding medical gases) until they had developed patient group directions (PGD), trained staff in medicines and associated policies and procedures. A PGD is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Staff took carry bags containing oxygen and nitrous oxide cylinders on each patient transport vehicle. Only eight out of 14 staff members had completed training on medical gases, but all staff were permitted to carry and use medical gases on the patient transport vehicles.

Medical gasses were checked and stored in line with national guidance. Four medical gas carry bags were stored in a locked storage cupboard within the ambulance base. Each bag was secured with a green security tag. The tag denoted the date the medical gases had been last checked. All four bags had been checked in December 2020. Each bag was signed out of and back in to the storage cupboard on a sign in sheet within the locked storage cupboard. The key to the storage cupboard was stored in the managing director's office. Medical gas cylinders not in use were stored in an outdoor metal storage cage. The cage was locked on the day of inspection and inspectors saw the cylinders were stored separately according to type of medical gas and if they were full or empty.

The service had a controlled drug accountable officer and a Home Office controlled drug licence. A controlled drug is a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction. The control applies to the way the substance is made, used, handled, stored, and distributed. Controlled substances include opioids, stimulants, depressants, hallucinogens, and anabolic steroids.

Are Patient transport services well-led?

Inadequate

Our rating of well led stayed the same. We rated it as inadequate.

Leadership

Leaders did not have the right skills, ability or experience to run the service. They did not understand or manage the priorities and issues the service faced.

The managing director was informed at the previous inspection that this provider was incorrectly registered with the Care Quality Commission in January 2020. An application was not made to resolve this until September 2020. The managing director applied to cancel the current individual registration and applied to be a registered organisation with the Care Quality Commission. This application is being considered by the registration team. There was no registered manager at the time of inspection.

Inadequate

Patient transport services

The provider missed opportunities to engage with CQC and to improve the service. Prior to the inspection the manager failed to provide information requested by the CQC about the service and this information had to be requested using our powers under section 64 of the Health and Social Care Act (2014) and regulation 10 of the Care Quality Commission (Registration) Regulations 2009. A letter warning, from the Head of Hospital Inspection, was sent to the responsible individual informing them their actions amounted to obstructing the CQC from carrying out their regulatory work.

The managing director was unable to show an appreciation of changes needed to drive the required service improvements identified at the last inspection. Staff were unable to locate the post-inspection action plan and the managing director said it had not been reviewed for a substantial length of time.

We found a chaotic leadership style in the service. This meant there was a fragmented approach to resolving issues and addressing concerns. The staff told us they were did not understand the priorities of the business and what changes needed to be made to ensure they were working with regulation.

Staff's current knowledge base was insufficient to drive the changes needed to improve standards. It was clear staff were trying their hardest to address the shortfalls in the service, but their own training and development needs were not being identified or met. We also identified occasions where staff attempted to address specific concerns but were not given the autonomy or support to do so.

Staff told us there was a lack of leadership visibility and we received a mixed response when we asked if they were approachable. However, it was widely recognised by staff that the recent changes to the service structure meant they felt there was better support and manager visibility. The provider had recently employed a paramedic who was the clinical lead for the service, a training lead and a patient transport manager who had responsibility for fleet logistics.

Vision and strategy

The service had vision for what it wanted to achieve but did not have a strategy to turn it into action

The service had a vision for what it wanted to achieve. The service's vision remained unchanged from our previous inspection. It was "To be committed to delivering high quality care to patients while developing ways of working to ensure patients receive the best care in a timely manner." The service's mission was, "To provide a caring, positive, and safe experience for all our patients." The service had a set of values, these were, 'Respect and dignity; Compassion; Working together for patients; Everyone counts."

However, it was clear when talking to the managing director, managers and staff that this was not embedded in practice. We found no evidence of any monitoring systems to measure the quality of the care or the values outlined in the mission statement.

Culture

Although managers across the service told us the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values, some staff reported not feeling they could talk openly to the provider.

Inadequate

Patient transport services

Our last inspection found some staff felt unable to talk openly to the managing director. Our findings at this inspection remain mostly unchanged. However, recent steps had been taken to make the patient transport services (PTS) and training managers the main contact for staff. Staff told us this was beginning to have a positive impact on the level of support provided and their ability to raise concerns.

Over a period of six months we received information of concern regarding the culture of this organisation. The information alleged staff were unable to raise concerns with the leadership team. At this inspection we found there was no formal way for staff to raise concerns and little had been done to reassure staff their concerns would be listened to or taken seriously. During the inspection, the leadership team gave us a recent example where staff recently felt unable to raise a specific concern. However, despite knowing staff felt unable to raise what sounded like a potentially serious concern, no action was taken to address the serious nature of the issue, or to improve the systems for staff to raise a concern without fear of reprisal.

The staff we talked with showed compassion and care for the roles they performed and people they cared for. It was also clear there was a genuine commitment from staff to improve the service. We saw commitment from the staff to do the right thing but this was limited by the chaotic management style and inability to take action.

Governance

The service did not have clear governance processes overseen by the managing director. The service was not using a systematic approach to continually improve the quality of its services.

The managing director had failed to address the issues outlined in our previous inspection report so the service could not be assured it was providing safe, effective, caring, responsive and a well led service. Our 2019 inspection found serious concerns with governance systems and processes. Our current inspection found no real improvement.

The managing director and managers were unable to describe the governance systems and processes. There had a very poor understanding of what constituted governance, although the managing director told us they understood the impact of not having effective governance systems and processes.

Information about the safety and quality of the service was not routinely collected, collated or reviewed because there were no formal auditing processes to do so. This meant the provider could not be assured of the quality of service or prevent safety incidents by reviewing incident and safeguarding information. It also meant the provider missed an opportunity to continually review their practice and reduce risk of noncompliance with the regulations.

The service did not have systems for gathering, recording and evaluating accurate information about the quality and safety of the service provided. We were provided with a sample of governance meeting minutes. However, there was very little recorded that could be used as enough evidence of a functioning governance meeting, systems or processes. There was no set agenda and no actions recorded despite the provider assuring CQC in January 2020 a new minute taking template would be introduced.

Management of risks, issues and performance

The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Patient transport services

The service provided inspectors with a hard copy risk register and an electronic risk register. However, when we reviewed the information logged in both systems, they neither matched or contained appropriate risks. The risks recorded related to the everyday running of the service, rather than the strategic risks to the organisation. We saw examples of risks we would have expected to see recorded, but which were absent. For example, the provider had recently lost a contract at a local NHS trust; we would have expected the substantial financial risk to the business to be an entry on the risk register. We would also have expected to see an entry related to COVID-19.

The service did not continuously monitor known risks and may have missed an opportunity to mitigate and manage the specific risks. We found risks associated with the "business as usual" aspects of providing a PTS service were identified and recorded. However, these risks were not regularly updated. This meant the service was unaware of the current risks in the service. For example, we would have expected to see risk assessments in relation to the COVID pandemic or loss of business contracts with the local trusts in their risk register.

The service had introduced an electronic application incident reporting system which staff used via their phones. There was no evidence staff were provided with training on incident management.

There was insufficient evidence to show all staff were being made aware of the learning from incidents, or any changes to practice as a result. We found no evidence to suggest actions resulting from incident management were completed There was no system to monitor and implement the agreed actions from incidents and there was no process for analysing trends and themes to prevent recurrence.

We reviewed three incidents and identified concerns with staff reporting, investigation outcomes, and proposed actions. For example, we saw delays in staff reporting, and one incident which had been reviewed twice and had two different actions recorded. The proposed actions for one incident was to provide staff with additional driver training. However, the staff member assigned to provide the this was not qualified to do so, and the staff member never received it.

The service did not have a formal patient acceptance criteria. It was unclear how staff were making the decisions to accept transport journeys. The leadership team told us crews stayed onsite at their local NHS trusts and took referral directly from the clinical areas by telephone. However, with no formal acceptance criteria and a lack of a robust risk assessment process the service could not be confident it was able to meet people's individual needs. We were told that if the crews were unsure, they could call the duty phone for support. Staff we spoke to confirmed they had telephoned the duty manager when they needed advice.

The service could not be assured that all staff were aware of their role and remit. The service had a 'Deteriorating Patient' policy which stated staff should not work outside their remit. However, there was no formal description of what the specific staff roles and remits were at the service. However, we did find one example where staff were alerted to a situation that required an urgent convey to hospital. Staff called 999 for assistance from the local NHS ambulance trust.

Many of the policies were not regularly reviewed to ensure they reflected national and best practice guidance. For example This meant the provider was missing an opportunity to ensure safe care and treatment for those using the service. It also meant there was a lack of clear guidance for staff working in the service.

Did they have business continuity, major incident, inclemenyt weather plans plans etc?

Information management

Inadequate

Patient transport services

The service did not formally collect, analyse, manage or use information to support all its activities. However, the service's electronic systems had security safeguards.

The inspection findings related to data management remain unchanged. The service failed to use information in a way to monitor and improve the quality of care. However, the provider had started to count the number of journeys undertaken and recorded the type of journey.

The service had computer-based business management systems to support the business and its operations. These systems were set-up with individual password protection for each person. This allowed staff access to the parts of the system they needed to fulfil their role and enabled the service to restrict access to systems people did not need. The provider also had an information security system to protect all private and confidential data.

The leadership team told us there was a staff member who held a lead role on data protection.

Public and staff engagement

There was limited engagement with patients and staff, the public and local organisations to plan and manage services.

The provider had a system to collect patient feedback. This was collected in two ways, electronically by using a QR code and a tablet device, and with hand written comment cards. The leadership team told us they had not received any concerns or complaints in the last six months. We saw three thank you cards during the inspection with positive feedback. The service did not formally collate feedback for trend and theme analysis.

There was no structured way to communicate or engage with staff at the time of the inspection. There was no formal way to seek information from staff to improve patient and staff experience. However, managers told us they were in the process of starting up formal meetings.

At our last inspection the leadership acknowledged a staff survey was an area for improvement; this had not been implemented.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	S18 Notice of Decision to suspend registration of a regulated activity • There was very little improvement since our last inspection in January 2020 • The inspection action plan submitted to CQC had not been updated or used to drive improvement. Therefore, there was little progress made on the must do and should do actions identified on our January 2020 inspection • Staff training was not always undertaken. Staff did not receive training to the standard needed to enable them to meet the needs of those they cared for. An example of this included (but was not limited to) providing a service to patients detained under the Mental Health Act. • Safeguarding training, systems and processes did not protect people from the risk of abuse. Safeguarding notifications were not submitted to CQC • There were no systems or processes to monitor governance, risk or monitor quality in the service • There was insufficient leadership in the organisation.