

Ambulnz Community Partners Ltd

# Ambulnz Community Partners Ltd

## 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

Inspected but not rated



Are services safe?

Inspected but not rated



Are services effective?

Inspected but not rated



Are services well-led?

Inspected but not rated



# Summary of findings

## Overall summary

Our rating of this service stayed the same. We did not rate the service at this inspection.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Staff had access to good information.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services. Staff were committed to improving services continually.

However:

- The services risk register contained instances where a risk had been identified as being able to be mitigated, however there was no detail provided about the mitigation put in place.
- The service did not have face to face, or equivalent, team meetings, where all staff members were present, however there were station drop-in sessions and weekly one to one meetings available.
- The service did not always appraise staff within annual time limits.
- Records of manager's one to one sessions with staff were not structured or detailed in a clear way.

# Summary of findings

## Our judgements about each of the main services

| Service                   | Rating                  | Summary of each main service |
|---------------------------|-------------------------|------------------------------|
| Emergency and urgent care | Inspected but not rated |                              |

# Summary of findings

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# Summary of this inspection

## Background to Ambulnz Community Partners Ltd

Ambulnz Community Partners Ltd is operated by Ambulnz Community Partners Ltd. It is an independent ambulance service in Manchester, Lancashire. The service provides ambulance transport services to both adults and child patients across England, from five sites located in; Audenshaw, Rotherham, Goosnargh, Cramlington and Watford.

The service opened in 2018 and has had a registered manager in post since November 2018. It carried out the following regulated activity:

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

For the period of December 2020 to November 2021, the service carried out the following types of journeys:

- 28827 patient transport journeys;
- 14090 emergency department patient journeys;
- 5106 mental health patient journeys; and
- 952 urgent care journeys

We have inspected Ambulnz Community Partners Ltd previously in July 2019 and we rated the service as good overall. During our last inspection we did not identify any breaches of regulations and we did not carry out any enforcement action.

## How we carried out this inspection

We carried out an unannounced focussed inspection of the service on 7 December 2021. We focussed on the emergency and urgent care core service. We carried out this unannounced focused inspection because we received information giving us concerns about the assessment of patient risk. We inspected the parts of the safe, effective and well-led key questions for the service.

The team that inspected the service included a lead CQC inspector and a team CQC inspector. The inspection was overseen by an inspection manager.

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

## Areas for improvement

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

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

#### Emergency and urgent care:

## Summary of this inspection

- The service should ensure that a register of risks to patients is completed fully, with a description of the controls put in place, if a risk is documented as being able to be mitigated. (Regulation 12(2)(a))
- The service should ensure that staff appraisals are within annual time limits. (Regulation 18(2)(a))
- The service should consider a way to facilitate full team meetings, if they cannot be held face to face.
- The service should consider recording staff one to one sessions in a more detailed and structured manner.




# Our findings

## Overview of ratings

Our ratings for this location are:

|                           | Safe                    | Effective               | Caring        | Responsive    | Well-led                | Overall                 |
|---------------------------|-------------------------|-------------------------|---------------|---------------|-------------------------|-------------------------|
| Emergency and urgent care | Inspected but not rated | Inspected but not rated | Not inspected | Not inspected | Inspected but not rated | Inspected but not rated |
| Overall                   | Inspected but not rated | Inspected but not rated | Not inspected | Not inspected | Inspected but not rated | Inspected but not rated |

# Emergency and urgent care

|           |   |
|-----------|---|
| Safe      | Inspected but not rated  |
| Effective | Inspected but not rated  |
| Well-led  | Inspected but not rated  |

## Are Emergency and urgent care safe?

Inspected but not rated 

### Mandatory training

**The service provided mandatory training in key skills including basic life support training to all staff and made sure everyone completed it.**

Mandatory training modules included principles of health and safety, equality and diversity, fire safety, infection control, mental health awareness, mental capacity act and deprivation of liberty safeguards. We reviewed the training completion data for all staff and noted a high degree of completion across the service.

Staff were able to tell us about the training they received, what it was for and when they would have refresher training. Staff could also tell us that there was a training manager in place, whose role was to monitor and contact staff members and prompt to complete any outstanding training.

We observed the provider had an electronic system in place which gave a compliance colour of red, amber or green to an employee's role. This was available for the employee and their manager to view by logging in to their account. From this an employee or manager could identify which modules of learning were required to be completed.

### Safeguarding

**Staff understood how to protect patients from abuse and the service alerted other agencies as required. Staff had training on how to recognise and report abuse and they knew how to apply it.**

We reviewed the organisations adult and child safeguarding policies. This detailed the named professional for safeguarding for the provider, which was the operations manager. We reviewed documents which demonstrated that the operations manager had completed level 5 adult and child safeguarding accredited training. The policies included the different types of abuse and the process for reporting any safeguarding alerts, which was through the provider's designated safeguarding lead. Within the child safeguarding policy, there was specific sections which covered female genital mutilation and, the prevention of radicalisation.

Staff told us that they had annual safeguarding training that covered both adults and children at level 2. If they were part of a mental health patient transport crew, staff told us adult and child safeguarding at level 3 had to be completed.

We reviewed safeguarding training compliance information, which demonstrated:

## Emergency and urgent care

- 94% of staff compliance with child safeguarding level 2 training
- 95% of staff compliance with child safeguarding level 3 training
- 93% of staff compliance with adult safeguarding level 2 training
- 97% of staff compliance with adult safeguarding level 3 training

We reviewed staff records which evidenced references and DBS checks were obtained and in date, prior to a staff member being employed.

### Cleanliness, infection control and hygiene

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

We reviewed documentation which included training about hand hygiene and clinical and non-clinical infection control. Compliance levels were 97% for hand hygiene, 100% for non-clinical infection control and 95% for clinical infection control.

We reviewed seven policies that the service had about infection prevention and control. These policies covered areas such as; COVID-19 measures, how to handwash, management of clinical waste, ambulance vehicle cleaning standards, station cleaning procedures and infectious diseases information. We reviewed deep cleaning audits and ambulance station cleaning logs, for all ambulance sites. The audits and logs were completed in line with policy and a sampled selection of the audits showed an average level of 95% compliance.

Personal protective equipment was located within both the ambulance station and ambulance vehicles for crew to access. Staff members could access the operations manager for advice and support with infection control and prevention issues.

### Environment and equipment

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

We observed that the ambulance station on site was clean, tidy and uncluttered. The floor of the ambulance station was colour coded which clearly marked ambulance parking bays and walkways. Patient consumables were stored within locked areas and were all within expiry date.

We observed that there were designated areas for; storage of oxygen tanks, cleaning products and clinical waste management. Each designated area had visible posters or information, to remind staff about the requirements and legal obligations of using them.

We reviewed documentation which included training about medical devices, principles of health and safety and waste management.

## Emergency and urgent care

We observed a sample of ambulance vehicles and noted they were clean, tidy and in working order. All equipment within the vehicles was within expiry date. We reviewed the vehicle fleet safety and service record from the provider, which recorded vehicle MOT tests where applicable, most recent service details and any outstanding repairs required. We reviewed documentation and observed onsite that portable appliance testing was carried out within required time frames.

Transport vehicles for patients who were detained, were appropriate and safe.

### Assessing and responding to patient risk

**Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.**

We reviewed patient transfer policies which detailed risk assessing a patient's individual circumstances, before any journey took place. The Patient Transport Risk Assessment included common patient risks, any controls that would be actioned immediately and further additional controls as needed to reduce the risk to as low as reasonably possible.

We reviewed patient transfer policies which related specifically to the transporting of patients who have a mental health need. These policies described a clear process of risk assessment at the point of booking and during the transport journey.

We spoke with staff who told us how the risk assessment process would happen in practice and observed two calls that were taken by the control room staff where the risk assessment documentation was completed. This was comprehensive and in line with policy documents.

Staff told us that they were trained to carry out their own assessment of patient risk and level of need so that the right support could be provided. This approach included staff recognising that it was their responsibility to assess this and to not rely on the instruction of another organisation or professional, alone.

We reviewed the patient transport risk policy document and also, we were told by staff about the procedure for any patient deterioration during a journey. Depending on the type of journey being undertaken this was to either provide lifesaving interventions by the crew or to stop the journey and request emergency ambulance support.

### 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 and adjusted staffing levels and skill mix. All staff were given a full induction.**

The service's staffing levels showed there were 194 members of staff across the providers five ambulance sites. We reviewed staff training records, which detailed that relevant training was completed by staff dependent on the type of journey that they would crew. For example, urgent care journeys had staff that would be trained and qualified in either level 3 or 4 first response emergency care (FREC) and mental health journeys had staff trained in mental health awareness and learning disability awareness.

# Emergency and urgent care

We reviewed the electronic system used by the service which planned the staffing levels for each vehicle. This system was able to inform managers about crew members who had worked over a certain number of hours or had not enough rest time between shifts, to enable better planning. The system supported managers to arrange cover for staff who could not work due to sickness or leave.

We reviewed the new staff induction training timetable and materials and sampled a member of staff's completed induction record. The induction was completed over a period of five days and included key learning of both; classroom-based work and also being on shift under the supervision of a team leader. The service did not employ any agency or locum staff. All bank staff followed the same induction and training as other staff members.

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

The service had a data management policy in place which included details about the data to be processed by the organisation and, the roles and responsibilities of all members of staff. We reviewed a sample of five urgent care patient records and five mental health transport patient records.

The five urgent care patient records included relevant information about the patient's circumstances, presentation and outcome of the journey. Within the patient record there were specific sections to be completed by the crew such as; cardiopulmonary resuscitation and defibrillation details and patient monitoring. There were additional patient continuation forms, which could be attached to the patient record, to document any relevant information.

The five mental health transport patient records also contained relevant information which included, whether the patient was detained under the Mental Health Act 1983 and if any degree of restraint was used and reasons for this. Before or during a journey, ambulance crew could be informed of special notes or information by the control centre by a system which would transmit these, to crew tablet or mobiles phones located within the ambulance. The patient record and any continuation form was also the basis for a handover to the receiving organisation.

Staff told us that patient record forms were collated centrally following each patient journey and then scanned into a secured electronic system, the paper copies were then destroyed. Staff told us they had password protected access to their own area of the secured system, to be able to view records, training and information which was relevant to their role within the service.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned 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.**

We reviewed the providers adverse events policy, which detailed the procedure of recording any events or incidents, the roles and responsibilities of staff members relating to an incident and how staff would be trained. The policy included requirements about supporting patients where an adverse incident had impacted upon them, for example telling them about an investigation outcome and where required, giving an apology.

Staff told us that any non-routine occurrence during a journey, was to be recorded as an adverse incident or journey and details were to be entered onto the electronic system about what had happened.

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We observed the electronic system where staff could report incidents and we also reviewed a sample of adverse incident forms. The adverse incidents forms contained a level of detail which was proportionate to the incident and where appropriate included a record of the investigation and any outcomes. Where there were recommendations and learning, this was recorded in the form of an action plan which was assigned to a staff member to be completed by a certain time.

The service made information about policy and procedure changes, available to staff by updating training modules and posting bulletins on the provider's staff intranet page.

### Safety Performance

**The service used monitoring results well to improve safety. Staff collected patient journey information and shared it with commissioners.**

We reviewed journey information reports which were provided to organisations who commissioned the service. This broke down journey types into categories for example, incidents where restraint had been used. The safety performance information that had been gathered over the previous twelve months to inspection was consistent

## Are Emergency and urgent care effective?

### Evidence-based care and treatment

**The service approached 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.**

We reviewed the service's patient transport policy. This document provided guidance and information to staff which clearly referenced relevant parts of the Mental Capacity and Mental Health Act and associated codes of practice.

Staff told us that they were aware of their responsibilities when carrying out a patient journey. This included crew introducing themselves by name and asking the patient how they are. Staff told us that a key theme in any patient interaction was being open and honest with them.

During our time on site, we observed that managers could look at an overview of an employee's general role compliance. This was highlighted by a colour coded system, which helped inform a manager's next steps in identifying areas for improvement.

We also observed and reviewed several patient experience cards, which were noted by the ambulance station manager on duty and fed into staff feedback and service improvement.

# Emergency and urgent care

Staff were able to tell us about the different types of Mental Health Act detention that patients could be under and the differences for example, the detention time limits under sections 2 and 3. They were aware of the requirement for correct paperwork to be produced, so that the transport was lawful and correct. The crew would contact the control centre to abort a journey, if the correct detention forms could not be provided.

Staff were aware that patients could not be transported against their will or restrained in any manner, if they were an informal patient. An informal patient is a person who is within a hospital setting voluntarily and is not detained under any section of the Mental Health Act.

## Patient outcomes

**The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

We reviewed feedback from audits that were carried on the service by other organisations and noted that where improvements were suggested, action plans were put in place. An example of action taken was to implement the use of single use mop heads at all sites.

The service compiled journey statistics and number breakdowns and reported these back to commissioners at monthly meetings, to identify trends and patterns. This could be fed into service improvements, if any were identified.

## Competent staff

**The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance, within the services prescribed time limits.**

We reviewed staff induction materials which included training about basic life support skills, managing medical conditions, patient moving and handling and ambulance vehicle familiarisation. We reviewed a sample of four employee records. This evidenced that appropriate checks were carried out, for example driving licenses.

The service had a dedicated training manager in post to provide in house training, learning and development. Where a staff member's training record was flagged as being non-compliant, this was monitored in real time and within quarterly senior managers meetings.

We reviewed staff training records which clearly detailed completion and expiry dates for modules, so that managers were aware of when staff would have to undertake refresher training. Training included a module on mental health awareness, which covered supporting patients experiencing a mental health crisis and also patient restraint.

We reviewed the service's probation and appraisals policy, which clearly detailed the probation period and appraisal process for employees. The policy gave guidance on what was expected from both managers and employees from the appraisal process. For example, the information discussed included a review of an employee's driving behaviours, absence record and disciplinary record.

In reviewing a record of employee appraisals and when they would be due to take place, we found that 38 were overdue. However, the provider acknowledged that the difficulties caused by the COVID-19 pandemic, were a contributing factor to this.

# Emergency and urgent care

## 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.**

The service worked with their commissioners, which included NHS ambulance trusts, to agreed service standards and procedures for example staff training, competencies and uniform requirements.

Staff told us that at the start of any journey, they engaged with hospital staff for a handover of patient information. For example, within mental health patient transfers, this included the detention paperwork and any other relevant information that would update a risk assessment. This meant that changes to the journey could be altered to better meet patient needs.

We observed staff roles that looked to assist the team as a whole. For example, the service deployed 'vehicle make ready operatives'. Their role was to ensure that all vehicles were correctly supplied and ready for deployment.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

We reviewed the service's capacity to consent policy. This provided staff with information and guidance about gaining patient consent, doing so in a valid way and what to do if a patient withdrew it. The policy also recognised the principle of 'Gillick competence'. This is a legal principle which means that, in certain circumstances, persons under the age of 16, may give consent to treatment themselves.

We reviewed the service's mental capacity and deprivation of liberty safeguards policy. This gave clear guidance and information about when a person would be unable to make a decision themselves because they lacked capacity. The policy also correctly identified that a person would not be legally deprived of their liberty during a journey, unless this had been explicitly ordered by a court.

Staff told us about best interests decisions that could be made on behalf of patients, where they lacked capacity and, who would be the most appropriate decision maker in the specific circumstances. The mental capacity and deprivation of liberty safeguards policy required staff to record details of any best interests decision made, which they had been a part of.

Senior management told us that restrictive measures would only be used against a patient's wishes if the person was under the correct legal framework for example, the Mental Health Act and the measures were both proportionate and the least restrictive. Where restraint was used, this was alerted as an adverse journey and reviewed for further investigation if required.

## Are Emergency and urgent care well-led?

# Emergency and urgent care

## Leadership

**Leaders had the 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.**

Senior leaders told us that all divisional leads had significant experience within the independent ambulance sector. Specialised staff were recruited to fill divisional roles that required expertise. For example, the human resources lead, had a level 5 qualification in people management.

Leaders told us about the challenges and issues that the service faced and the actions that were in place to mitigate these. For example, the COVID-19 pandemic meant that there were quicker journey turnaround times required and, unavoidable levels of staff absence due to sickness and self-isolation. Leaders told us to mitigate this, they were actively undertaking recruitment of new staff.

We reviewed staffing structure documents which identified lead persons for areas of the service such as; health and safety, mental capacity, dementia and equality and diversity. Senior management told us that the lead persons were easily identifiable to staff, through the online electronic system that was used.

Staff told us about the procedure for reporting issues to senior management, if their line manager was unavailable. They said that they would go to a different senior manager about the issue, as they were easily approachable and contactable.

Senior management told us that they promoted staff skills in their area of interest to work in. For example, if a staff member expressed a desire to work within emergency care, they would be supported to undertake the first response emergency care qualification.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients and staff could raise concerns without fear.**

Staff told us about initiatives within the services which promoted positive working practices. For example, there was a monthly award for one employee which was based on driving performance.

We also observed notice boards within the ambulance station where crew members could highlight issues with the ambulance vehicles and equipment for repair or replacement.

We reviewed the services duty of candour policy, which promoted a culture of openness, learning from mistakes and an emphasis on staff doing the right thing, when things go wrong. The policy included a section 'what staff should do' to fulfil the duty of candour and also a decision making flowchart.

# Emergency and urgent care

Senior managers told us that staff were reassured about raising any incidents, so as to strive for improvement in patient journeys.

Senior management told us that staff wellbeing was a high priority for the service. Although, the COVID-19 pandemic had made certain aspects difficult, for example in person team meetings, action had been taken to help this. This included staff drop-in sessions with managers and staff surveys. The surveys were run twice per year with one to gather views on operations and another to ascertain views on how staff wellbeing.

A freedom to speak up guardian was in place within the service, to support staff concerns to be raised.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. They had regular opportunities to meet and discuss issues with their line management. The service relied on staff accessing information and key learning independently, rather than within a team meeting setting.**

We reviewed the governance structure chart for the provider. This included clear streams of processes and policies for specific areas, such as safeguarding, clinical oversight, staff compliance, training quality and compliance, operational performance and IT systems.

We reviewed the service level agreements that were in place with partner organisations. These included key details, requirements and expectations about the service that would be provided. For example, as part of contracting with an NHS ambulance trust, the service was required to have a minimum level of indemnity cover in place.

Staff members had regular individual meetings with their line manager, however we noted that the meeting records lacked detail about any issues that were discussed and did not give any context to the structure of the meetings.

Senior managers told us that face to face team meetings had not taken place due to the COVID-19 pandemic, however the provider attempted to supplement this by providing individual drop-in sessions. We reviewed the provider's online dashboard, which was the main medium to disseminate key messages and information to staff members. All staff had electronic access to this system by with their own username and password. Through this, staff members could access the provider's policies.

Policies were structured in a way which clearly defined which members of staff were responsible for which actions. As an example, the managing mental health patients during transportation protocol had documented responsibilities for; the managing director, operations manager, service lead and all staff.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks. The service did not always identify 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.**

We observed staff demonstrate the electronic systems that were used to carry out operations.

# Emergency and urgent care

This included an all in one system which provided managers with an overall level of role compliance for an employee and also for management and monitoring of staffing and shift patterns. The system included an alert which notified potential crew stress, from the shifts that they had worked or were scheduled for.

Staff told us that the service was investigating the purchase of a new equipment scanning system, which would interlink individual equipment with a specific ambulance vehicle. We reviewed the services three risk registers. These included what the risk was, the impact of the risk and if the risk was to be mitigated or tolerated. However, we noted that the description of some risks did not provide a full context and there was not always a description of actions to mitigate any risk that was recorded as being treatable.

The provider had a business continuity plan and policy in place. This described the key activities of the service and the designated senior members of staff who would be responsible for different tasks. Senior management contact details were contained within the plan, so that staff could easily access these. Staff were encouraged to highlight issues with the ambulance vehicles and equipment for repair or replacement by a whiteboard located within the ambulance station. Senior management told us that there was an annual survey which sought feedback and views of staff on operational practices.

Staff were encouraged and supported to report any nonstandard journey or incident as an adverse event. Adverse events were categorised as either ambulance crew, fleet and equipment, operations or service user, to correctly escalate for review.

We reviewed the patient care record audit policy. This evidenced staff responsibilities, the audit process and that compliance of the policy was monitored by the services clinical lead and clinical operations manager.

## 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. Staff were aware of notifications to external organisations which were required to be made.**

Data was collected and processed through an electronic system. This included service statistics, training compliance, staff absence, staffing rotas and also feedback from staff members and patients. This allowed managers to be able to make real time decisions about operational capability.

All documentation was processed electronically. If any paper documents were completed, these were collated within the ambulance station and then sent to a central location to be uploaded. Paper copies were then securely destroyed.

Staff were provided with tablets and handheld devices to be able to access documents and information which was pertinent to patient journeys. For example, risk assessment information would be able to be accessed this way, so that crew members could react accordingly for any further dynamic risk assessment.

The electronic system used was password protected. Staff were able to access the electronic system with their own username and password and could see system information relevant to their role and seniority. We observed a desktop computer was available for use within the ambulance station by staff, which was larger and more accessible than tablet or handheld devices.

## Emergency and urgent care

The service had a dedicated information governance lead, who was also the Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Staff told us they were aware of the service leads who would be responsible for making alerts and notifications and what to do if they were not contactable.

### Learning, continuous improvement and innovation

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

The service had both a training manager and a training operational supervisor in post. The training manager worked across all of the provider sites and was able to deliver a number of service specific courses inhouse. Where required, the service sourced outside training for mandatory modules.

We reviewed certification documents, that showed the service had been accredited by nationally recognised quality assurance programs. Managers and staff also told us that a restraint reduction training program was being implemented within the service, through a national learning disability training provider.