Ambuline Limited

Ambuline Chesterfield

Quality Report

Ambulance desk
Outpatient department
Chesterfield Royal Hospital
Chesterfield
Derbyshire
S44 5BL
Tel: 01915 204000
Website: www.arrivatransportsolutions.co.uk

Date of inspection visit: 13, 14, 15 and 27 March 2017
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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambuline Chesterfield is operated by Ambuline Limited, which is a subsidiary of Arriva Transport Solutions Ltd. Ambuline Chesterfield provides a non-emergency patient transport service (PTS) in North Derbyshire. They have a 'control desk', which operates from the NHS hospital's outpatients department. The service has a base approximately two miles from the hospital where the vehicles are stored and crews start their shifts. The service operates to transport patients to and from neighbouring NHS hospital outpatient departments, and to and from the patients' home address.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection between 13 and 15 March 2017, along with an unannounced visit on 27 March 2017.

We visited the control desk, which was located at the NHS hospital and the service's ambulance station at Chesterfield. We inspected these locations in order to speak to patients and staff about the ambulance service.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

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

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

We found the following issues that the service provider needs to improve:

- We were not assured that there were reliable systems, processes and practices in place to safeguard adults, children and young people from avoidable harm.
- Staff told us that it was difficult to report incidents, as they did not have direct access to the electronic incident reporting system. Staff were not able to give examples of when lessons were learned when incidents occurred or things went wrong.
- The lead for safeguarding did not have regular contact with all of the social care safeguarding leads for the locations in which they provided care to the public.
- Infection prevention and control processes were in place however the cleaning of vehicles was not visibly cleaned to a consistent standard. Staff did not have time allocated within their working hours and vehicles were cleaned in their own time.
- Staff we spoke with could not describe the meaning of the process concerning duty of candour. This is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- Staff received annual mandatory training however; the majority of staff we spoke with did not feel that the training provided them with all of the skills and knowledge required for their role.
- Records were stored in a filing cabinet, which was locked however; the cabinet could potentially be accessible to the public when control staff were off duty.
- Road staff did not make operational decisions in relation to faults on a vehicle check. However, they were sometimes told to take the vehicle on the road despite a fault being identified, which caused conflict and disagreements.

Summary of findings

- All staff we spoke with did not have supervised observational practice sessions with their manager.
- The service had not completed staff appraisals to meet the service target.
- The service had a strategy and vision. However all of the staff we spoke with were not able to articulate the vision and strategy of the organisation.
- The service had a governance process however this was not managed effectively and frontline staff were not involved with the process.
- Staff were committed to improve the service but felt unable to do so.
- The leadership team were not visible and staff did not feel able to approach them to discuss their concerns.
- There was a concern that a blame culture existed when accidents or incidents were reported.
- Local team meetings did not have action plan trackers to ensure actions were implemented.

However, we found the following areas of good practice:

- Policies for care and treatment reflected relevant research and guidance.
- Patients were assessed using national evidence based guidance.
- Staff, teams and services worked together effectively to deliver effective care and treatment.
- Response times were good and feedback from service users confirmed this.
- The service monitored their performance and was the highest performing service in the region.
- Hospitals receiving patients from the service told us that they had effective handovers from staff.
- Patient's consent to care and treatment was obtained in line with legislation and guidance.
- Staff positively interacted with patients; we observed staff communicating effectively with patients.
- Staff treated patients with kindness, compassion, dignity and respect at all times.
- Staff responded compassionately when patients needed help and supported patients emotionally. This was reflected in patient feedback and their care and treatment.
- Feedback from patients was unanimously positive about the care and treatment they had received.
- Staff took the needs of different patients into account when providing transport services.
- There was a shared understanding between staff that every patient had individual needs.
- Services were planned and delivered in a way, which met the needs of the local population.
- There was a system to support staff to communicate with non-English speaking patients.
- Complaints were investigated in accordance with the service's policy.
- Staff we spoke with were extremely proud of the care the frontline staff gave to the patients in their care.
- Staff were very positive about their local line manager who was visible and staff could approach the manager with any concerns they had.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with four requirement notices and a warning notice that affected patient transport services. Details are at the end of the report.

Importantly, the provider must take action to ensure compliance with regulations 15 13, 17, 18 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Ambuline Chesterfield is operated by Arriva Transport Solutions Ltd. We inspected the service on an announced inspection on the 13, 14 and 15 March 2017, followed by an unannounced inspection on 27 March 2017. Overall we have not rated patient transport services (PTS) for Ambuline Chesterfield Ambulance Services because we were not committed to rating independent providers of ambulance services at the time of this inspection. PTS was provided from a base in Chesterfield with the control desk based within the main entrances of a neighbouring NHS hospital. All of the vehicles were kept and maintained at this base and this was where we undertook our inspection. All of Ambuline Chesterfield Ambulance PTS Services were contracted by the neighbouring NHS hospital trust.

Ambuline Chesterfield

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Ambuline Chesterfield

Ambuline Chesterfield is operated by Ambuline Limited, which is a subsidiary of Arriva Transport Solutions Ltd, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Ltd is part of an international transport group Deutsche Bahn (DB). Since December 2013, Ambuline Chesterfield have provided non-emergency patient transport for the Derbyshire area. The service covers a mix of urban and rural areas including Derby City, towns such as Mansfield and Chesterfield and rural areas such as Derbyshire.

The aims and objectives of Arriva Transport Solutions Ltd are to provide private ambulance services for non-emergency patient transport on behalf of the NHS. The journey types and categories of patient they transport include; outpatient appointments, hospital discharges, hospital admissions, hospital transfers, oncology, palliative care, intermediate care, mental health and bariatric (patients over a certain weight).

Our inspection team

The team that inspected the service comprised a CQC sub-team lead inspector, one other CQC inspector and a specialist advisor with extensive knowledge and expertise in emergency ambulance services and non-emergency patient services. An inspection lead oversaw the inspection team.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection between 13 and 15 March 2017, along with an unannounced visit on 27 March 2017. During the inspection, we visited Chesterfield control desk and Chesterfield station. We spoke with 24 members of staff including; control staff, patient transport drivers, managers and senior managers. We spoke with six patients and one relative. During our inspection, we reviewed five sets of booking records and checked four vehicles. We also travelled with ambulance staff to observe the experience of patients.

Detailed findings

Facts and data about Ambuline Chesterfield

Ambuline Chesterfield undertakes approximately 2,600 patient journeys a month. The service employs 26 members of staff who are employed for a total establishment of 23 full time equivalent posts. The service provides transport services 12 hours a day, seven days a week and the ambulance control operates from 8am to 6pm, five days a week Monday to Friday. At the weekend, the discharge lounge at the neighbouring NHS hospital coordinates the transport services. The service has a fleet of 15 vehicles.

Ambuline Chesterfield is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely

The service has had a registered manager since 2012.

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 once and the most recent inspection took place in March 2014. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety at that time.

Track record on safety between December 2015 and November 2016

- Zero never events were reported.
- Fifteen clinical incidents were reported but not categorised.
- No serious injuries were reported.
- Six complaints were received.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Ambuline Chesterfield is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely

The service has had a registered manager since 2012.

Summary of findings

We always ask the following five questions of each service:

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

We found the following issues the service provider needs to improve:

- We were not assured that there were reliable systems, processes and practices in place to safeguard adults, children and young people from avoidable harm.
- The lead for safeguarding did not have regular contact with all of the social care safeguarding leads for the locations that they provided care to the public.
- Staff told us that it was difficult to report incidents; they did not have access to the electronic incident reporting system. Staff were not able to give examples of when lessons were learned when incidents occurred or things went wrong.
- Infection prevention and control processes were in place however the cleaning of vehicles was not visibly cleaned to a consistent standard. Staff did not have time allocated within their working hours and vehicles were cleaned in their own time.
- Staff we spoke with could not describe the meaning of the process concerning duty of candour.

Patient transport services (PTS)

- Records were stored in a filing cabinet which was locked however, the cabinet was accessible to the general public when control staff were off duty.
- Road staff did not make operational decisions in relation to faults on a vehicle check. However, they were sometimes told to take the vehicle on the road despite a fault being identified, which caused conflict and disagreements.
- Staff told us that they had not received mentorship when they started their employment.

However, we also found the following areas of good practice:

- Staffing levels were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Equipment storage and suitability had been reviewed and all items of single use equipment were in date and stored correctly on vehicles.
- Medical gases were stored safely in stations and for use on vehicles.
- All vehicles had an up-to-date Ministry of Transport test (MOT), annual service and were insured.
- All staff working on the ambulances had been trained in basic first aid.
- Staff had received anti-terrorist training and were aware of how to respond to a major incident.
- Staff received annual mandatory training; the majority of staff we spoke with said that the training provided them with all of the skills and knowledge required for their role.

Are services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

Policies for care and treatment reflected relevant research and guidance. Staff, teams and services worked together effectively to deliver effective care and treatment.

We found the following issues that the service provider needs to improve:

- Staff we spoke with did not have supervised observational practice sessions with their manager.
- Response times were good and feedback from service users confirmed this.
- The service monitored their performance and was the highest performing service in the region.
- Hospitals receiving patients from the service told us that they had effective handovers from staff.
- Patient's consent to care and treatment was obtained in line with legislation and guidance.

Are services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff positively interacted with patients; we observed staff communicating effectively with patients.
- Staff treated patients with kindness, compassion, dignity and respect at all times
- Staff responded compassionately when patients needed help and supported patients emotionally. This was reflected in patient feedback and their care and treatment.
- Feedback from patients was unanimously positive about the care and treatment they had received.

Are services responsive?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

Staff took the needs of different patients into account when providing transport services. There was a shared understanding between staff that every patient had individual needs.

We found the following issues that the service provider needs to improve:

- Staff told us the targets they had to achieve meant they found it difficult to pick up a patient or a number of patients up and drop them to a community or acute hospital in the time allocated.

Patient transport services (PTS)

This was because they felt the times given to complete these journeys did not take into account the frailty or mobility of the patient and the time that was needed for them to board the ambulance.

- Staff could not give us any examples of learning from complaints.
- Services were planned and delivered in a way which met the needs of the local population.
- There was a system to support staff to communicate with non-English speaking patients.
- Complaints were investigated in accordance with the service's policy.
- **Are services well-led?**

  We do not currently have a legal duty to rate independent ambulance services.

  We found the following issues that the service provider needs to improve:

- The service had a strategy and vision. However all of the staff we spoke with were not able to articulate the vision and strategy of the organisation.
- The service had a governance process however this was not managed effectively and frontline staff were not involved with the process.
- However, we also found the following areas of good practice:
- Staff we spoke with were extremely proud of the care the frontline staff gave to the patients in their care.
- Staff were very positive about their local line manager who was visible and staff could approach the manager with any concerns they had.
- Staff were committed to improve the service but felt unable to do so.
- The leadership team was not visible and staff did not feel able to approach them to discuss their concerns.
- There was a concern that a blame culture existed when accidents or incidents were reported.
- Local team meetings did not have action plan trackers to ensure actions were implemented.

Are patient transport services safe?

Incidents

- There were no never events reported in this service between December 2015 and February 2017.
- There were no serious incidents reported between December 2015 and February 2017. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to ensure a comprehensive response (NHS England, March 2015).
- Between January 2016 and February 2017 there were 22 incidents reported for this service. Information provided by the service indicated that 11 of these incidents related to injury or illness, four related to resources such as staffing or the environment, six related to transportation, admission and discharge issues and one incident related to abusive, violent or disruptive behaviour or a safeguarding concern.The information provided by the service did not indicate the severity of these incidents or whether these incidents had been graded.
- The organisation had an incident management policy that outlined the arrangements for reporting, managing and learning from incidents occurring as a result of the organisation's activities and those of any subcontracted or agency working on behalf of the organisation. The policy also set out how the organisation would learn from and act on incident reports from all personnel to improve the quality and safety of its service delivery. The policy set out the accountability, responsibility and reporting arrangements for all staff in relation to incidents. The incident management policy stated that incidents should be reviewed within 48 hours and an investigated completed within 14 days.
- Incidents were reported through an electronic incident reporting system, which was not directly available to ambulance staff. This meant that ambulance staff had to rely on their manager or control room staff to put their incidents onto the electronic incident reporting system. Ambulance staff told us they had to telephone

their manager to report an incident. During our inspection, staff told us it was often difficult to contact a manager due to their workload and resulted in delays in reporting incidents.

- We saw no evidence of local learning or local actions being undertaken in relation to these incidents. Staff we spoke with were not able to give examples where learning had taken place as a result of incidents. In addition, staff told us they did not receive feedback about the incidents they had reported.
- Lessons were not learned and potential for improvements were not identified when things went wrong. Staff we spoke with during the inspection were unaware of the incident management policy and were not able to give examples where learning had taken place as a result of incidents.
- Incidents were discussed at the regional operational quality performance group meetings on a monthly basis. We reviewed the monthly minutes of these meetings and saw that discussions around incidents focused on the numbers of incidents reported and the issues around incident reporting. There was no discussion concerning themes and trends and sharing of information so that lessons could be learned.

Duty of candour

- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- We did not see any incidents that required duty of candour to be applied. Managers we spoke with had a good understanding about duty of candour; they talked of being open and transparent with the public. However ambulance staff could not describe what duty of candour was and did not receive training. Staff we spoke with could not describe the meaning of the process concerning duty of candour.

Cleanliness, infection control and hygiene

- There was a corporate infection control manual that addressed all relevant aspects of infection prevention and control including decontamination of medical devices, environmental cleaning and laundering of uniforms.
- Staff completed four hours of infection control training on induction. An update was provided at their annual mandatory training day. Information provided by the service indicated that 97% of staff had undertaken this training against the provider's target of 85%. Although this indicated staff had attended this training, we were concerned about the quality of the training staff received given the annual update covered vehicle cleaning and infection control and was delivered in a time frame of 30 minutes.
- Staff had access to cleaning sprays, cloths, wipes, disposable gloves and aprons. These could all be replenished at the bases when required. Cleaning products on ambulances were kept in an overhead storage locker.
- The service used colour coded mops with different cleaning products to prevent cross-contamination. Safety information and instructions for use of the cleaning products were on display to ensure staff safety when using the products. Sluice areas at stations were visibly clean and tidy.
- We saw the 2016 audit of vehicle infection prevention control which demonstrated that the service had achieved 94% against the service's target of 100% However, throughout our inspection we saw vehicles varied in levels of visible cleanliness and most had not been thoroughly cleaned, especially in the track rails. Vehicles were equipped with appropriate equipment including spillage kits, antibacterial wipes and personal protective equipment for staff. The service did not undertake regular deep cleaning of vehicles.
- The service did not undertake deep cleaning of vehicles. However, in the service's infection control manual, dated December 2014 and overdue for review since May 2016, it was stated that deep cleans should take place every nine weeks and every six weeks for high dependency vehicles. The service was therefore not following its own guidance for the deep cleaning of vehicles. Ambulance staff were required to clean vehicles daily with a full clean once a week. Staff were

not allocated time to clean the vehicles and the majority of staff told us that some vehicles were not cleaned to an acceptable standard because they were not paid overtime to clean their vehicles.

- Ambulance staff told us they could request a deep clean if there was an incident of a significant contamination, for example bodily fluids. Staff told us that under these circumstances, deep cleans could be undertaken quickly and the vehicle was taken off the road whilst the deep clean took place. Staff told us they had never experienced an incident of significant contamination and therefore had never had the need to request a deep clean. The service therefore had no records relating to deep cleaning taking place.
- Alcohol hand gel was readily available and allocated to staff and we observed staff using this appropriately.
- All staff we spoke with had correct uniforms with name badges in accordance with the uniform policy. All staff were bare below the elbow when administering care. Staff were provided with uniforms which staff were responsible to launder themselves.
- Each vehicle also had the correct bags for the safe disposal of clinical waste. There was a local agreement with the neighbouring NHS hospital and staff told us of the correct procedure for disposing of their clinical waste.
- The service's infection prevention control (IPC) audit of premises for September 2016 demonstrated 92% compliance and the vehicle IPC audit for 2016 demonstrated all 15 vehicles were 96% compliant against the target of 100%. This did not correspond with our findings. We checked four vehicles and found they would not have met best practice standards of cleanliness because we found vehicles had not been thoroughly cleaned.

Environment and equipment

- The service had a system in place to ensure all equipment was safety checked by an external provider and the service's fleet manager monitored this. All checks were kept on a central spread sheet.
- Daily vehicle safety checks were carried out by operational road staff who used electronic hand held devices assigned to each individual vehicle to record them. A new electronic format had been introduced and equipment checks were recorded and individually stored for each vehicle on a database. Managers were required to check this daily to identify any action required to rectify issues with vehicles, which required repair.
- The operational road staff undertook the safety checks to ensure their vehicle and equipment was safe to use. Staff we spoke with told us that if the vehicle checks identified a fault they would report this to their manager and not take the vehicle out on the road. However we were given examples by staff where they had been told to continue to use the vehicle and staff had to stand by their decision and refuse to drive a faulty vehicle.
- . The equipment we reviewed had been serviced regularly and stickers were in place to confirm the next service. Other equipment such as the first aid kit and fire extinguishers were all within their service date.
- Seats in the back of all vehicles had seatbelts. Patients conveyed on trolleys were strapped in using belts and trolleys were fitted with locking mechanisms to stop them moving during conveyance. Equipment was available to transport children safely.
- We checked four vehicles and found them all to be acceptable however, ambulance staff told us they were very noisy when in transit and there had been no risk assessment to identify risk to staff hearing. Two out of the four ambulances we looked at did not have a heater which worked properly which meant patients could be cold on journeys. Staff told us that they had reported this on numerous occasions.
- The service used a neighbouring garage for the management and repairs of its fleet.
- We saw completed and up to date vehicle maintenance schedules. All vehicles had an up-to-date MOT, annual service and insurance.
- Essential emergency equipment was available on all vehicles inspected and was fully serviced and tested. Packages containing sterile supplies were intact and in date. Medical gases on the vehicles we inspected were in date and stored securely.
- We observed staff checking patients were safely secured prior to the vehicle moving.
- Each ambulance was fitted with a tracking system which performed several different functions. When staff logged in, the system enabled managers and control staff to

view the status of the ambulance; for example, the location, whether they were driving or stationary so work could be allocated more efficiently. It also monitored the driving performance of the driver.
- There was a system in place to ensure stock on the ambulances were replenished at the start or end of each shift. There was a store located at each base which held items such as personal protective equipment, for example aprons, gloves and hand gel.
- The service had a local agreement with the neighbouring NHS hospital to which it was contracted that enabled them to use and launder their blankets and sheets as required.

Medicines

- The service had a medical gases policy, due for review in May 2017, which incorporated medicines management.
- No medicines were stored on any of the vehicles or within the office buildings and ambulance staff did not administer medication.
- Oxygen was stored safely for use on vehicles; we checked four vehicles, all of which had oxygen cylinders stored securely and were half-full. Each ambulance was equipped with oxygen and staff who had been trained to administer oxygen were able to administer this to patients if it had been prescribed by a doctor. Staff were not permitted to alter the flow rate of the oxygen. If a patient required an increased dose of oxygen, a nurse escort would be provided. Staff were not permitted to administer any other medicines.
- At the time of our inspection oxygen cylinders at the base locations were stored securely in a ventilated room with a warning sticker on the door.

Records

- Patient records were created from the control centre and received by each ambulance crew through a hand held electronic device, which was associated with each vehicle. Control staff collected relevant information during the booking process and recorded the information regarding each patient's health and circumstances. For example, information regarding access to the patient's property or health conditions. This meant that ambulance crews were informed about any needs or requirements the patient may have during their journey.
- All booking records were managed and disposed of correctly and were stored in a locked filing cabinet behind the control desk. However there was a risk that the cabinet could be accessed when unattended due to it being situated in an open plan area at the entrance of the neighbouring NHS hospital. This control room had not been risk assessed and we raised this as a concern with the registered manager.
- We observed that all patient records were stored securely on vehicles. Vehicles were kept locked when they were unattended.
- There were no audits of the booking record. We observed four booking sheets which demonstrated staff had fully completed the documentation.
- When booking patient transfers, details of any patients with 'do not attempt cardio pulmonary resuscitation' (DNACPR) documentation in place would be recorded on each job sheet, if this information was available at the time of booking.
- Staff we spoke with told us that where a patient had a DNACPR form in place, they would not transfer them unless the DNACPR form was dated and completed accurately. Staff told us of an example where staff insisted a doctor amended a form before transferring a patient.

Safeguarding

- The service had safeguarding policies for adults and children. The safeguarding policies were not accessible to ambulance staff whilst they were conveying patients at work. However, in the ambulance stations there was a safeguarding flowchart which was displayed on a notice board.
- The safeguarding policy and the safeguarding flowchart stated that staff should contact local authorities directly if they needed to raise a safeguarding concern. In addition, a safeguarding flowchart had recently been placed in a folder on each vehicle for staff to refer to if necessary.
- Staff we spoke with during the inspection could not consistently describe how they would make a safeguarding referral and were not always aware of the situations when they would be required to do so. Some staff told us they would contact their manager or area manager, some would contact the control room and some would contact the local authority directly.
- Staff who telephoned the control room to report a safeguarding incident told us they were given

inconsistent support. During induction, staff completed an introduction to safeguarding training course that they attended in person. Training compliance was 90%, against the service target of 85%.

- All staff undertook annual mandatory training. However all staff said that the training was not effective because it was carried out over one day and it was rushed..
- Staff were required to complete a short written assessment as part of the safeguarding training. We reviewed nine staff training files and found that all of them had been signed off as having completed the safeguarding training even if the staff member had not answered all the assessment questions or had answered them incorrectly. We were therefore not assured of the validity of the safeguarding training or whether it adequately prepared staff to identify abuse or adhere to the organisation's policies.
- We were not assured that the safeguarding lead for the service had links with the local authority safeguarding teams to enable good communication and working relationships. In addition, the safeguarding lead did not have regular contact with the safeguarding leads for the social care locations for which they provided a service.
- Although the safeguarding lead had knowledge of the processes for raising a safeguarding, they did not articulate a knowledge or oversight of the safeguarding incidents within the service.
- Throughout our inspection, the safeguarding lead told us they planned to source additional training for themselves and their trainer and that they would propose to the senior leadership team that more safeguarding leads were developed to support the safeguarding lead at an executive level.
- Disclosure and barring service (DBS) checks were carried out for all staff including volunteers. DBS was checked as part of the compliance checks for the use of third party providers such as taxi drivers and other independent ambulance providers sub-contracted by this service.

Mandatory training

- All operational staff undertook a one day mandatory training update on an annual basis. Mandatory training included a safeguarding update (including deprivation of liberty safeguards (DoLS) and Mental Capacity Act (MCA) 2005), basic life support, oxygen therapy update, vehicle cleaning and infection control, patient handling with a practical element, incident management, operational updates, information governance and fire safety.
- Control room staff and non-operational managers attended half day mandatory training which included updates on safeguarding including DoLS and MCA, dealing with incidents, operational updates, information governance and fire safety.
- Senior managers told us the content of the yearly mandatory training could change depending on the needs of the service.
- Staff told us they were given time at work to complete mandatory training.
- Mandatory training records showed that 90% of staff had received their mandatory training at the time of our inspection. This was more than the organisational target of 85%. However, we were not assured the training was effective because of the inspection team's concerns regarding staff knowledge of safeguarding, manual handling and mental health.
- All but one member of staff we spoke with said the training was not effective because it was delivered in one day and it was rushed. Staff also told us the training did not cover essential aspects of their role, such as supporting people with mental health conditions, dementia and first aid at work training.
- Driving level qualifications and revalidation dates of driving level training were recorded on the provider's training spreadsheet. This was 100% compliant.
- The senior team lead told us of a mentoring programme. However, staff we spoke with did not recall being allocated a mentor after they started work.

Assessing and responding to patient risk

- Staff were trained in basic first aid during their induction, which gave them initial skills to notice if a patient was deteriorating and when to ask for emergency help. All staff we spoke with told us if a patient deteriorated they would call 999 for the emergency services to attend.

Patient transport services (PTS)

- If a patient had a specific medical condition the service ensured that staff were trained and competent to care for the condition they had, otherwise they requested a nurse escort.
- Policies and procedures were in place to manage patients who displayed challenging behaviour such as violence and aggression, but not all staff felt they were trained and equipped to deal with these sorts of patients. Staff we spoke with were clear on the protocols they would follow to meet the demands of challenging behaviour.
- We did not see any evidence that staff had received conflict resolution or 'breakaway' training.

Staffing

- We reviewed the human resources dashboard, which demonstrated the full staffing establishment for this service was 23 full time equivalent posts.
- Managers we spoke with advised that if the service did not have sufficient personnel to deliver a service safely, the contract or transfer would not be accepted.
- We saw evidence that total staff sickness rate was between 4% and 5% between January 2017 and March 2017. A process was in place with manager reviews and occupational health referrals where appropriate.
- Station managers at a local level managed any anticipated staffing shortages by scheduling rotas in advance and managing pre-planned holidays and other leave.
- The staffing rota was over a period of seven weeks, the first five weeks were a combination of a week of early shifts or a week of middle shifts; the last two weeks were a mixture of both. Staff found the mixture of both difficult to manage a good work life balance because the shift times would sometimes be confirmed the day before.
- Staff we spoke to told us they were able to have their breaks. Control informed staff when they were able to have a break to prevent delays in transporting patients.

Response to major incidents

- As an independent ambulance service, the provider was not part of the NHS major incident planning and the service did not have a major incident policy. However, the service did have a business continuity management policy, which gave guidance on what should happen if an incident occurred that affected the running of the service.
- The staff had received 'prevent' training. Prevent training is the counter-terrorist programme which aimed to stop people from becoming terrorists or supporting terrorism.
- Managers told us they did not have a service agreement with local NHS trusts to be involved with their major incident policies. However, if a request to provide services was made they would endeavour to meet those demands.
- Adverse weather conditions were addressed by the staff and managers collectively in accordance with their severe weather policy.

Are patient transport services effective?

Evidence-based care and treatment

- Staff we spoke with were aware of the national guidance relevant to their practice. For example 'do not attempt resuscitation' pathways of care. Staff were encouraged to read the station staff notice board for new or updated policies.
- Staff assessed and provided transport to patients in line with national and local guidelines. This happened through staff assessing whether patients were appropriate to receive transport using a specific set of questions based on the Department of Health guidelines.
- Patients had to confirm they were registered under a GP in the commissioning area and that they required transport to or between NHS funded providers before they were allocated transport.
- Operational staff had been given personal identification numbers so they could access guidelines and protocols from their own personal computers. However, unless they were at a base and a manager was available to log them on to a work's computer, they were unable to access guidelines and protocols whilst on duty.

Assessment and planning of care

Patient transport services (PTS)

- The organisation had planning and control staff to assess the demand and levels of care for patients. Staff would plan routes or allocate crews dependent on the needs of the patient for example, a vehicle with a stretcher, or a vehicle that was suitable for a heavier person. Staff used an electronic system, which identified patient care requirements and automatically scheduled journeys. However, staff could override this to plan in additional journeys.
- Staff we spoke with were confident to handover to the receiving party. This meant that systems were in place to enable the continuity of care and treatment.
- Staff were involved in planning the care for individuals. For example if a piece of equipment was required to improve transportation needs they would be consulted to take their views into consideration. There were stretcher vehicles, wheelchair assisted vehicles, seated ambulances and a vehicle designed to take patients of a certain weight available depending upon the patient's individual need.
- Risk assessments were completed for complex patients, for example, patients with bariatric needs. Bariatrics is a branch of medicine dealing with the study and treatment of obesity, including prevention. The World Health Organisation (WHO) describes people who have a body mass index greater than 30 as obese and those having a body mass index greater than 40 as severely obese (WHO, 2000). Bariatric patient needs make supporting patient's mobility, moving and handling needs hazardous to staff and patients.
- Staff generally identified any serious health needs of patients. The booking form prompted the call taker to ask if the patient had any mental health problems but did not prompt staff to request any further detail. However staff who were experienced would ask further questions to identify the patient's needs for any potential transfer arrangements.
- Food for patients was not carried on vehicles and where possible, journeys were planned to take into account meal times for patients. However, there were arrangements in place to provide drinks for those patients that were on a vehicle for a long period of time. Water was available at each ambulance station for the crews to take on the ambulances and bottles were carried on ambulances and could be provided if required on long journeys or hot days. Water bottles could be replenished at the ambulance bases.

Response times and patient outcomes

- Staff could monitor performance against targets on screen; green showed no problems completing the journey within target, orange showed getting close to breaching and red was breaching.
- Demand outside of contract levels (extra contractual journeys) was managed in an ad-hoc way.
- The service completed formal benchmarking against other regions. The service's performance in achieving their targets was good for their area.
- Patients we spoke with returning home from clinic journeys told us they very rarely waited long before being taken home, the longest example we were given was 20 minutes. Hospital staff at the clinics, treatment centres and discharge areas said the patients were rarely delayed.
- The service used a number of performance tools. These included an operational measurement tool, which reviewed vehicles off road, sickness and compliance checks, a dispatcher tool, which measured auto allocation and aborted journeys, and the call taker tool to measure ready time, talk time and calls handled.
- The service achieved 90% of outward journeys being within the service target of 45 minutes and, 95% of their inward journeys. Staff told us they did not always receive feedback on their achievements.
- For the period April 2016 to January 2017 the service met both their time spent on vehicles key performance indicators (KPIs).
- For the KPI indicating that 95% patients should not arrive more than 60 minutes before or 0 minutes after their appointment fluctuated in and around the target. Between November 2016 and January 2017, performance ranged between 88% and 92% meaning the service was just below their targets.
- For the KPI indicating that 90% of patients should be collected from an agreed location within 45 minutes after their identified throughput time at the clinic, becoming available for their return journey, performance was around the target. Between November 2016 and January 2017, performance averaged 89%.

Patient transport services (PTS)

Competent staff

- A training programme was provided for new staff. The course lasted two weeks and incorporated driver training, mandatory training, manual handling and two days of being an observer on a vehicle with the crew. The training policy stated that a mentor would support staff during the first six weeks of employment however; staff we spoke with could not recall having a mentor for six weeks.
- All staff were provided with training to enable them to undertake their work. However staff who completed the training did not feel it equipped them with the necessary skills to carry out their roles. All staff wanted more first aid training and training related to supporting patients living with mental health conditions and dementia.
- The management team advised us that all crews who worked on the ambulances had six monthly observed practice by a mentor, team leader or manager. However, staff and managers we spoke with told us this was not happening and did not have records to demonstrate that this was embedded in practice. This was not in line with the provider's supervision policy, which had been agreed in March 2016.
- All staff we spoke with had received an appraisal in the last year and information provided by the service indicated that 100% of staff had received a review at six months. We found 12.5% of staff had completed a professional development review at 12 months. The manager for this region had not received appraisals annually.
- The driving of each ambulance was constantly monitored electronically. This took account of the speed travelled, breaking times and force of breaking. These aspects of driving had a direct impact on patient comfort during the journey. Each driver received scores which could be accessed at any time by the team leaders or managers. We were told the scores were monitored and worked on an average over one month and exceptions are also taken into account. However if the driver accrued a score of more than one, those staff employed on a bonus scheme would lose their bonus for that month.
- Staff we spoke with felt this type of monitoring was unfair. Staff told us heavy breaking could be due to a vehicle in front breaking harshly, someone stepping out into the road or traffic light changes and these situations were not taken into account when bonuses were removed from staff pay. Managers we spoke with told us the ambulances and cars were set to identify the same breaking parameters for both ambulances and cars, which meant that cars would record higher rates of harsh breaking. Therefore, staff driving cars who were employed on the bonus scheme of pay would be continually penalised if they had to drive the single person cars.

Coordination with other providers and multi-disciplinary working

- When staff transferred a patient's care to another healthcare provider such as a hospital or hospice, they ensured the patient handover at pick up was clear and precise to enable a thorough handover to staff receiving the patient.
- We spoke with staff at other healthcare providers where the service transferred patients to and from, all staff were extremely positive and they commented about how reliable and professional the ambulance staff were.
- The manager of the service had a good working relationship with the neighbouring NHS trust and with the transport co-ordinator employed by the trust. Ambuline staff told us they could call them to discuss any concerns. This ensured timely discharges for patients.
- We observed good communication among the control staff, with callers and the crews. We observed the call takers clarifying information with callers and received positive feedback from staff about how well the whole team worked together.

Access to information

- Each vehicle had an allocated electronic hand held device that was carried by the ambulance crew during each shift. The electronic hand held device enabled the crew to see the patient record, provide information to dispatch as to their status during their shift, for example if they were mobile or waiting to pick up a patient. The crew could also use the hand held device to telephone and/or send messages to the control centre.
- Operational staff received full patient handovers when collecting patients from providers.

Patient transport services (PTS)

- Patient information was kept secure during transfers and journeys in sealed envelopes.
- Each vehicle had its own individual information box which was carried by the crew during each shift. The box contained information that crews may have needed when out on the road such as how to contact a translator and important phone numbers.
- All vehicles had up-to-date satellite navigation systems. Staff we spoke with said these were reliable in helping them to reach a patient's home and where they needed to be transferred.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed training on the Mental Capacity Act (MCA) 2005 and Mental Health Act (MHA) as part of their initial training. Compliance was 95% against the service target of 85%.
- Patient's consent to care and treatment was obtained in line with legislation and guidance. Staff understood that consent was needed, for example we observed staff gaining consent when moving patients.
- Staff told us when a patient was living with dementia or was confused an escort was usually present.
- Staff told us they had received training in the Mental Capacity Act 2005. They felt the training had been useful but was too short and had not given them enough information for them to assess people's capacity to give consent. The majority of staff were not confident to describe how to undertake basic mental capacity assessments.
- Staff told us they did not transfer patients with a mental health diagnosis.
- Do not attempt Cardiac Pulmonary Resuscitation (DNACPR) orders were discussed with the staff on the wards of local NHS hospitals prior to leaving. If these were not current a discussion with the nurse and doctor would take place to ensure a current DNACPR order was written for the patient prior to transfer.

Are patient transport services caring?

Compassionate care

- Staff gave patients and their relatives or carers opportunity to feedback through the complaints process or through the friends and family test (FFT) questionnaire cards. We saw completed FFT cards at bases and posters in vehicles explaining how patients could feedback.
- For the period January 2016 to December 2016, the service scored 100% for six out of 12 months. The service did not score below 93% for this period. This meant the majority of patients who used the service would recommend it to others.
- Patient feedback received was extremely positive in terms of patient care, which was consistently over 85% from February 2016 to January 2017.
- We observed that ambulance staff always maintained the privacy and dignity of patients throughout their journey.
- Patients told us staff were respectful and caring and that they went above and beyond to make sure they were in their homes before driving off.
- Feedback from every patient we spoke with was positive about all aspects of the care they received.
- Staff were passionate about providing good experiences for patients and building relationships with patients who used the service regularly.
- Overwhelmingly, we observed staff providing care that was compassionate and patients being treated with respect and dignity and having their privacy respected at all times.

Understanding and involvement of patients and those close to them

- Relationships between people who used the service, those close to them and staff were strong, caring and supportive. Patients who used the service told us staff were kind and very professional. Staff were welcoming to relatives and carers travelling with patients.
- Patients we spoke with told us that staff explained everything to them and they could ask questions at any time, nothing was too much trouble.
- We observed excellent communication from the staff to the patients and their carers. It was evident they knew some of the patients very well.

Emotional support

Patient transport services (PTS)

- Patients who used services and those close to them received the support they needed to cope emotionally with their care. Patients attending the oncology day care unit of the neighbouring NHS hospital were prioritised to ensure they were at their appointments on time. Staff from the unit told us patients were not normally late for their treatments, only in exceptional circumstances. This meant the transfer was less stressful for patients attending the unit for chemotherapy treatments.
- We observed staff reassuring patients and communicating in a meaningful manner to reduce any fears that patients may have had. For example explaining where they were going and how many patients would be on the vehicle.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- This was a small service, which was commissioned through a neighbouring NHS hospital. The contract provided non-emergency patient transport for patients coming in and out of the neighbouring NHS hospital.
- There was a fleet of 15 vehicles, which included a mix of stretcher, seated, wheelchair accessible and car types. This meant the service could meet the needs of a wide range of people.
- Monthly and quarterly activity reporting took place which enabled the service to identify areas in which there was opportunity for improvement to better meet the needs of patients. Staff told us for example if a journey meant a patient was consistently late this would be reviewed to ensure the patient was not late.
- The journey types and categories of patient had been contracted to meet the needs of patients' journeys carried out which included, outpatient appointments, hospital discharges, hospital admissions, hospital transfers, oncology, palliative care and bariatric patient transfers.
- The service was able to respond to the needs of patients living with a learning disability, patients living with dementia and bariatric patients. This was supported by the service's equality and diversity policy as well as equipment provision.
- Staff told us the targets they had to achieve meant they found it difficult to pick up a patient or a number of patients up and drop them to a community or acute hospital in the time allocated. This was because they felt the times given to complete these journeys did not take into account the frailty or mobility of the patient and the time that was needed for them to board the ambulance.
- The service monitored response times to patient pickups. If a vehicle had the engine running but not moving it was known as idling. Staff told us they were often seen by their manager to discuss the length of time their vehicle was idling. Staff felt this was unfair due to the time some frail elderly people take to board the vehicle and in the winter months it was required to heat the vehicle to ensure the windscreens were clear and safe to drive.

Meeting people's individual needs

- The service had a system to access interpreters for patients whose first language was not English. The interpretation service was available in 23 different languages. There was a hearing loop signage system on the control desk to support patients with hearing impairments. There were no aids for patients with significant sight loss.
- The service aimed to take into account the needs of different people, including those in vulnerable circumstances. The service had an equality and diversity policy. The aim of the policy was to define and promote equality and diversity by all employees, and to ensure there were defined guidelines for employees to follow if necessary. We observed staff caring for all patients consistently regardless of race, gender, gender identity, religion, belief, sexual orientation, age, physical/mental capability or offending background.

Access and flow

- The service provided patients with timely transfers to enable them to access treatments and out-patient appointments.
- The control and crews worked very closely with discharge lounge staff to ensure patients had timely discharges from hospitals to prevent unnecessary delays in hospital stays.
- Delays were not common and the policy was for patients to be ready to leave home two hours before

their pickup time. Patients we spoke with did not mind this request because they were waiting in their own homes. Patients who used the service regularly, waiting to be discharged did not experience long delays.

- Outpatient staff at the neighbouring NHS hospital directed mobile patients or took immobile or vulnerable patients to the control desk waiting area. Transport was initiated by the control staff and patients told us they did not wait very long, from five to 20 minutes before they were picked up to be taken home.
- We did not witness any delays in the control staff answering calls. The service was top of the region for call answer times, which staff were very proud of.

Learning from complaints and concerns

- The service had a management of patient complaints policy which was in date and due for review September 2017. The policy gave detailed directions on how a patient complaint should be investigated. This policy stated that complaints must be acknowledged within three working days, with an investigation and response taking place within 25 working days.
- A regional complaints dashboard recorded complaints within each area of the Midlands region categorised by type of complaint, with response times to the complainant.The dashboard did not include information which explicitly benchmarked between areas or listed actions taken because of complaints.
- Between December 2015 and November 2016, 100% of complaints were acknowledged within three working days. Between the same timeframe, 100% of complaints were completed within 25 days.
- The service had six complaints between December 2015 and November 2016; three of which were in June 2016. The service reviewed this and found no trend or reason for this rise.
- Two complaints were regarding late arrival for a journey to or from the hospital. Both of these were caused by delays on previous journeys, which were not updated to the control team for any corrective actions to be taken in a timely manner. These complaints led to an internal communication improvement which changed procedures to ensure all delays were communicated to patients and hospital staff.
- All complaints were logged within the electronic incident reporting system to identify if the complaint was linked to an incident. The process for dealing with complaints was detailed within the service management of complaints policy.
- We saw posters in all of the vehicles advising patients how to feedback to the service. Information relating to how a member of the public could make a complaint was displayed on all vehicles. However, these were all written in English. This meant that patients who did not speak English as a first language may not have known how they could provide feedback or how to make a complaint.
- Staff were not able to give examples of lessons learnt or actions taken as result of complaints.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The senior leadership team of the service consisted of a managing director, national head of patient transport services, head of quality and standards, the registered manager/head of contracts and another head of contract.
- Staff told us that the local manager was not as visible around control as they had previously been due to an office move however; the manager was supportive and accessible. Staff also confirmed that they would have no concerns in raising any issues directly with them should the need occur. However all but one member of staff we spoke with said the senior leadership team were not visible and would not feel comfortable in approaching them.
- Operational staff were able to see their manager on a daily basis at their base station where they picked up the vehicles.
- The majority of staff told us they were unhappy about how investigations and complaints were managed. Staff explained to us that they perceived a blame culture and had to prove their innocence which made them reluctant to approach senior managers.

Patient transport services (PTS)

- Staff told us of the process of investigating a collision which resulted in damage to a vehicle. When headlights or wing mirrors were accidently damaged and staff were required to pay for the damage by loss of earnings, some staff had been through disciplinary processes.
- Two members of the senior management team told us they were not aware that staff felt there was a blame culture, and told us that staff were responsible for their standards of driving and that all incidents involving vehicles were investigated by the AGMs. The company was intent on decreasing the number of accidents involving vehicles. We therefore observed there could be a potential disconnect between the senior management team and operational staff.
- The majority of staff told us they did not feel there was an open and transparent culture within their service and many staff told us they felt devalued by the organisation.
- Due to some staff undergoing TUPE (transfer of undertakings protection of employment) to Ambuline from a previous ambulance provider, staff were on varying conditions but were undertaking the same roles. This led to a culture of disharmony within the teams and resentment towards the organisation.
- Staff told us the resource planning managers took future holidays into account, however, staff told us they found this difficult, as they were required to book their annual leave for the year ahead. Staff also told us they were not able to take holidays or days off at short notice unless they negotiated this with other staff that were available to cover their short notice leave requests. Three members of staff we spoke with told us that they were going to lose annual leave due to an inability to book it prior to the end of March 2017.

Vision and strategy for this this core service

- There was a vision and strategy to support good quality care. The vision was to provide a safe, compliant and high quality service to customers and to accept and embrace personal accountability for work. The strategy was to acknowledge change as a permanent feature of work and recognise that change brings opportunities.
- There were four key objectives to provide an effective and safe service with consistent quality. The vision had been reinforced in a booklet given to all staff detailing their role in achieving the service's set aims and objectives. The objectives had also been incorporated in staff appraisals.
- The majority of staff were not aware of the vision and values of the organisation and could not describe how they would apply them to their role. Some staff did not know the booklet had been introduced as part of the appraisal process.
- All staff had the same vision to provide the best possible care and service to the patients.

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

- Performance was discussed regularly at the leadership operational quality performance group. This group had manager representatives from all the service's areas. This group reported to the senior leadership team. Monthly policy performance and senior leadership team meetings took place. We reviewed the minutes from the senior leadership team meetings 2016 and found they did not reflect anything that had been discussed at the operational quality performance group meetings. There was no discussion relating to complaints, incidents or other aspects of the service that affected patients. Discussions were more focused around topics such as mobile telephones and the prodometer tool; an electronic hand held device which provided performance statistics. We were therefore not assured that the senior leadership team had oversight of some of the risks in the service relating to things such as complaints, incidents and safeguarding.
- Local monthly team meetings were held and staff told us discussions took place; however set agendas were not in place to enable an oversight of issues discussed. Staff received information from the management at this forum.
- We reviewed three sets of minutes from the local team meetings in September 2016, October 2016 and December 2016. There was no set agenda or an action log to evidence completion of any issues raised. This meant the managers did not have oversight of governance at a local level.

- Governance processes were not always effective, for example, there was no oversight of the quality of training that was being delivered despite staff raising concerns that they felt the training was rushed and did not equip them to effectively undertake their role.
- The service had a local risk register. We reviewed the local risk register for non-emergency patient transport services, which included asbestos in the station building and concerns regarding control staff's working environment. The control staff were working with equipment that was ergonomically (designed to prevent injury to staff) incorrect. The risk register stated that all working desks had been assessed; however, the control desk in the neighbouring NHS hospital used by Ambuline Chesterfield staff had not been assessed. We raised this with the senior management team as an urgent concern because we were concerned for the physical welfare of staff working in that environment. The senior leadership team took immediate action and undertook a risk assessment.
- A risk register review featured on the operational quality performance group meetings agenda. The minutes of these meetings indicated that managers were responsible for monitoring the risk registers for their location. The contents of the risk register were not discussed but it had been identified that the risk register was not being reviewed and updated by managers. When we reviewed this risk register for this location, we saw that some of the risks had gone past their action target completion date but the risk register had not been updated. We also noted the previous registered manager for this location was still named as a 'risk owner' on the risk register, despite no longer being employed by the provider. We were therefore not assured that risk registers were being effectively managed.
- Even though the concerns in relation to incident reporting were known to the attendees of the Operational Quality Performance Group, and the concerns were ongoing, this had not been included on the service's risk register.
- A system called 'checkpoint' was used where each member of staff completed a checkpoint form at the end of their shift. The checkpoint forms were provided at the start of each shift and used to confirm vehicle checks were made, the crews driving scores were recorded and any issues they had encountered during their shift could be shared.
- As part of the services annual audit process, feedback was displayed on the staff notice board. For example, response times and key performance indicators.
- The provider did not use a clinical dashboard because this was a patient transport service. Staff were not clinically trained. However, the provider used several dashboards to monitor the safety of their service. The provider monitored performance of control room staff in relation to talk time, allocation time, aborted journeys, inward and outward journeys, infection control practices, capacity and demand. The provider monitored performance through the use of observational, manual and electronic audits. The provider used specific electronic audit software to monitor and analyse results.
- Results demonstrated high demand, sometimes over and above service capacity. Audits demonstrated some key performance indicators (KPIs) were not being met, for example, inward and outward journey times and mixed infection control results.
- Managers displayed and shared performance at ambulance bases using notice boards. The boards were clearly visible to staff and contained relevant performance information. Performance was compared with the previous month. The electronic audit software created reports for managers to discuss at monthly and quarterly management performance reviews.

Public and staff engagement

- The Arriva Transport Solutions Limited (ATSL) Midlands 2016 staff survey had a response rate of 71%.
- The organisation's ATSL Midlands 2016 staff survey highlighted staff concerns regarding engagement and communication from senior management. The survey highlighted this should be a priority for the organisation. The organisation saw a decline in satisfaction for all questions asked about communication and engagement. Data showed in 2016, that 26% of staff were satisfied overall with communication, information and involvement.
- The staff survey reflected staff comments and morale. The survey asked staff about their satisfaction and data from the 2016 survey showed decreasing satisfaction for staff working at the organisation from the 2015 survey. Staff were less positive about being proud to work for the company (36% in 2016 from 48% in 2015), enjoying

their work (50% in 2016 from 63% in 2015) and 29% of staff said they would recommend their employer to others in 2016. Overall satisfaction with the company had dropped from 40% in 2015 to 35% in 2016.

- Staff told us they did not feel safe to raise concerns and told us they had not been included in the planning and delivery of their service.
- The organisation had recently introduced a private social media group for staff as a way of engaging and enabling staff to discuss a range of topics.
- Managers held monthly base meetings where they held a questions and answers session for staff to raise any concerns. We looked at the minutes of these meetings and saw questions staff raised questions and managers gave answers. However, when we looked at the minutes from future meetings, we did not see evidence of actions being followed up or feedback being given to staff about their concerns.
- Staff gave patients and their relatives or carers opportunity to feedback through the complaints process or through the friends and family test (FFT) questionnaire cards.
- The organisation conducted a quarterly patient survey. Results for the period November 2016 to January 2017, 249 (62%) of patients gave feedback for the Chesterfield service. The results demonstrated the majority of patients were either very satisfied or satisfied with the service they received.

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

- At the time of this inspection, we could not identify any evidence to demonstrate the service had delivered their strategy and objectives of commitment to quality improvement and innovation.

Outstanding practice and areas for improvement

Outstanding practice

- Overwhelmingly, we observed staff providing care that was compassionate and patients being treated with respect and dignity and having their privacy respected at all times. Staff were passionate about providing good experiences for patients and building relationships with patients who used the service regularly.

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure staff are aware of safeguarding pathways.
- The provider must review the training for safeguarding adults and children to ensure all staff have clear guidance on how to make a referral and to whom.
- The provider must ensure an appropriately qualified trainer provides safeguarding training.
- The provider must ensure there is sufficient oversight of safeguarding incidents and the organisational lead is appropriately qualified.
- The provider must ensure staff are aware of incident reporting pathways and that they are facilitated to report and manage incidents in a timely way.
- The provider must ensure any feedback and learning from incidents is shared with staff.
- The provider must ensure staff know about the duty of candour and understand its principles of being open and honest.
- The provider must ensure staff follow infection, prevention and control procedures to assure themselves vehicles and equipment are clean.
- The provider must ensure staff receive appropriate training to enable them to effectively carry out their roles.
- The provider must ensure staff have appropriate access to key policies and procedures.
- The provider must ensure staff are supported in their roles by effective supervision, competency monitoring, mentoring and appraisal systems.
- The provider must ensure that timely and effective governance and risk management systems are in place and where risks are identified, timely and appropriate action is taken.
- The provider must ensure learning from complaints and concerns is shared with staff.

Action the hospital SHOULD take to improve

- The provider should have a set agenda and action log for minutes of meetings to evidence completion of any issues raised.
- The provider should ensure records are stored in an area not accessible to the general public.
- The provider should ensure that if staff identify a fault on a vehicle check they are supported to take the vehicle off the road.
- The provider should ensure all working areas are risk assessed and equipment is provided for staff to have a safe working environment.
- The provider should ensure there is a safe culture to enable staff to work in a blame free environment and enable them to raise concerns.
- The provider should ensure processes are reviewed to enable staff to feel valued.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: There were ineffective infection control practices in place to ensure vehicles were clean and prevented the spread of infection. Deep clean schedules were not in place to ensure regular thorough cleans of vehicles. Regulation 15 (1) (a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There was no oversight of the training staff received to ensure it was effective. Managers did not share learning from complaints with staff. The organisation did not take action to ensure staff were aware of incident reporting pathways and that they are facilitated to report and manage incidents in a timely way. The organisation did not have sufficient oversight to assess, monitor and mitigate risks. Regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Staff did not have adequate access to policies and procedures. Regulation 18 (2a)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour How the regulation was not being met: Staff did not know or understand their responsibilities under the Duty of Candour Regulation. Regulation 20 (1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to meet this regulation because: Staff were not consistent in their knowledge of how to make a safeguarding referral. The person who taught the safeguarding session had no safeguarding training or qualifications to enable them to be a competent trainer. Staff files indicated the trainer was signing staff off as having completed the training even if the staff had incorrectly answered or not answered all the assessment questions. We could not establish the level of safeguarding training although the provider told us it was level 2. The senior leadership team were not able to articulate knowledge or oversight of the safeguarding incidents within the service. The lead for safeguarding was not appropriately qualified and did not have regular contact with all of the social care leads for the locations that they provided care to the public. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service failed to meet this regulation because:

This section is primarily information for the provider

Enforcement actions

There was a lack of understanding amongst staff about the processes to follow for reporting and managing incidents.

There was no oversight in place to effectively assess, monitor incidents and improve the safety and quality of the care and treatment provided.

Staff did not receive feedback about incidents they had reported

There was no evidence of staff learning from incidents and common themes relating to incidents were not shared across the service.

Concerns relating to incident reporting were known to the attendees of the Operational Quality Performance Group, and the concerns were ongoing but had not been included on the service's risk register.

Regulation 17 (1) (2)(a) & (2)(b)