NSL Limited

NSL South West Region

Quality Report

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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information 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

NSL South West Region is part of NSL Limited, a nationwide provider of patient transport services. NSL have provided non-emergency patient transport for the commissioners in Kernow (Cornwall), North and East Devon and Somerset since October 2013.

We carried out a scheduled comprehensive inspection on 3 and 4 November 2015 to review the service's arrangements for the safe transport of patients.

Our key findings were as follows:

SAFE:

- The provider had systems in place for reporting and investigating incidents. We found inconsistency in the reporting of incidents amongst staff. There was no evidence that staff received feedback following investigations into incidents and staff could not tell us where improvements had been made as a result.
- The provider had a statutory obligation to report certain incidents to us, we found that this did not always happen.
- There was inconsistency in the professional development training (mandatory training) between new staff and staff that had transferred from the previous NHS provider. Staff told us that the training courses provided were generally adequate and relevant to their roles.
- We were concerned that staff told us they would only report a safeguarding concern with the patients consent. This was confirmed in the provider's policy. This had the potential to put patients at risk of further abuse because staff did not report concerns, or their concerns were not passed to the local authority.
- The provider had good systems in place to deep clean the vehicles on a regular basis. All the vehicles and ambulance stations we saw were clean and tidy. Staff washed their hands and made good use of personal protective equipment such as gloves.
- Staff consistently carried out their vehicle checks before each shift and noted any defects. We observed that vehicles were not always repaired in a timely way. There was no overall oversight across the South West with regards to vehicle maintenance and servicing.
- Risk assessments were carried out by staff when necessary. Staff were informed of any special measures that they need to take with each patient such as mobility problems.
- Staff told us they regularly worked additional hours and missed their breaks because of demand. At the time of our inspection, we noted 31 full time vacancies throughout the South West, although the provider told us that most of these were for bank staff. The provider had a recruitment plan in place to recruit ambulance care assistants.
- Incidents that must be notified to the Care Quality Commission were not always done, which is an offence under the Health and Social Care Act.

EFFECTIVE:

- Staff were confident to refuse to transfer a patient if they felt the patient needed more specialist care.
- A patient liaison officer was in place at one acute hospital. This was highly regarded by the hospital and fostered a good relationship between the provider and the trust. It improved communication and transport bookings for patients.
- Staff had been trained in the mental capacity act, but did not feel it had given them enough information or the confidence to undertake mental capacity assessment.

Summary of findings

CARING:

- Ambulance care assistants were described as polite, courteous and patient focused. Other health care professionals told us that the staff went above and beyond for their patients. We received very good feedback from patients about the care and treatment they received from the ambulance care assistants.
- We observed staff interacting with patients. They introduced themselves, were friendly and appropriate in their manner. They put patients at ease when they were anxious and chatted with the patients during their journey.
- Staff made sure patients were as comfortable as possible during their journey. Staff made sure patient's privacy and dignity was maintained especially when transferring to and from the vehicle.
- We observed the ambulance care assistants calling patients to confirm a journey or if there was going to be any delay in picking them up. We noted that these calls were not consistently carried out by all staff every day.

RESPONSIVE:

- Staff were frustrated that they were frequently unable to meet their performance indicators for the collection and arrival times for patients. Staff felt this was a combination between increased demand and poor planning with unrealistic journey schedules.
- There was a lack of resilience. Spare vehicles were available in each ambulance station. However, we saw that these were routinely used on a daily basis because of demand or when other vehicles were off the road.
- There were no facilities for patients whose first language was not English. We saw that one patient had been conveyed for three months with no provision put in place for her language needs. We were told that staff would find it acceptable to use a child to interpret for their parents if necessary.
- Staff were given journey sheets which detailed who the patient was, pick and drop off locations and times and any additional information the crews needed. We found that this information, whilst useful to the crews did not always contain everything they needed to know. We saw examples where the information was completely ignored by the planners with the journey schedules.
- Details of how to make a complaint could be found on every vehicle. Staff were aware of the complaints process and would try to resolve concerns for patients to prevent them becoming complaints. Staff told us they did not receive any feedback once complaints had been made and were not aware of any improvements that had been taken as a result.
- Relationships with the control and planning staff were at times strained. We observed the planners set unrealistic schedules at times that were impossible for the crews to stick to. Some crews told us that they were set up to fail in meeting their targets for picking patients up on time.

WELL LED:

- Ambulance care assistants felt well supported by the team leaders and assistant team leaders. The majority of team leaders and assistant team leaders were visible, accessible and highly respected by staff.Some of the team leaders did not feel as supported by their managers.
- A risk register was maintained but did not reflect the full needs of the service. Some risks had not been updated since May 2015 despite being graded as critical (red rated)
- Daily teleconferences were in place across all the ambulance stations which allowed managers to understand the resources that were available on that day.
- Local governance meetings had started which fed concerns through to the overall governance forum for NSL. This forum reported to the trust board for NSL.

Summary of findings

- Monthly quality reports were provided to each of the three clinical commissioning groups (Cornwall, Somerset and Devon). These reports contained performance information, details of any incidents and complaints and information on training.
- Communication from senior management to staff was felt to be poor. There was a system of organisation team briefings, but staff meetings were infrequent. Team leader meetings were supposed to take place monthly, but these were not consistent.
- Staff had been kept informed of the on-going contractual issues that were taking place at the time of our inspection (NSL had terminated all three contracts with the assumption that it would re-tender for the contracts).
- Staff told us they enjoyed their jobs and were very patient focused.
- Patient feedback forms were available on each vehicle and the service received positive feedback via these forms. As an example 77 out of 86 people said they would recommend the service in Devon to other people.

We saw several areas of outstanding practice including:

- We observed outstanding care and treatment provided by ambulance care assistants towards their patients
- The overall feedback we received from patients and other health care professionals showed that the ambulance care assistants went above and beyond in their care of their patients

However, there were also areas of poor practice where the location needs to make improvements, including:

- The provider must put systems in place to give an oversight across the South West on the servicing and maintenance of vehicles.
- The provider must have appropriate systems in place to make sure vehicle servicing and repairs are carried out in a timely way and that vehicles with defects are removed from service pending repair.
- The provider must have appropriate systems in place to make sure safeguarding concerns are recorded and reported to the local authority.

In addition the location should:

- The provider should have appropriate systems in place that encourage staff to report incidents, and that they are provided with feedback following the investigation.
- The provider should improve the governance arrangements across the South West Region to have reassurance that consistent practice is being achieved across all six ambulance stations.

Professor Sir Mike Richards
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)		We found there was inconsistency with staff reporting incidents. Some staff had no hesitation in reporting incidents, whilst others told us they didn't report them. When incidents were reported, they were investigated properly and actions taken where necessary. We also found inconsistencies in the training offered to new staff compared to the training offered to staff who had transferred over from another organisation. Staff had received training in adult and child safeguarding at level one. However, the service transported children and none of the staff used to care for children had received training at level two. This was contrary to national recommendations. The majority of staff we spoke with said they would only report a safeguarding concern if the patient gave their consent. This potentially put people at additional risk of abuse because concerns were not shared in a timely way with the local authority. We found the provider had systems in place to make sure patients were not put at risk due to cross infections by making sure vehicles and equipment were cleaned appropriately. Equipment was found to be serviced according to manufactures instructions. However, we saw evidence that showed vehicles were not always maintained or repaired in a timely way. This put patients and staff at risk by travelling in vehicles with defects. Risk assessments were completed by staff when necessary and appropriate. Staff were informed of particular needs for each patient. Staff told us they regularly worked additional hours and missed their breaks because of demand. The provider had a recruitment plan in place to manage their vacancies across the region. New staff had all received a comprehensive induction at the start of their employment. They were able to shadow more experienced staff and received probationary reviews at regularly intervals. Staff who had transferred over from the previous NHS Provider had not received this induction which lead to inconsistencies in the training staff received. Staff were expected to attend three one hour training sessions and complete an annual workbook to refresh their skills. We had concerns that three hours per year was insufficient

Summary of findings

time to cover the necessary topics for mandatory professional development. Staff had received training in the mental capacity act but did not feel it gave them enough information for them to judge people's capacity to give consent. Staff did not transport a patient if they had assessed they did not have the necessary skills in which to do so safely. Each vehicle had bottles of water for patients should they need it. Where patients had been scheduled for longer journeys, the referring hospital would provide the patient with a snack box for the journey.

We found the staff at NSL South West Region to be extremely caring and dedicated towards their patients. We received very good feedback from patients, other health care colleagues and care home managers. We observed very good communication between ambulance care assistants and their patients. The ambulance care assistants treated patients with dignity and respect and at times went out of their way to make sure the patient was comfortable. Crews called patients to inform them if they were going to be late and also to confirm the journey was still planned.

We saw examples of where the planners scheduled journeys that were impossible for the crews to make. There was a lack of resilience with the vehicles across the south west, to cope with the demand. The service had no facilities for patients who did not speak English. Staff encouraged relatives to accompany patients to act as interpreters and told us they would also use children to interpret. This put patients who did not speak English at risk of being unable to make their needs known to staff whilst on a journey. Specially adapted ambulances were available to accommodate bariatric patients. Crews were provided with journey sheets which contained all the information the staff needed such as assistance with mobility. We saw evidence that in some cases; this information was not followed. Each vehicle had details for patients on how to raise concerns or make complaints. Staff we spoke with were aware of the complaints process and could direct patients accordingly.

There was no central system in place to provide managers with an overview of their fleet across the south west. A risk register was in place but we saw that it did not always reflect the needs of the service and some

Summary of findings

risks had not been actioned. Staff were not aware of the overall vision and strategy for NSL South West Region or NSL Ltd. Staff had concerns that the three contracts had been terminated and some were concerned for their jobs. Staff told us they felt supported by their team leaders and assistant team leaders. We had concerns about the level of support and training the team leaders and assistant team leaders and the managers received. Patient feedback forms were carried on every vehicle, although they were not completed regularly. Those that were completed, overall were very positive about the service they had received. The last staff survey was completed in November 2014.

NSL South West Region

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Background to NSL South West Region

NSL South West Region is part of NSL Limited, a nationwide provider of patient transport services. NSL have provided non-emergency patient transport for the commissioners in Kernow (Cornwall), North and East Devon and Somerset since October 2013. This followed a tender process that identified NSL Limited as the highest scoring and performing organisation that bid to provide these services.

NSL South West Region serves a predominately rural area, but also cities such as Exeter and large towns such Taunton, Truro and Penzance.

We inspected all the key elements of the five key questions including whether the service was safe, effective, responsive, caring and well led. We visited the ambulance stations at Exeter, Redruth, Bodmin, Wellington and Shepton Mallet.

Our inspection team

Catherine Campbell, Inspection Manager oversaw a team of three CQC inspectors and three specialist advisors who had extensive experience and knowledge of ambulance services and patient transport services.

How we carried out this inspection

We undertook an announced inspection at NSL South West Region on 3 and 4 November 2015. We visited the ambulance stations at Redruth and Bodmin in Cornwall, Wellington and Shepton Mallet in Somerset and at Exeter in Devon. We spoke to ambulance 14 care assistants, four team leaders, five managers, 20 patients and other health care professionals such as staff at local hospitals. We observed care of patients whilst on their transport journey and we inspected vehicles to check they were clean and had been maintained and serviced.

We requested a broad range of documents both before and during the inspection, including policies and procedures, performance and quality reports, incidents and complaints, safeguarding referrals, training information and vehicle maintenance information. We sought feedback from the three clinical commissioning groups responsible for commissioning services from NSL South West. We also sought feedback from other organisations that came into contact with NSL and their staff. These organisations included four individual care

Detailed findings

homes and the acute hospitals in Taunton, Truro and Exeter. This inspection was part of a pilot inspection for independent ambulance services and therefore has not been rated.

Facts and data about NSL South West Region

NSL South West Region is registered to provide transport services and triage and medical advice provided remotely. The service had a fleet of 80 vehicles including ambulances that could cater for stretchers and wheelchairs, patient transport cars and bariatric ambulances.

NSL undertook over 175,000 patient journeys each year within the South West Region. The service employed over 150 staff and provided transport services 24 hours a day in two of their stations in the South West.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

NSL is one of the UK's largest private, non-emergency patient transport providers, working with clinical commissions groups and their patients in 14 regions across England. NSL South West Region is part of the main provider NSL and provides non-urgent transport between people's homes and healthcare establishments across Devon, Cornwall and Somerset.

NSL South West Region is registered to provide transport services and triage and medical advice provided remotely. The service had a fleet of 80 vehicles including ambulances that could cater for stretchers and wheelchairs, patient transport cars and bariatric ambulances. NSL undertook over 175,000 patient journeys each year within the South West Region. The service employed over 150 staff and provided transport services 24 hours a day in some of their stations in the South West.

At the time of our inspection NSL South West Region had given notice to terminate each of its three contracts in April to September 2016 and was in the process of re-tendering for the Devon contract and intended to re-tender for the Somerset and Cornwall contracts in 2016. NSL South West Region were continuing to provide a service to the three commissioners until April to September 2016.

We inspected the service in November 2013 and were concerned about patients arriving late for their appointments, staff recruitment practices and the safety of their vehicles. We re-inspected the service in June 2014 and were concerned about the lack of consistency of training provided to new staff as opposed to staff that had transferred over. We were also concerned that action was not taken over vehicle defects. We told the provider of the actions it needed to take and monitored these actions at a follow up inspection in December 2014. During this inspection we found the provider had improved its recruitment practices. We re-inspected the service again in February 2015 and found the provider had made significant improvements in their performance. We also found concerns that the provider did not have robust systems in place to provide assurance that people's needs were met and that risks to staff and people were identified and addressed. At each of our inspections, we found the staff to be very caring towards their patients, and this was reflected in the positive comments received from patients about the staff.

Patient transport services (PTS)

Summary of findings

This inspection was part of a pilot programme for independent ambulance services. As a result the service has not been rated.

We found there was inconsistency with staff reporting incidents. Some staff had no hesitation in reporting incidents, whilst others told us they didn't report them. When incidents were reported, they were investigated properly and actions taken where necessary. The provider did not always notify us of incidents involving the police. We also found inconsistencies in the training offered to new staff compared to the training offered to staff who had transferred over from another organisation. Staff had received training in adult and child safeguarding at level one. However, the service transported children and none of the staff used to care for children had received training at level two. This was contrary to national recommendations. The majority of staff we spoke with said they would only report a safeguarding concern if the patient gave their consent. This potentially put people at additional risk of abuse because concerns were not shared in a timely way with the local authority. We found the provider had systems in place to make sure patients were not put at risk due to cross infections by making sure vehicles and equipment were cleaned appropriately. Equipment was found to be serviced according to manufactures instructions. However, we saw evidence that showed vehicles were not always maintained or repaired in a timely way. This put patients and staff at risk by travelling in vehicles with defects. Risk assessments were completed by staff when necessary and appropriate. Staff were informed of particular needs for each patient. Staff told us they regularly worked additional hours and missed their breaks because of demand. The provider had a recruitment plan in place to manage their vacancies across the region.

New staff had all received a comprehensive induction at the start of their employment. They were able to shadow more experienced staff and received probationary reviews at regularly intervals. Staff who had transferred over from the previous NHS Provider had not received this induction which lead to inconsistencies in the training staff received. Staff were expected to attend three one hour training sessions and complete an annual workbook to refresh their skills. We had concerns that three hours per year was insufficient time to cover the necessary topics for mandatory professional development. Staff had received training in the mental capacity act but did not feel it gave them enough information for them to judge people's capacity to give consent. Staff did not transport a patient if they had assessed they did not have the necessary skills in which to do so safely. Each vehicle had bottles of water for patients should then need it. Where patients had been scheduled for longer journeys, the referring hospital would provide the patient with a snack box for the journey.

We found the staff at NSL South West Region to be extremely caring and dedicated towards their patients. We received very good feedback from patients, other health care colleagues and care home managers. We observed very good communication between ambulance care assistants and their patients. The ambulance care assistants treated patients with dignity and respect and at times went out of their way to make sure the patient was comfortable. Crews called patients to inform them if they were going to be late and also to confirm the journey was still planned.

We saw examples of where the planners scheduled journeys that were impossible for the crews to make. There was not enough vehicles across the south west, to cope with the demand. The service had no facilities for patients who did not speak English. Staff encouraged relatives to accompany patients to act as interpreters and told us they would also use children to interpret. This put patients who did not speak English at risk of being unable to make their needs known to staff whilst on a journey. Specially adapted ambulances were available to accommodate bariatric patients. Crews were provided with journey sheets which contained all the information the staff needed such as assistance with mobility. We saw evidence that in some cases; however, that this information was not followed. Each vehicle had details for patients on how to raise concerns or make complaints. Staff we spoke with were aware of the complaints process and could direct patients accordingly.

Patient transport services (PTS)

There was no central system in place to provide managers with an overview of their fleet across the south west. A risk register was in place but we saw that it did not always reflect the needs of the service and some risks had not been actioned. Staff were not aware of the overall vision and strategy for NSL South West Region or NSL Ltd. Staff had concerns that the three contracts had been terminated and some were concerned for their jobs. Staff told us they felt supported by their team leaders and assistant team leaders. We had concerns about the level of support and training the team leaders and assistant team leaders and the managers received because of the lack of specific training and the hours worked. Patient feedback forms were carried on every vehicle, although they were not completed regularly. Those that were completed, overall were very positive about the service they had received. The last staff survey was completed in November 2014, this showed mixed results such as staff felt they got satisfaction from their job but felt the organisation was not well structured.

Are patient transport services safe?

Services provided by NSL South West Region did not make sure that systems and processes kept patients and staff as safe as possible.

There was inconsistency with staff reporting incidents. Some staff had no hesitation in reporting incidents, whilst others told us they didn't report them. When incidents were reported, they were investigated properly and actions taken where necessary. The provider had an obligation under the Health and Social Care Act to notify us of certain incidents. We found this was not always done. We also found inconsistencies in the training offered to new staff compared to the training offered to staff who had transferred over from another organisation.

Staff had received training in adult and child safeguarding at level one. However, the service transported children and none of the staff who care for children had received training at level two. This was contrary to national recommendations. The majority of staff we spoke with said they would only report a safeguarding concern if the patient gave their consent. This potentially put people at additional risk of abuse because concerns were not shared in a timely way with the local authority. We found the provider had systems in place to make sure patients were not put at risk due to cross infections by making sure vehicles and equipment were cleaned appropriately.

Equipment has found to be serviced according to manufactures instructions. However, we saw evidence that showed vehicles were not always maintained or repaired in a timely way. This put patients and staff at risk by travelling in vehicles with defects. Risk assessments were completed by staff when necessary and appropriate. Staff were informed of particular needs for each patient. Staff told us they regularly worked additional hours and missed their breaks because of demand. The provider had a recruitment plan in place to manage their vacancies across the region.

Incidents

- Between September 2014 and May 2015 the provider recorded 47 incidents. On average two incidents were recorded each month, however in April and May 2015,

this rose to nine a month. When we looked at this further, none of these incidents involved patients or the care they received, but related to issues such as staff and planning issues.

- There was a varied response from ambulance care assistants about reporting incidents. Some ambulance care assistants we spoke with were clear about those things they would report and why they should report them. Other ambulance care assistants were less sure about what they should report. Staff in all the locations we visited were familiar with the incident reporting process and some staff told us that they had reported incidents. Staff and managers also told us that incidents were not always reported. We were shown a quality report for the Redruth station completed in May 2015 that found knowledge around incident reporting and processes was poor. We did not see any evidence that these concerns had been addressed.
- Whilst data from incidents was collected and recorded, the majority of staff we spoke with reported that they received no feedback from incidents. Some staff told us this lack of feedback discouraged them from reporting incidents because they felt it was a waste of their time when they could see no action being taken to address their concerns. However, some staff told us they had received feedback from incidents that they had reported.
- Team leaders could not provide us with an overview of incidents which had been reported in their locality. This information was held centrally. The majority of staff we spoke with were not able to describe any changes in practice or improvements which had taken place following the investigation of incidents.
- Where incidents were recorded, the ambulance care assistants or team leader would add the information onto an electronic risk management system. Categories were assigned which enabled the organisation to identify trends where incidents were happening more frequently. These were discussed at staff meetings when they took place.
- We saw evidence that senior staff investigated incidents and actions were developed where necessary. Once the investigation had been completed and actions addressed, the incident would be closed. Incidents were reported to the commissioners via the monthly quality reports.
- Where serious incidents took place, we saw that they were reported to the clinical commissioning group and further action taken as necessary.
- We could not see mentioned within the incident policy that where police had been involved the CQC must be notified. We checked the incident log and it showed an incident that took place on the 27 July 2015 that involved the police. Updates in the incident log on the 12 August and 9 September 2015 were asking the investigating manager if the CQC had been notified. We did not see any evidence that his had been followed up and CQC had not been notified. Failure to notify the Care Quality Commission of incidents such as this was an offence under the Health and Social Care Act.
- The provider had a policy in place regarding their obligations under the Duty of Candour. We found that most of the managers we spoke with had received training and were aware of their responsibilities. Several managers gave us examples of where Duty of Candour had been put into action. For example, an incident had taken place with helping a patient in their own wheel chair onto an ambulance. The manager had made contact with the patient to apologise and to explain the investigation process.

Mandatory training

- There was a variable record in relation to mandatory training (known as professional development training within NSL) Those staff that had been recruited the last two years prior to our inspection went through induction and a range of training. Those staff that had transferred from another organisation had not received the same level of training. The organisation was aware its training was inconsistent and that not all staff were trained to the same standard. A new programme was due to be launched in January 2016.
- Staff we spoke with said that the training courses provided were generally adequate and relevant to their roles. A number of staff mentioned the dementia training and how this had helped them to support

people living with dementia. They said they could better understand what life was like for a person living with dementia. Staff said the basic life support training was a good course delivered by an experienced trainer.

- E-learning had been brought in by the organisation. Staff told us that they had difficulty accessing computers to complete this training and often lacked the log-on details to access the training. In some stations the staff were expected to carry out their training in the staff room which could be busy with other staff and they may get interrupted. Staff were allowed to claim an hour's overtime to complete their training and were able to complete it at home if they had the computer facilities.
- Training records showed that 100% of new starters had completed their induction. However, staff attendance at the three mandatory continuing professional development sessions ranged from 94% for the first session, 87% for the second and 37% for the third session. All staff had completed bariatric training, driver awareness training and emergency first aid at work.
- Workbooks were used to refresh mandatory training skills for staff had been issued to 87% of staff, but only 67% had returned them. We saw little progress to chase staff to return the completed workbooks.
- Courses on managing teams and team leader development were available, 70% of team leaders had undertaken these.
- Staff had received training in the moving and handling of patients. However, some staff told us they did not feel the time allocated to the training was sufficient. We had received feedback prior to our inspection which indicated that a crew had helped a person into their wheelchair by pulling them up underneath their arms. This is not following best practice for the moving and handling of patients and puts the patient at risk of injury.

Safeguarding

- Staff were in a position to recognise potential signs of abuse both for adults and children because a number of people transported by NSL had regular journeys, often with the same crew. Staff said that this consistency helped them to see if something was wrong with an individual patient.
- Not all staff were acting in a consistent way to report safeguarding concerns. The majority of staff we spoke with demonstrated knowledge and understanding of their responsibilities to report safeguarding concerns. Some staff told us that they were not encouraged to report safeguarding concerns because of the time it took to report them.
- A safeguarding hotline number was displayed in every vehicle. Laminated sheets were available on each vehicle which contained information about what to do if the crew were concerned about a patients safety. These had been well thought out and had all the appropriate guidance and information. There was a flow-chart and a simplified mental capacity checklist to help staff determine if a patient did not have the capacity to make their own decisions.
- Staff had a basic introduction to safeguarding included in their induction training. All staff were then expected to have completed the level one safeguarding training. Team leaders were expected to complete training at level two and the clinical governance team received training to level three in safeguarding. We saw evidence that this had been achieved. We were told that the staff manning the safeguarding hotline (who had been in place since 2013) had been trained to level two and were working towards level three.
- NSL had implemented an online training module for safeguarding. Staff had told us that they had been problems in accessing the system because of lack of access to computers and because staff had not been given log on details. Only 11% of staff had been able to complete this new online training.
- Staff told us that they would always seek consent from a patient before making a safeguarding referral. If the person had capacity and refused to give their consent for a safeguarding referral to be made, some staff told us they would not report their concerns. If the patient was a child, the consent would be sought from the parents. When we asked the registered manager about this, they confirmed that in line with the Care Act 2014 consent was always sought.
- Staff were not acting in a way that would protect people from potential abuse by not consistently reporting concerns. Concerns were not always reported to the local authority as the lead agency for investigating

safeguarding concerns. NSL safeguarding policy states ”if consent is not given and their mental capacity is fine, then you can still report it using the hotline, but it will not be escalated by them.” We asked for further information from the provider about this and were shown an information sheet for staff called ”no decision about me without me”. This stated that patients should always be able to make decisions about their treatment. This included any action from moving them to referring a safeguarding issue. This was an incorrect interpretation of the ‘no decision about me without me’ because it did not apply to safeguarding concerns. The Care Act 2014 states ”it is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency”. In the case of an independent ambulance service, the lead agency would be the local authority that would be responsible of carrying out safeguarding investigations and to gain consent when necessary.

- We looked at three referrals to the NSL safeguarding team that had been made in the few weeks prior to out inspection. All three cases contained enough information that warranted referral to the local authority for follow-up and possible investigation. In one case the patient had not given their consent for a referral to be made. In this case, whilst the crew had reported the concerns correctly, no referral was made to the local authority. This decision had later been overturned following a review of the concerns by the registered manager. After a delay, a safeguarding referrals was made to the local authority. This delay had the potential to expose the patient to further risk of abuse.
- We were told that the staff that were able to offer advice via the safeguarding hotline were trained to level two. This was not sufficient to advise and support staff on safeguarding matters.

Cleanliness, infection control and hygiene

- Ambulance care assistants were responsible for cleaning their vehicles inside and out after use. Staff said they were given 15 minutes before each journey to complete their cleaning and spot checks. They told us that they thought this was enough time. Cleaning materials were available at each ambulance station for this purpose. Systems were also in place to use colour coded brushes within each ambulance station to prevent cross infection. We were told that mop heads were replaced weekly. Disinfectant wipes were available on ambulance vehicles. Deep cleaning of ambulances took place every four weeks and was undertaken by a third party contractor. We saw evidence that this was more regular if the ambulance needed it because of contamination. Records we looked at confirmed ambulances were cleaned appropriately.
- Clinical waste bags were carried on each ambulance. These were loose in the ambulance and could expose patients and staff to cross infection risks. Bags were disposed of either at hospitals or at ambulance stations. There was a suitable clinical waste bin at each station. We observed that clinical waste bags were not labelled to show their contents and source and they were stored unsealed on ambulances. There was no apparatus on the vehicles to store the waste during transit.
- During our inspection an ambulance crew was requested to convey a patient who had MRSA. They had been made aware of this status by their control room. The staff demonstrated good understanding of the infection risks associated with this journey and took appropriate precautions to prevent the spread of infection. They returned directly to their base following the journey to clean their vehicle before conveying any further patients.
- Staff wore appropriate work wear and were provided with appropriate disposable personal protective equipment. All vehicles we saw had a stock of hand gel, gloves, aprons, masks and eye wear to protect staff in they needed to support a patient with a known infection or any cross-contamination risks.
- Hand washing facilities were available at each ambulance station. We observed staff washing their hands and using the sanitising gel appropriately.
- All the vehicles we looked at were clean and tidy. The ambulance stations we visited were clean, tidy and well organised. The floors were swept clean in the ambulance parking area and there was excess equipment, so the areas were not cluttered making them easy to clean. There was hot and cold running water and cleaning equipment available in each

ambulance station. Staff said that this was available at all times.We observed staff preparing vehicles for departure and ensuring the vehicle and any equipment carried was clean and safe to pick up patients.

- Patients were able to comment on the cleanliness of the ambulance in the comment cards handed out by the staff. The majority of patients completing comments cards found the vehicles warm, clean and comfortable.
- In the quality report for Cornwall, it was reported that 100% of staff had received training in infection control.
- We were provided with the results of quality audits that were undertaken at each ambulance station. These audits look at how clean the vehicles were and whether policies and procedures were being adhered to. The results were from January 2015 to September 2015 showed: Wellington, Bodmin and Redruth stations consistently achieved nearly 100% compliance.

Environment and equipment

- Information provided to us before the inspection showed that NSL South West Region had 82 vehicles across six ambulance stations.
- The fleet audit showed Wellington and Bodmin scoring 100% for maintenance checks with the vehicles. Exeter scored just over 90%, Redruth and Shepton Mallett scored just over 95%.On previous inspections we found that disposable equipment was not always in date. We checked items of equipment on a number of ambulances at all the ambulance stations we visited. Ambulances were equipped in accordance with checklists and items were in good condition and in date.
- Equipment such as stretchers and wheelchairs had all been serviced according to the manufacturer's instructions. This was evidenced by stickers detailing when they were last serviced and when the next service was due. Stores were well organised and well stocked. However, one ambulance care assistant told us they repeatedly asked for batteries to be supplied for the torch on their ambulance and these had not been provided.
- Staff were provided with equipment to keep them safe when transporting and moving patients. All staff had high-visibility jackets. All the crews wore uniforms made from resilient material which was easy to keep clean. The uniforms carried the logo of the provider and staff and badges they wore at all times to reassure patients of their identity.
- Staff were issued with a personal communication device which they called PDAs. These devices were kept on charge at each ambulance station ready to be used the following day. They provided a crew with a means of communication back to the control room and to receive updates on their journey plans. Phone calls could also be made to and from each device so that crews could stay in contact with their control room and patients where necessary. We saw from the daily teleconference between stations that these devices did not seem to be resilient. On one of the days we visited it was reported that 11 of these devices had been taken out of service because of poor battery charge or other faults. Staff across all the stations we visited told us they did not think the devices were fit for purpose. They said they were unreliable and could not access the information they needed in relation to the additional notes on a patient journey. They told us the devices lost a data connection regularly especially in the more rural areas. This meant they could not receive updates to journey plans.
- Paper versions of the journey plans were available for crews to take with them or return to base to collect as a contingency.
- The environment within each ambulance station in which staff worked were kept safe. All the fire exits were clearly marked with the recognised green sign. Those we checked were not locked from the inside so staff could safely use them in an emergency. We saw that there was a problem with the exit at the back of the Redruth station. There was no lighting outside to guide staff to safety if it was dark. There was no light from street lights or other buildings and no torches provided at the exit.
- Each ambulance station had a white board in the team leader's office which displayed details of each ambulance vehicle. Information such as the registration number, call sign, mileage, MOT and tax date and service history. Mileage was updated by the team leader/ assistant team leader using information recorded by the ambulance crews on their journey sheets completed each shift. We were told that vehicles were serviced every 12,000 miles instead of the

manufacturer's recommendations of 30,000 miles. At the Shepton Mallet station, we found one ambulance that had not been serviced in accordance with the interval set by NSL. Instead it had been serviced at intervals ranging from 13,979 to 16,335 miles. Whilst this was within the manufacturers guidelines, it was not adhering to NSL policy. We discussed this with the assistant team leader who told us that an improved and systematic approach to vehicle servicing was not in place. The information on the white boards supported this.

- We were concerned that there appeared to be no organisational oversight for vehicle servicing and maintenance. The regional head office had no assurance that these were taking place in a timely way. We spoke to the fleet manager for NSL. They advised us that the management of vehicle servicing and maintenance was a local issue. However, they told us that they undertook quarterly audits to offer appropriate assurance. We looked at the audit information for several stations which showed they audited one vehicle only. The audits did not include a review of mileage to determine if the vehicle had been serviced in a timely manner. For Wellington and Shepton Mallet stations the most recent audit was for July 2015 and the previous audit was completed in July 2014.
- Vehicles were not repaired in a timely way. At the start of each shift, staff completed a vehicle daily inspection checklist. Any identified defects were recorded and a carbon copy of the checklist was given to the team leader/assistant team leader to action. Evidence showed that defects were not repaired swiftly. For example, staff had documented that the rear number plate lights were not working on a particular ambulance. They had documented the fault on the daily checklist and a note had been added indicating that the problem had been fixed. The fault was reported again on the following day, indicating that the fault had not been fixed. It was then reported again over a week later. We asked for an explanation of this and were told that the fault had been fixed the first time.
- A second example at the Shepton Mallet station showed that one ambulance had been identified on the 13 October 2015 as having noisy brakes. Over the following weeks there were repeated defects raised in relation to the brakes on the vehicle. The vehicle remained in service until the 30 October 2015 and had travelled over 2,000 miles since the defects were first identified which had the potential to cause harm to the staff, patients and other road users. We asked the assistant team leader the rationale for keeping the vehicle in service. They told us that the nearest Peugeot dealer was more than an hour away and that a vehicle sent for repair might be gone for two or three days. There was no spare vehicle available and therefore they conducted a brake test themselves. Having found the noisy brakes were performing, they kept the vehicle in service until it was reported the brakes became 'sluggish'. We spoke with the fleet manager for NSL who stated that a vehicle with noisy brakes should have been taken out of service immediately.
- On another vehicle we saw that a reversing alarm was identified as not working on the 23 October 2015. Twelve days later this had not been fixed. We rode out on this particular vehicle and we were reassured that the crew made sure that one crew member guided the driver when reversing into parking spaces.
- At the Wellington station, we saw that a worn tyre was identified during a daily check and was replaced in a timely way. However, it was reported on 22 September 2015 that three vehicles had ripped seats, which presented an infection control risk. The problem was reported to the fleet department on 23 October 2015 and had not been resolved by the time of our inspection.

Medicines

- Oxygen was carried on each ambulance vehicle. Oxygen cylinders were appropriately secured in the ambulance and checked during each vehicle inspection. We found that they were in date.
- Oxygen cylinders were appropriately stored in most of the stations we visited. However, at Shepton Mallet ambulance station, some large cylinders were not appropriately secured, presenting a risk of injury to staff due to their size and weight. Stocks of oxygen had been checked which showed the cylinders were in date and ready for use.
- The organisation did not carry or stock any medicines. Patients or carers who accompanied patients were responsible for bringing and looking after their own medicines. A number of staff we spoke with said they

transported patients who were sometimes anxious to make sure they remembered their medicines. The ambulance care assistants said they often made sure the patient had any medicines with them that they needed and had picked up those they had been given by the hospital to take home.

- A medicines management policy was in place. This confirmed that prescription medicines and controlled medicines would not be administered by staff.

Records

- We checked a sample of vehicle inspection checklists at each of the stations we visited and found these were consistently completed.
- The stations had limited records about patients and only kept information it needed to provide safe care. The job plans given to the crews had a number of notes about the patient which included information to keep the patient and crew, and anyone accompanying the patient safe and well. Information included whether a patient had any particular anxiety, mental health problem, and known infections or illnesses. The way the patient needed to be transported was also recorded. For example, if the patient needed a wheelchair or stretcher. One of the team leaders explained how any new information about a patient or their circumstances would be added to help when the patient was picked up next time.
- During previous inspections, we found discrepancies in the staff personnel files. We looked at 19 personal files for staff that had started with NSL since our last inspection. We found these files to be up to date and contained the necessary information. This included checks made under the disclosure and barring system, training records, probationary reviews and risk assessments where necessary.

Assessing and responding to patient risk

- Patients were observed by an ambulance care assistant during their journey. Staff were able to contact the emergency services if they needed urgent assistance in the event of an emergency.
- Known risks or special needs were identified for each patient at the time that their transport was booked. This information was not always adequately conveyed via the hand held electronics devices and had to be printed off at the ambulance stations. Staff told us that information was not always adequate for them to assess any risks. During the inspection we accompanied crews on journeys to convey patients from hospital to their home address. On one of these journeys, the access to a patient's home was extremely challenging. The crew undertook a dynamic risk assessment at the scene to determine the safest way to transfer the patient from the vehicle to inside of their home. The crew felt that the information they had been provided with did not adequately describe the challenges they faced.
- Three out of six staff at the Wellington station reported concerns during their ride along reviews about the information that was available to them to inform them of safe patient handling. We did not see any evidence that these concerns had been acted upon.
- Where possible, team leaders carried out risk assessments at patients' homes or hospitals from where patients would be collected. These assessments would be carried out where patients had limited or no mobility to ensure the ambulance care assistants were able to safely reach the patient and move them with limited risk. There were a limited range of bariatric vehicles and equipment available for patients who needed this and this was assessed as part of the review.
- Staff said there were times when they had transported patients where there had not been time to complete risk assessments. This had resulted at times in the crews being unable to safely assist the patient into their home. Staff described how they had been faced with several flights of stairs for a patient on a stretcher or corners that were impossible to get around with a stretcher or wheelchair. This had resulted in the crews then being delayed for their next appointment as they needed to take the patient back to the hospital for appropriate arrangements to be made. There were times when they were able to get the patient home, but it took significantly longer to do this safely than they had been given.
- Patients who had complex needs were supported. Either when bookings were made, or from existing knowledge of patients, extra resources were considered. Crews were matched against certain patients where possible, such as bariatric patients or those where one of crew

might need to be a specific gender. Patients who were living with dementia or had a learning disability would have a care worker, a member of their family or a close friend accompany them on the journey.

- The comments cards that patients completed from January to September 2015 showed that 31 (out of 36) patients in Somerset, 30 (out of 33) patients in Cornwall and 55 (out of 58) patients in Devon said they felt safe whilst on the vehicle.
- We were shown evidence of special operational procedure notices that were issued to staff when necessary. For example, one of these notices was issued for the storage of medical gases. The notice was dated and contained an introduction to the issue, guidance for staff and actions they should take. Managers and team leaders should disseminate the information to their teams.
- Recognising a deteriorating patient is covered briefly in the staff training. If a patient does deteriorate whilst on the ambulance, staff are instructed to call '999'. Staff were aware of this procedure.

Staffing

- There was a significant shortfall in the number of operational staff employed across the service. Data provided for September 2015 showed that the total number of operation staff that should have been in place was 248 whole time equivalent roles, but only 158.5 whole time equivalent roles were filled. There were significant vacancy rates in all stations: Exeter had a vacancy rate of 38.8%; Barnstaple of 32%; Shepton Mallet of 36%; Wellington of 32%; Bodmin of 39% and Redruth had a vacancy rate of 35%. The vacancy rate for administrative staff and account managers was 3%.
- At the time of our inspection, sickness levels in the South West region were on average 1.4%. However, at Wellington it had risen to 4.5% and in Exeter it had risen to 3.6%. The provider considered these figures to be very low and allowed the local management team to manage capacity relatively easily. To cover shifts where there was an absence, a pool of bank ACAs was maintained who were able to fill the shifts. Overtime was also offered to staff who wished to take it. As a last resort third party companies such as other private ambulance companies and taxi companies were used to convey patients.
- The provider had systems in place to actively recruit staff to maintain establishment levels across the South West. For the recruitment of ambulance care assistants, the provider's internal standard from advert to offer is 14 working days. This meant that from the time the advert closed, the shortlisting, interview and offer should take no more than the 14 days. This aimed to ensure that vacancies caused minimal disruption to capacity and demand. Recruitment administration was completed centrally to ensure fast, consistent and compliant processes are met. Local management teams were responsible for the interviews and driving assessments. All offers were made subject to satisfactory references and clearance under the Disclosure and Barring Service (DBS)
- Information given to us during this inspection told us that there should be 214 full time equivalent staff across Devon, Somerset and Cornwall. This equated to approximately 285 staff. We were told that at the time of our inspection there were 183 full time equivalent staff in post. This meant that the service currently had 31 full time equivalent vacancies. When we asked about this, we were given conflicting information as to how many vacancies existed, ranging from eight to ten. The rest we were told were made up of bank staff. The conflicting information provided to us before and during our inspection showed that staff were not aware of the true number of vacancies within the South West Region.
- Within the quality reports to the commissioners of its service. Staff sickness was reported to have fluctuated between 2 and 5%. In particular, in Cornwall the staff turnover rate rose to 9% in June, July and August 2015 from 2.5% in the previous two months.
- At the time of our inspection, six members of staff were off sick within the control room. This amounted to 40% sickness in the control room.
- Staff told us that they regularly worked additional hours because the journey times were longer than planned. They told us that their breaks were frequently missed due to extended patient journeys or poor planning.
- The provider had a recruitment plan for additional permanent ambulance care assistants, bank staff, team leader and contract manager positions. This was an going process at the time of our inspection.

- At the Bodmin ambulance station, staffing rotas were organised so each member of the crew worked a variety of different shifts in line with their contract. The station operated on a Saturday and these shifts were shared fairly among the staff. There were a reducing and now small number of vacancies for ambulance care assistants at the Redruth station and these were being advertised. There were a number of regular bank staff among the crews who were able to fill vacant shifts or the crews worked agreed overtime. There was, however, a lack of rotation among the crews at Redruth. Unlike Bodmin staff were not being rostered in rotation and the rotas showed crews were not being mixed or sharing less popular shifts with any consistency.

Anticipated resource and capacity risks

- Station managers at local level managed anticipated resource risks by scheduling rotas in advance and managing pre-planned holidays and other leave. Staff said the resource planning to take booked holidays into account had significantly improved. Staff were able to take holidays or days off at short notice if they negotiated this with colleagues or bank staff were available. Those staff we met said they were able to take unplanned time off (such as for funerals or medical appointments) and the managers were helpful and sympathetic towards this.
- Every morning the team leaders at the various stations would hold a telephone conference with the registered manager and control room staff. This allowed issues to be picked up in each area to assist planning for the day. Major road works were noted, but we did not see that daily traffic alerts were communicated to staff in a consistent basis. This would have allowed the journey planners or the crews themselves to avoid road closures, accidents or road works to reduce any possible delays. It was expected that staff rely on their own local knowledge to avoid traffic congestion.
- We observed that it was a common occurrence for staff not to get their breaks. They told us that this was because not enough time was allowed in the schedule for staff to take their breaks. We saw that on occasions journeys would be booked in immediately after the crew's break which meant they then had to drive during their break. Staff told us that they only got their breaks about 50% of the time.
- One manager told us that there was one spare ambulance for each station. They told us that it was always used to convey patients on a daily basis because there was not enough resources to meet the demand. It was acknowledged that this lack of capacity had an impact on when repairs and defects were carried out. But we saw no evidence that this had been addressed.
- Other companies were used on a sub-contract basis by the provider. These companies ranged from other private ambulance companies to private taxi companies. We did not see risk assessments in place for the capacity of these companies to provide a safe and effective service.

Response to major incidents

- The team leader for Cornwall had recently attended a multi-agency desk-top resilience planning event. This included, for example, the local healthcare providers, the police and fire service. This gave each of the service providers in attendance an insight into the role they would play in the event of a major incident. Another team leader said the key contact numbers for the provider were shared with the local hospitals and they would be contacted in the event the service would be asked to support any major incident.

Are patient transport services effective?

We found that services provided by NSL South West Region needed to be improved to make sure their services and staff were effective for patients.

New staff had all received a comprehensive induction at the start of their employment. They were able to shadow more experienced staff and received probationary reviews at regularly intervals. Staff who had transferred over from the previous NHS Provider had not received this induction which lead to inconsistencies in the training staff received. Staff were expected to attend three one hour training sessions and complete an annual workbook to refresh their skills. We had concerns that three hours per year was insufficient time to cover the necessary topics for mandatory professional development. Staff had received training in the mental capacity act but did not feel it gave them enough information for them to judge people's capacity to give consent.

Patient transport services (PTS)

Staff did not transport a patient if they had assessed they did not have the necessary skills in which to do so safely. Each vehicle had bottles of water for patients should then need it. Where patients had been scheduled for longer journeys, the referring hospital would provide the patient with a snack box for the journey.

Staff at an acute hospital reported very good relations with NSL staff, but commented on the delays that patient's sometimes experienced. Relationships with control staff and planning staff were at times strained. There was a perception amongst ambulance crews that control and planning staff had a limited understanding of operational demands and that journey schedules were unrealistic. Staff had received training in the Mental Capacity Act 2005. This training was very short and only took approximately 20 minutes to complete.

Evidence-based care and treatment

- NSL staff did not set or assess patient's eligibility to travel on patient transport. The eligibility criteria was set nationally and it was the responsibility of the providers booking patient transport to make sure it was used for patients who meet the criteria.

Assessment and planning of care

- Staff did not transport a patient if they felt they were not equipped to do so, or the patient needed more specialist care. Staff were not clinically trained, but did seek advice from clinical staff at the hospital or care home as necessary or the clinical lead for NSL. If a patient was observed or assessed as being not well enough to travel or to be discharged from the hospital, the ambulance care assistants made the decision to not take them. Other arrangements would need to be made to support the patient during this time, such as them remaining at home or in hospital. If a patient was assessed during their journey as becoming unwell, the crew would safely stop the vehicle and call for an emergency ambulance.
- Ambulance care assistants were made aware of any special needs the patient might have via the notes on the journey sheets. These detailed if they had mobility needs, mental health needs or health needs that needed to be taken into consideration.

Nutrition and hydration

- Although most patients were undertaking a short journey, any nutrition and hydration needs were considered. Each vehicle carried bottled water for patients should they need it.
- Ambulance Care Assistants made sure any patients who might have longer journeys or be at the hospital for a long time had either had something to eat and drink before they left or access to food. One patient we spoke with said how the crew they travelled with had mentioned to the staff in the outpatient department how the patient had "not had a cup of tea for ages" and staff at the hospital made them a hot drink. Two of the ambulance care assistants told us they made sure any patients they were collecting from renal dialysis appointments (a frequent type of journey) had been given a cup of tea and something to eat so they felt well enough for the journey home.

Patient outcomes

- The ambulance care assistants ensured patients were not left at home without being safe and supported. Some patients were discharged from hospital and had a package of care to be arranged at home. If the support person or team had not arrived when the patient came home, the ambulance care assistants called the station to find out where they were. The patient would not be left alone until either the care team arrived, or the patient was safe in the care of their family or carer. If the care team were not coming due to an administrative or other error, and the patient could not be left, they were returned to the hospital to be looked after until arrangements could be remade.
- Over the two and a half years since being awarded the contracts, the provider had not been delivering to the performance standards agreed in the contracts. Delays in getting patients to their appointment had the potential to directly affect their care and treatment. At previous inspections we saw examples where patients had missed their treatments because of delayed transport. Prior to this inspection the commissioners confirmed that they had seen improvements to their performance, but it still remained a concern. We looked at quality reports for each of the three commissioners however, no specific performance data was provided.

Competent staff

Patient transport services (PTS)

- The service had recently (six weeks before our inspection) introduced a structured system of supervision and review. Each staff member was required to undergo a 'ride along' assessment twice yearly and each assessment would be followed by a performance review two to three weeks following the ride long. At Bodmin and Redruth stations, the appraisals and 'ride along' reviews were up-to-date or booked in. However, at the Wellington station, where the team leader worked single-handedly and was responsible for 33 staff, progress had been slow. At the time of our visit only seven staff had received a ride along assessment and no performance reviews had been undertaken. Some of the documentation was incomplete and had not been signed by the staff member or the assessor. Neither of the team leaders at Wellington had received a performance review since they had been in post. They had also not received regular formal supervision or support from their direct line manager, the client account manager.
- Ambulance care assistants felt they had adequate training which equipped them for their role. New staff employed by NSL completed a week's induction training and were then required to complete a work book (that refreshed and tested their knowledge on safeguarding, manual handling, infection control and health and safety) and a reflective learning log over a period of twelve weeks. During that period they were reviewed by their team leaders at four, six and eight weeks. The newly appointed staff we spoke with told us their induction had been useful and had equipped them well for their role. Staff who transferred to NSL from the predecessor NHS provider had not undergone NSL induction training.
- Each new member of staff had a set induction programme plus a workbook. Their training and progress was monitored by the team leader. The course followed was training to be an ambulance care assistant. This was undertaken by not just the patient transport team, but also the team leaders and regional managers. Most staff then went out with a two-person crew for three days to observe and learn and for their driving to be observed by the more experienced crew. If a new member of staff felt they wanted a longer period of being the third crew member, this was at their discretion and that of their manager. We observed a new member of the team in Bodmin being asked by their team leader if they felt ready to work in a two-person team, as they were observed as doing well, or if they wanted any more time. This was a mutual decision between the team leader and the new member of staff.
- A training and development policy was in place. The policy stated that each year every employee had to complete a continuous professional development (CPD) workbook. The workbook included sections on safeguarding, capacity to consent, infection control issues, greener driving, information governance and basic life support. In addition to the workbooks, staff had to attend three one hour training sessions which incorporated manual handling, basic life support, oxygen therapy, looking after an unconscious patient and control of bleeding. We were told that between 81% and 84% of staff had attended the practical sessions and that NSL expected 85% of staff to complete them. We did not see this 85% target specified within NSLs training policy. When we asked the training manager about this, we were told it was just a target that they had picked and not one set across the provider. By not setting an organisation wide target, managers would be unable to assess performance against the targets.
- We found that team leaders had received limited supervisory training for their role.

Coordination with other providers

- There was a patient liaison officer employed at one acute hospital, who worked alongside the hospital's transport manager. The patient liaison officer was highly regarded within the hospital and staff said that when this person was off, the post was not covered. They felt that this absence should be filled. Staff at an acute hospital reported there was a good relationship with NSL and felt that communication between the two organisations had improved. They told us that NSL demonstrated flexibility and ability to respond to and prioritise patients based on their clinical need.
- Staff in the discharge lounge at the acute hospital reported a good relationship with NSL staff. Staff also report that they were unhappy about long waits for some patients who were awaiting ambulance transport to take them home.
- In Cornwall, the relationship with other providers was improving and efforts had been made by NSL and the

other providers to understand the roles of one another. The Cornwall manager had met with the transport coordinator at an acute hospital and had regular conversations and monthly meetings with them to ensure things were running relatively smoothly. The service managers also spoke with GPs to make sure they had sufficient information about a person before going to pick them up.The ambulance care assistants spoke regularly with the hospitals and other providers such as care homes if they were running late or had encountered problems. There was a good working relationship with the local hospitals in Cornwall, for example. Staff said the hospitals would cooperate as much as possible to accommodate patients who were going to be late due to circumstances outside anyone's control.

Multidisciplinary working

- Relationships with control staff and planning staff were at times strained. There was a perception amongst ambulance crews that control and planning staff had a limited understanding of operational demands and that journey schedules were unrealistic. Most of the staff we spoke with expressed frustration that they were unable to meet scheduled times and key performance indicators which had been agreed with the commissioners of the service. They were concerned about the impact on patients who frequently experienced delays and long journey times. Staff member told us "I always seem to be apologising." Staff also told us that unrealistic scheduling put pressure on them and resulted them working longer hours and missing their breaks. The control room staff told us they had to book the journeys even though they knew the ambulance could not do it in the time allowed in order to meet demand.
- There was criticism of the control team from one acute hospital that we spoke with. We were told by senior healthcare professionals how the control team, in their opinion, could be rude and unhelpful at times. They said the controllers appeared to have no appreciation of the vulnerability of patients. They said the service planning was poor and did not treat the patients as individuals with specific needs. They told us there was an impact on patients who were sometimes upset and felt undervalued. Other staff at the hospital said they had a high degree of respect for the local teams, but the organisation was not enabling them to deliver a good service. They had sympathy for the complexities of managing an ever-changing service, but said even the regular planned trips for patients were unreliable.

Access to information

- Staff received patient details via hand held electronic devices (known as PDAs) at the start of their shift. Information about particular needs were included but could not be viewed on the PDA. This required the team leaders to access the information and print it for the crews or for the crews to contact control to ensure they had all relevant information. The service was experiencing regular problems with PDAs not working and there were frequent occasions when staff relied on mobile phones for communication. Staff told us this was sometimes problematic in rural areas where mobile coverage was unreliable.
- After some consultation with the local clinical commissioning groups, the service now had a resolution for how it was to receive and handover information about patients' decision around resuscitation. The service insisted that ambulance care assistants were provided with the original document describing a patient's or their loved one's wishes should the patient suffer a cardiac or respiratory arrest. This document should stay with the patient during the journey and handed to the appropriate professional on arrival so that it stays with the patient. The document needed to be current and properly completed by the appropriate healthcare professional. All the commissioners or providers associated with the service had been told that the ambulance care assistant would commence resuscitation for a patient if required if this document had not been provided. Staff consistently applied the policy across Somerset, Devon and Cornwall. The document would be returned to the patient or their carer either by the service or the healthcare provider when the patient was discharged from their care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training in the Mental Capacity Act 2005. This training was very short and only took approximately 20 minutes to complete. Staff told us that the training had been useful but had not given them enough information for them to judge people's capacity

to give consent. Where staff had concerns, they said they were able to phone the control room for advice. The control room staff however did not have any additional training to be able to advise crews.

- We found that staff we spoke with had no working knowledge of the Deprivation of Liberty Safeguards (DoLS) or how they applied in practice. There was no training for staff in understanding the way in which DoLS might relate to their services, even though this would be in a limited sense. Staff did not have the confidence to undertake basic mental capacity assessments.
- Staff understood the need to have valid consent when supporting patients. Examples included staff asking patients for their consent to be moved, placed into a wheelchair or a stretcher. The ambulance care assistants said they also knew they could not expect a patient to do anything against their will. If they were supporting a patient who did not have the mental capacity to make their own decisions, they would support them as much as possible. Staff said, however, they would act in the patient's best interests but would not expect a patient to comply with anything they clearly did not want to do. We were given an example in Cornwall, for example, when a confused patient refused to board a vehicle at the hospital. The ambulance care assistants took the decision to return the patient to the hospital where they could be cared for. They requested their control team to rebook the journey for later that day when the patient was then able to travel without anxiety.

Are patient transport services caring?

We saw that NSL South West Region provided caring services to its patients. We found the staff at NSL South West Region to be extremely caring and dedicated towards their patients. We received excellent feedback from patients, other health care colleagues and care home managers. We observed excellent communication between ambulance care assistants and their patients. The ambulance care assistants treated patients with dignity and respect and at times went out of their way to make sure the patient was comfortable.

Crews called patients to inform them if they were going to be late and also to confirm the journey was still planned.

Compassionate care

- Ambulance care assistants were variously described by hospital staff as "polite and courteous", "patient focussed" and "good at communicating with patients". One hospital staff member told us "patients are happy; they really enjoy the journey". At another hospital, the staff commented upon the excellent caring and compassion of the NSL staff, describing how they went 'over and above' to support patients.
- We observed staff interacting with their patients. We saw them introduce themselves to patients and chat to them in a friendly and appropriate manner. They checked with patients how they wished to be addressed. One patient felt anxious about their transfer from the ambulance to their home. The crew spent time kneeling at the level of the patient explaining what they were going to do and reassuring the patient that they were safe. We observed a crew chatting to an elderly patient about their experience during the war. Another crew chatted to their patient about their family and their pet.
- Staff took care to ensure patients were comfortable. They warned patients before they drove over any bumps in the road. They offered blankets to a patient. One patient told us " I have been treated like royalty."
- The privacy and dignity of patients was maintained. Patients who were being moved in wheelchairs or stretchers were encouraged to have a blanket to cover them or keep clothes from riding up. A patient we spoke with said they used the service regularly and staff did not talk about other patients or divulge their private information. The patient said although other patients on the transport might talk freely about their appointment or health, staff treated this information confidentially and "don't gossip about other patients."
- Three patients we talked to on the phone, who regularly used the Cornwall service, spoke highly of the service they received.One said they "could not find fault with the service" and "they are brilliant the staff, all of them." The ambulance care assistants called their patients before they left the station to pick them up to say they were on their way.
- Staff cared about doing the right thing for the patient. One patient told us how staff always asked where they wanted to sit when they were dropped off their

outpatient appointment. The patient used a wheelchair and said they had experienced with another provider just being sat somewhere where there as a space and it was easier for the staff. NSL staff, however, made sure the patient sat where they wanted to be and made sure there was enough room for them to be comfortable. Ambulance care assistant staff said they checked with patients if they needed to use the toilet before they were transported, and gave them some idea of how long they might be on the vehicle if that helped them to decide.

- Before our inspection, we asked for feedback from stakeholders on the services provided by NSL. The comments that we received were very positive overall. A manager of a care home said "We have found them to be very obliging and helpful. They are often a little late for pick up, but this may be understandable due to time scales". "The crew were very good and helpful" (Manager of another care home).
- One care home manager told us that they had concerns about the length of time some of their residents spent on ambulances.
- We looked at the responses of the returned comment cards from January 2015 to September 2015. These showed that in Somerset 33 out of 41patients said they would be likely or very likely to recommend the service to their friends and family. In Cornwall 38 out of 49 patients said they would be likely or very likely to recommend the service to their friends and family. In Devon, 77 out of 86 patients said they would be likely or very likely to recommend the service.

Understanding and involvement of patients and those close to them

- Patients were treated with patience and kindness to help them understand what was happening or where they were going. Ambulance care assistants explained how some patients could be anxious or confused. They said they would try and help the patient to understand where they were going and why and how they would be looked after in the vehicle. Patients who were known to be living with dementia or were anxious usually had a carer such as a family member to go with them on the journey, and this was encouraged and welcomed by the crew.
- We saw that crews were supposed to call patients ahead of their planned pick up time to confirm they were on time of if the ambulance was subject to any delays. We found this was not consistent practice amongst staff. Some staff told us they regularly phoned patients, but other staff told us they didn't phone for a variety of reasons. One member of staff told us that they had to pick one patient up very early in the morning and felt it was inappropriate to call the patient before 7am. Staff told us they had not been given any guidance on this. Another member of staff told us they had been given the incorrect number. Phoning ahead could reduce unnecessary journeys that had been cancelled but the transport had not been informed of this.

Emotional support

- On the rare occasion a patient died in the care of the service, family members and carers were supported. The ambulance care assistants would contact their office to alert their manager and would then be given time, if the situation needed it, to support the family until other people arrived to help.
- Staff recognised where they could help patients. As an example a patient we spoke with said how the crew who were taking them home spotted a frail patient who was waiting for transport which would be some time in arriving. The staff contacted the control team who arranged to bring this patient onto that service. The patient was then taken home much earlier than they would be. The other patient said they had been asked if this was OK with them and they said they were only too happy to have seen this patient helped.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

We found that the services provided by NSL South West Region were not always responsive to people's needs. We saw examples of where the planners scheduled journeys that were impossible for the crews to make. There was a lack of resilience with the vehicles across the south west, to cope with the demand. Each ambulance station had a vehicle that could be used as a replacement whilst other vehicles were in for service or repair. We saw that these vehicles were in use every day because of the demand. There were therefore no spare vehicles to cover when necessary.

Patient transport services (PTS)

The service had no facilities for patients who did not speak English. Staff encouraged relatives to accompany patients to act as interpreters and told us they would also use children to interpret. This put patients who did not speak English at risk of being unable to make their needs known to staff whilst on a journey. Specially adapted ambulances were available to accommodate bariatric patients.

Crews were provided with journey sheets which contained all the information the staff needed such as assistance with mobility. We saw evidence that in some cases; however, this information was not followed. Each vehicle had details for patients on how to raise concerns or make complaints. Staff we spoke with were aware of the complaints process and could direct patients accordingly.

Service planning and delivery to meet the needs of local people

- Staff expressed frustration that they were frequently unable to achieve key performance indicators (KPIs) in respect of patient collection and arrival. There were widespread concerns expressed that journey schedules were unrealistic and not achievable. One staff member told us "we are set up to fail". As an example. A crew came on duty at 11.30am and their first journey was to collect a patient from an outpatient appointment at a hospital located 16 miles away. Using a recognised route planner we saw that this journey was estimated to take 31 minutes. This allowed no leeway for any unexpected delays and more importantly, did not take into account the time required (15 minutes) to undertake mandatory vehicle checks before leaving the station. The journey time was in fact 34 minutes and the patient was late being collected, which then immediately had a knock on effect on the remainder of their schedule.
- There were times when the centralised planning of jobs for the crews in Cornwall did not take sufficient account of local geography or terrain. There were examples shown on job sheets of times given to crews to pick up a patient or a number of patients and drop them to the local community or acute hospital. The times given to complete these journeys did not, for example, take into account the frailty or mobility of the patient and it taking longer for them to board the ambulance than a more able person. All the crews we met said this, coupled with a lack of sympathy or understanding from the control team, was their biggest concern.
- There was a lack of resilience within the service in Cornwall. The Redruth station had 11 vehicles to meet the contractual work. There was one vehicle maintained as a spare to support the fleet. However, this vehicle was in almost full active service to meet demand for journeys. There were vehicles hired from a third party to supplement the fleet at times. When we were at Redruth one of these was in use. It had been supplied; however, with faults. The winching system for pulling a stretcher into the vehicle was broken and staff were having to use the vehicle without this facility. There was a risk that had not been considered in Bodmin due to six of their seven vehicles having their MOT due in the same week. This could have resulted in any of these vehicles being out for repair at the same time. We were told that these vehicles would be booked in over the course of a month for their MOT, but at the time of our inspection this had not been evidenced.
- Staff for example, had sometimes to refuse to carry patients who were not fit to travel. Patients, who were usually described as high dependency, did not meet the criteria for the emergency ambulance team, but also did not meet the criteria for the patient transport service provided by NSL. The ambulance care assistant crews were clear on the criteria for their patients and, rightly, not prepared to put patients at risk by transporting a patient who needed more support or facilities than could be provided. This was something not always understood by the hospitals, GPs or care homes booking NSL services. Staff said this had placed them in difficult positions with other providers who did not have other options available to them at short notice.
- The provider had developed their own patient's charter which was displayed in every vehicle. This set out what patients could expect from NSL South West Region.
- Staff had told us about being set impossible journeys by the planning and control room. This meant that the patient arrived late for their appointment or treatment. During our inspection, we spent time in the control room and observed this in action. As an example, one crew had been allocated five minutes to drive from Exeter to Exmouth (a distance of approximately 10 miles). The crew raised this with the planner and were told that it had to be 'squeezed in'. This had an impact on later work for that crew which had to be re-planned.

Meeting people's individual needs

Patient transport services (PTS)

- There were no facilities for patients whose first language was not English. This meant staff were unable to communicate with non-English speaking patients' and were not able to identify their needs during the transport journey. We asked the managers about this and were told that no policy existed within NSL and no arrangements were in place with an interpreting service. We were told that some staff spoke other languages and were able to translate, but that they were not qualified interpreters. We were also told by managers and staff that they would allow a child or young person to interpret for their family member. National good practice dictates that qualified interpreters should be used when necessary and that under no circumstances should children be used to interpret for their parents or relatives. Staff told us about one patient that they conveyed regularly that did not speak English. Staff said they always encourage a relative to accompany them on their journey to interpret when necessary, but admitted that this was not always possible. We asked what happened when the patient was alone, and what if she experienced any problems during the journey. We were told that the patient would make themselves known, but could not give details on how they would do this.
- Staff who had received induction training provided by NSL told us they had received helpful training to assist them to care for people who lived with dementia. Staff who had transferred to NSL from another provider had not received this training. Those staff told us they had been encouraged to read leaflets and access on-line training resources instead. Staff we met had good knowledge and experience of working with people living with dementia or with a learning disability. One ambulance care assistant said "lots of smiles and encouragement really help." Care workers and members of the patient's family were required to accompany the patient so they were able to support them at the hospital or make sure the patient was not alone when they went back home.
- Each station had access to a specially adapted ambulance equipped with a stretcher and wheelchair which could accommodate bariatric patients. Some staff told us that the wheelchair provided for bariatric patients was not fit for purpose because it was not sufficiently wide. Staff told us they had repeatedly reported concerns about the inadequacy of this equipment but it had not been replaced. We did not see these wheelchairs in use during our inspection. We asked the registered manager about the specifications for the bariatric equipment and were told they were fit for purpose. We were shown information from the manufacturer which confirmed they were sold specifically as bariatric equipment.
- The crews were given journey sheets detailing who the patient was, where they were picking them up from and taking them to. Notes were also included which gave staff additional information on the individual needs of the patient. As an example, one note stated "patient is wobbly and will need assistance into their property". Another example stated "please make sure patient is there on time as always late and misses treatment". Staff told us this information was very useful but that it was not always accurate especially when detailing access arrangements into people's property. We did see that in some cases the needs were ignored completed. As an example, on one journey sheet, it stated "mental health patient, has anxiety, travels alone with no other patient as patient can get emotional". We noted that despite this evidence in the journey sheet showed that this patient was picked up with another patient sharing the same ambulance.

Access and flow

- Patient delays were communicated to patients and providers as much as possible. The crews carried either mobile phones and/or personal digital assistants (PDAs) where they accessed information about their jobs for the day. They were in frequent contact with the control team or their station manager and would let them know if they were running late due to unforeseen circumstances.
- Patients were able to comment on whether their transport had arrived on time. In Cornwall 32 (out of 37), Somerset 31 (out of 39) and Devon 50 (out of 58) patients felt the punctuality was either good or great.

Learning from complaints and concerns

- Information provided to us prior to the inspection showed that from January to March 2015 the region received no complaints. However, this rose to 26 complaints in April 2015 (following the introduction of new systems to make patients aware of how to complaint), 24 complaints in May 2015 and then reduced to 19 complaints in June 2015 and 11

complaints in July 2015. For August 2015 through to October 2015 six complaints were received. No complaints were received that were graded as high risk from January to October 2015. The themes were predominantly about delays to patient journeys.

- There were leaflets displayed in ambulances advising how patients could complain if they had any concerns about their care or their ambulance journey. Staff we spoke with were not aware of any themes that had been identified through complaints because they received no feedback about this.
- One staff member told us they had been the subject of a complaint from a member of hospital staff. The complaint had been made at the beginning of the year but despite requesting feedback on numerous occasions, they had not received any. They said that they were frustrated that they were not fully aware of the nature or the detail of the complaint and could therefore not take any learning from this event or amend their practice accordingly.
- Most concerns or complaints were dealt with by local resolution and informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement followed up by a further letter once an investigation had been made into the complaint.
- Ambulance care assistants had not been given any formal information about any complaints made to the service and how they had been resolved. Staff knew from their patients; however, that most complaints were about a lack of communication or being late for visits, often due to circumstances beyond their control. Those we met in Cornwall felt communication with patients and other providers had improved. They also liaised with the local hospitals to tell them if they were unavoidably delayed and check if the patient's appointment could be moved forward – which they were often able to accommodate.

Are patient transport services well-led?

We found that NSL South West Region needed to make changes to make sure it's governance processes and systems were fit for purpose. There was no central system in place to provide managers with an overview of their fleet across the south west. A risk register was in place but we saw that it did not always reflect the needs of the service and some risks had not been actioned.

Staff were not aware of the overall vision and strategy for NSL South West Region or NSL Ltd. Staff had concerns that the three contracts had been terminated and some were concerned for their jobs. Staff told us they felt supported by their team leaders and assistant team leaders. We had concerns about the level of support and training the team leaders and assistant team leaders and the managers received.

Patient feedback forms were carried on every vehicle, although they were not completed regularly. Those that were completed, overall were very positive about the service they had received. The last staff survey was completed in November 2014. There was not enough capacity to meet the demand for patient journeys. Initiatives that worked in other NSL areas had not been suggested for the South West Region because we were told it 'was a local problem'.

Vision and strategy for this service

- The provider had developed a set of values and these were displayed in the ambulance stations. There was as patient's charter displayed in ambulances. Staff had not been involved in developing these values but in conversation with us they demonstrated that they were driven by the desire to provide good patient care. A number expressed that they felt the provider was not patient-centred but was driven by finance.
- Some staff were not aware of the vision and strategy for the service. They understood, to an extent, the strengths and weaknesses of the organisation as it related to patient transport. Staff in Cornwall were; however, aware of local-level strategies. They spoke to us of patients being their focus and delivering a caring and safe service were the local priorities.

Governance, risk management and quality measurement

- An account director led the team for NSL South West Region. They were supported by three client account

managers (one for each county), team leaders and assistant team leaders at each of the six ambulance stations. Additional support is provided by clinical governance managers and administration staff.

- A risk register was maintained but this did not fully reflect the concerns identified by team leaders during our visits. We noted that it was recorded in June 2015 that planned quality auditing to measure performance and offer time to ambulance care assistants was not consistently being completed across the south west. The associated action was recorded as "ensure that TLs [team leaders] have sufficient resource to undertake quality audits and these are planned into weekly duties. This risk register entry was closed, despite the fact that progress in completing the quality audits in Somerset was poor. A risk register was in place for the South West Region. In some instances we saw evidence that the risks assessed as red (critical) had actions against them and were being resolved. However, we also saw one risk had been added in May 2015 regarding vehicle maintenance and breakdowns affecting the ability to deliver. This risk had been rated as red, but did not have any actions or updates against it. During our inspection we identified areas of concern because vehicles were not being repaired in a timely way. The organisation was aware of this issue and yet no action had been taken to resolve it. We did not see the issues with e-learning log in or the personal communication devices recorded on the risk register.
- There was a daily teleconference attended by team leaders throughout the region and control. This forum had been established to improved communications between the control and delivery functions.
- The service had established a number of key performance indicators in consultation with commissioners. These included standards in relation to timeliness of patient collection and arrival. Performance for September 2015 had recently been shared with the stations. Staff told us this was the first time they had received this information and prior to this they did not know how they were performing. Performance data for October 2015 was not yet available at the time of our inspection.
- There had been little evaluation of the roles of the team managers and leaders. Those we met in Cornwall were carrying out a lot of administrative tasks with little time to support and manage their staff. There had been some improvements in Redruth with one of the ambulance care assistant staff taking responsibility for the rotas, but ambulance care assistants otherwise had no access to computers and relied upon managers to deal with all administrative or reportable matters.So, for example, staff had no access to the incident reporting system to be able to make their own reports. They could not access policies and procedures online and search for information. The team leaders were also taking responsibility for management of the vehicles, and this was not being centrally organised.
- Although this was favoured among the Cornwall management, there was no encouragement or provision for staff to have key roles.The ambulance care assistants did not have areas in which they could be trained as the expert. There were certain areas of the service, such as infection control, equipment management, patient feedback, where staff could take extra responsibility, but this was not happening. The ambulance care assistants were therefore not involved with audit work or any peer review. The organisation had not taken advantage of the experience and knowledge of their workforce in this way, and the enthusiasm among the staff to learn and develop staff for the future.
- A governance forum meeting took place monthly. The forum reported to the NSL trust board to assure them of patient safety, risk management, quality and compliance. Local governance meetings had been established. At the time of our inspection we were told that these meeting had just started and we were able to see the minutes from that meeting. The minutes were not dated although from the action log the meeting took place on 19 October 2015. The action log listed the actions to be taken following the meeting but no timescales had been specified. At the time of our inspection, all but two of the actions were still listed as pending.
- Each month, quality reports were produced for each of the three commissioners. We looked at a selection of these reports for Somerset, Devon and Cornwall for July and August 2015. The reports contained details of any serious incidents, complaints received, training for topics such as infection control.
- We saw evidence that NSL South West Region used third party companies to provide patient transport. We

checked what quality checks were in place with these companies so that the management would be reassured the third parties provided a safe and effective service. We were told that all the third party companies had yearly quality checks. We asked for evidence of these. We saw that the third party companies were required to submit a checklist confirming compliance in a number of areas such as staff held enhanced DBS checks. We did not see any evidence that NSL made any attempt to verify the information supplied in order to assure themselves of the services offered by these third party companies.

- The provider did not have robust systems in place to make sure that any company they sub-contracted work to was suitable to provide patient transport work on behalf of NSL South West Region.
- We were concerned that there appeared to be no organisational oversight for the servicing and maintenance of the vehicles across NSL South West Region.

Leadership of service

- Staff told us they enjoyed their jobs and they felt well supported by their team leaders/assistant team leader.
- Team leaders and assistant team leaders were visible, accessible and highly respected. Many staff expressed the view that these individuals were over-worked and under-supported. The team leader at Wellington Station had been without the support of an assistant for two months. They told us they were struggling to cope with the demands on them. They frequently worked long days without a break. They had raised concerns with their manager on numerous occasions but support had not been forthcoming. The day prior to our visits an ambulance care assistant was allocated to support the team leader on a short term basis. They told us they had provided support previously while the team leader was absent. They had received no training and little support in this role.
- The team leaders reported to the client account manager for Somerset. We were told by staff that the client account manager was present in the station two to three times a week at Wellington. However, they were seen infrequently at Shepton Mallet station.
- Staff told us that communication from senior management was felt to be poor. There was a system of organisation team briefing; however, meetings were infrequent. Team leader briefings were supposed to take place monthly but, the last meeting held was in July 2015.
- Staff meetings were also infrequent at both Wellington and Shepton Mallet stations. Meetings had taken place in October 2015. It was recorded in the minutes of the meeting held in October in Shepton Mallet that crews had been waiting two years for computer access and this had not been rectified. This had also been raised at the last staff meeting in April 2015. Staff also raised the fact that they could not access on line training. They were advised by the client account manager to access this via the team leaders' or assistant team leaders' account. Staff also raised concerns about unrealistic scheduling of journeys.
- Lack of communication was frequently cited by staff as an issue. We looked at the documentation completed in six ride along reviews (quality audits) recently undertaken at Wellington. Staff reported that they did not have opportunities to access team briefings and meetings and that they spent insufficient time with their line manager.
- A staff member at Shepton Mallet said "communication is letting staff down. Nobody above team leader wants to take responsibility." Another staff member said they were uncertain about what was happening with contracts and were not sure what direction the business was going.
- It was recorded in the NSL south west risk register recorded "Internal audit processes have identified that communication is a major issue amongst ambulance care assistant colleagues, with many feeling that they do not have sufficient time with managers and sufficient information." It was recorded that there were plans to introduce a programme of higher visibility management and to organise team briefing and meetings. Staff told us that only two meetings had taken place.
- Staff had received written and verbal information about the on-going contractual discussions with commissioners but expressed disappointment that senior managers had not communicated with them

directly regarding this. Team leaders had been informed via a teleconference and were then instructed to read a statement written by the account director to staff. This made sure that all staff received the same message.

- There was new leadership in the Cornwall team and staff told us that significant improvements had been made to low staff morale and performance management. The changes to management were not complete as recruitment for new staff was underway.However, the manager with oversight for the Cornwall stations at Redruth and Bodmin had already tackled many of the management failures and there were significant improvements. Both the management and the other staff recognised there was still work to do, but those things still to be addressed were understood and acknowledged. The staff we met said they were prepared to 'do their bit' to help the improvements embed and continue to raise morale.
- There was poor visibility or contact with the senior staff in the wider organisation. There were a number of senior staff around when we carried out our inspection. Most of the crews did not know who these people were and we noticed no effort by the senior staff to introduce themselves or speak with the ambulance care assistants.

Culture within the service

- Staff told us they enjoyed their jobs and they felt well supported by their team leaders and assistant team leaders. However, some staff reported in their ride along reviews that they did not feel respected and valued.
- Team leaders felt unsupported both in terms of practical and management support. The team leader at Wellington had told their manager that had a very large workload but this had not been addressed. At a local level in Cornwall we were impressed with the focus on the patient as the priority for all the staff. The service in Bodmin, for example, had a number of very regular patients the staff had got to know well. We spoke with two of these patients and they had high praise for the staff and their values and behaviours. We observed a cheerful group of people who worked hard and wanted to do a good job.The local station and county managers cared about their staff and their wellbeing.
- A number of staff we spoke with in Cornwall felt they were being given either very hard or impossible work schedules by the central control. They felt this was due to poor communication and a lack of understanding of local geography and time to meet patient needs by remote staff. It was also caused by pressure to complete workloads, which staff felt was understandable. Staff were told to complete their duties regardless of this being over their working hours and often without negotiation or empathy for their other personal responsibilities. Most staff complied with these requests (we were told they were paid for the extra time they worked) as they knew the effect it otherwise had on the patient or the other provider. Staff said the people in the central control gave them the impression they did not believe them when they explained how they could not meet a deadline. One said "there is just no trust." Examples of where staff were told to break with protocol included:
  - If a vehicle was contaminated with urine or vomit, staff had been asked to deal with this on the road but not return to base to deal with the infection risk properly.
  - When a member of staff had blood spilt on their uniform inadvertently by a patient they had been told to "carry on as they were already late."
  - The organisation had a counselling service available for staff for any work-related or non-work-related matter. Staff were encouraged to use the service if, for example, a patient had unexpectedly died when in their care. They also used it if they had witnessed an accident, for example, or one of their own family had died.

Public and staff engagement

- Patient feedback forms were carried on each ambulance. The forms were stored in the ambulance cab and were handed out to patients at the discretion of staff. Staff told us that they were encouraged to hand out at least 10 forms per month. Forms were printed on 'freepost' cards which could be posted by patients to the head office. Alternatively patients could hand their feedback forms to ambulance crews. These forms were deposited at the ambulance station and were forwarded by the team leader to head office. Staff at Wellington and Shepton Mallet told us they received little or no feedback about themes emerging from these surveys. Team leaders similarly did not have this

information although on occasions they were able to provide individual feedback to crews if they were identified on the forms which came via the ambulance station. We looked at the responses of the returned comment cards from January 2015 to September 2015. These showed that in Somerset 33 out of 41patients said they would be likely or very likely to recommend the service to their friends and family. In Cornwall 38 out of 49 patients said they would be likely or very likely to recommend the service to their friends and family. In Devon, 77 out of 86 patients said they would be likely or very likely to recommend the service.

- There was little staff engagement. We looked at six ride along reviews and saw that four out six staff reported that they did not feel actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.
- There was an improving level of engagement with staff in the Cornwall stations. Since the new area manager (called the client account manager) had joined the service in the summer, communication had improved. There were newsletters for staff and team meetings with those staff available. There were plans to make sure all staff were able to attend a team meeting as often as possible, and rotas would endeavour to take this into account.
- The organisation had appointed members of the ambulance care assistant crews to represent employees with senior management.This involved listening to staff concerns and bring them to an employee consultation committee meeting held each quarter with the senior management. This had only started just prior to our inspection.
- In the ambulance stations there were TV screens on the wall with messages from the central management team. These included the recently established 'my contribution' which was encouraging staff involvement in the wider organisation to look for ways to improve. It was therefore similar to a 'suggestion box'.
- Staff told us that staff meetings were sporadic. We asked when the last staff meeting was and were told just prior to our inspection and had been held because of our inspection. The staff we spoke with did not feel valued or listened to by the provider.
- The last staff survey was undertaken in November 2014. This showed mixed results. The areas the south west scored well in included staff felt their managers were open and honest. Staff felt they got satisfaction from their job. Staff felt they had a clear idea of what was expected from them. Where the survey did not do so well included the rewarding and recognising good performance with staff. Staff did not feel the organisation was well structured. Staff felt recruitment and selection was not fair, efficient or effective.

Innovation, improvement and sustainability

- At the time of our inspection, all three contracts with the clinical commissioning groups had been terminated by NSL Ltd. Plans were in place to re-tender for the contracts.

Outstanding practice and areas for improvement

Outstanding practice

- ▪ We observed outstanding care and treatment provided by ambulance care assistants towards their patients
- ▪ The overall feedback we received from patients and other health care professionals showed that the ambulance care assistants went above and beyond in their care of their patients.

Areas for improvement

Action the hospital MUST take to improve

- Put systems in place for oversight across the South West on the servicing and maintenance of vehicles to make sure vehicle servicing and repairs are carried out in a timely way and that vehicles with defects are removed from service pending repair.
- Have appropriate systems in place to make sure safeguarding concerns are recorded and reported to the local authority.
- Have appropriate systems in place that encourage staff to report incidents, and that they are provided with feedback following the investigation.
- Improve the governance arrangements across the South West Region to have reassurance that consistent practice is being achieved across all six ambulance stations.
- Systems need to be in place to support the communication needs of those patients where English was not their first language.

Action the hospital SHOULD take to improve

- Have appropriate systems in place to ensure patient journeys are realistically planned taking into account available crews, vehicles and distance.
- Have systems in place to learn from appropriate initiatives from other NSL areas to help improve capacity and demand and to make sure resources are used effectively.
- Ensure electronic communication systems for staff are fit for purpose when out in the vehicles.
- Have systems in place to make sure staff received feedback from incidents and complaints.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:- 1. Assessing the risks to the health and safety of service users receiving the care and treatment. 2. Doing all that is reasonably practicable to mitigate any such risks 3. Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely 1. Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way NSL South West Region failed to ensure that patients who used the service were safely transported at all times. This was because. Adequate arrangements were not in place to ensure vehicles were maintained and fit for purpose, because the vehicles were not always repaired promptly once the defect had been identified and reported by staff.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment 1. Service users must be protected from abuse and improper treatment in accordance with this regulation. 2. Systems and processes must be established and operated effectively to prevent abuse of all service users NSL South West Region failed to ensure that patients who used the service were safe from the risk of abuse and improper treatment. This was because: Adequate arrangements were not in place to make sure concerns raised by staff were reported to the Adult / child safeguarding teams within the local authority. Adequate arrangements were not in place to make sure staff had access to senior safeguarding advice and support by staff who had been trained to an appropriate level.
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements of this Part

This section is primarily information for the provider

Requirement notices

2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to –

1. Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

2. Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and other who may be at risk which arise from the carrying on of the regulated activity.

NSL South West Region failed to meet this regulation because.

- Adequate arrangements were not in place to assure the safety of the vehicle fleet across the South West.

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...