

Ambuline Limited

Ambuline Nottinghamshire

Quality Report

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Date of inspection visit: 13, 14, 15 and 27 March 2017
Date of publication: 30/06/2017

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 known 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)	
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Summary of findings

Letter from the Chief Inspector of Hospitals

Ambuline Nottinghamshire is operated by Ambuline Limited, which is a subsidiary of Arriva Transport Solutions Ltd. The service provides a patient transport service. Ambuline Nottinghamshire provides a non-emergency patient transport service (PTS) in Nottinghamshire, Derbyshire and Sheffield, South Yorkshire.

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

We visited five ambulance bases (Ashville and Quorn Road Nottingham, Mansfield, Carlton Forest and Sheffield) as well as the control room at the Ashville base in Nottingham.

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

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

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

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

- We were not assured that there were reliable systems, processes and practices in place to report incidents.
- Staff told us that it was difficult to report incidents; they did not have access to the electronic incident reporting system. Staff were not able to give examples of when lessons were learned when incidents occurred or things went wrong.
- The lead for safeguarding did not have regular contact with the social care safeguarding leads for the locations in which they provided care to the public.
- Infection prevention and control processes were in place however, the deep cleaning of vehicles was not consistent. Staff did not have time allocated within their working hours and vehicles were cleaned in their own time.
- Staff we spoke with could not describe the meaning of the process concerning duty of candour.
- Staff received annual mandatory training however the majority of staff we spoke with did not feel that the training provided them with all of the skills and knowledge required for their role.
- Some staff we spoke with did not have supervised observational practice sessions with their manager.
- The service had a strategy and vision. However, not all of the staff we spoke with were able to articulate the vision and strategy of the organisation.
- The service had a governance process however, this was not managed effectively and frontline staff were not involved with the process.
- Staff were committed to improve the service but felt unable to do so.
- The leadership team was not visible and staff did not feel able to approach them to discuss their concerns.
- There was a concern that a blame culture existed when accidents or incidents were reported.
- Local team meetings did not have action plan trackers to ensure actions were implemented.

Summary of findings

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

- Policies for care and treatment reflected relevant research and guidance.
- Staff, teams and services worked together effectively to deliver effective care and treatment.
- Hospitals receiving patients from the service told us that they had effective handovers from staff.
- Patient's consent to care and treatment was obtained in line with legislation and guidance.
- Staff positively interacted with patients; we observed staff communicating effectively with patients.
- Staff treated patients with kindness, compassion, dignity and respect at all times.
- Staff responded compassionately when patients needed help and supported patients emotionally. This was reflected in patient feedback of their care and treatment.
- Staff took the needs of different patients into account when providing transport services.
- There was a shared understanding between staff that every patient had individual needs.
- Staff we spoke with were extremely proud of the care frontline staff gave to the patients in their care.
- Staff were very positive about their local line managers who were visible and could be approached with any concerns they had.

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

Importantly, the provider must take action to ensure compliance with regulations 13, 17, 18 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and regulation 18 Care Quality Commission (Registration) Regulations 2009.

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Patient transport services (PTS)

Rating

Why have we given this rating?

Ambuline Nottinghamshire is operated by Arriva Transport Solutions Ltd. We inspected the service on an announced inspection on the 13, 14 and 15 March 2017, followed by an unannounced inspection on 27 March 2017. We have not rated patient transport services (PTS) for Ambuline Nottinghamshire Ambulance Services because we were not committed to rating independent providers of ambulance services at the time of this inspection.

PTS was provided from the five service bases in Nottinghamshire and South Yorkshire with the control desk based at Ashville station in Nottingham. These are the bases where we undertook our inspection.

Ambuline Nottinghamshire

Detailed findings

Services we looked at

Patient transport services (PTS)

Detailed findings

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Background to Ambuline Nottinghamshire

Ambuline Nottinghamshire is operated by Ambuline Limited, which is a subsidiary of Arriva Transport Solutions Ltd, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Ltd is part of an international transport group Deutsche Bahn (DB). The service was commissioned in 2012 to provide non-emergency patient transport to the communities of Nottinghamshire, Derbyshire and Sheffield in South Yorkshire.

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

Our inspection team

The team that inspected the service comprised a CQC sub-team lead inspector, one other CQC inspector and a

specialist advisor with extensive knowledge and expertise in emergency ambulance services and non-emergency patient services. The inspection lead oversaw the inspection team.

How we carried out this inspection

During the inspection, we visited all five bases and three liaison points in neighbouring NHS hospitals. We spoke with 34 staff including; patient transport drivers, control staff, managers and senior managers. We spoke with six patients and one relative. During our inspection, we reviewed four sets of booking records and eight ambulance vehicles. We also travelled with ambulance staff to observe the experience of patients.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once and the most recent inspection took place in January 2014, which found the service was meeting all standards of quality and safety at that time.

Detailed findings

Facts and data about Ambuline Nottinghamshire

The Nottinghamshire Ambuline (Arriva) non-emergency patient transport contract started to operate in 2012 under a five-year contract. The service is managed from a control room in Ashville, which carries out planning and dispatch functions. It has three ambulance bases in the county, which are Ashville, Quorn Road and Mansfield. It also provides services from stations at Carlton Forest, Derbyshire and Sheffield, South Yorkshire. General transport liaison points and dialysis transport liaison exist in a neighbouring NHS hospital.

The service has a fleet of 82 vehicles for the Nottinghamshire contract, which include a mixture of stretcher, seated, wheelchair accessible and car types of vehicles. Approximately 20,000 patient journeys are carried out in Nottinghamshire every month (240,000 annually). The service employs 174 members of staff. Ambulance control operates 24 hours a day and patient

transport services are provided 12 hours a day, seven days a week. The ambulances convey patients to and from neighbouring NHS hospital locations and patient addresses.

Ambuline Nottinghamshire is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

There had been a registered manager in post since 2012.

Track record on safety between December 2015 and November 2016

- Zero never events were reported.
- One hundred and seventy nine clinical incidents were reported but not categorised.
- No serious injuries were reported.
- Three hundred and twelve complaints were received.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Ambuline Nottinghamshire is operated by Ambuline Limited, which is a subsidiary of Arriva Transport Solutions Ltd, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Ltd is part of an international transport group Deutsche Bahn (DB). The service was commissioned in 2012 to provide non-emergency patient transport to the communities of Nottinghamshire, Derbyshire and Sheffield in South Yorkshire.

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Patient transport services (PTS)

Summary of findings

We always ask the following five questions of each service:

Are services safe?

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

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

- We were not assured that there were reliable systems, processes and practices in place to safeguard adults, children and young people from avoidable harm.
- The lead for safeguarding did not have regular contact with all of the social care safeguarding leads for the locations in which they provided care to the public.
- Staff told us that it was difficult to report incidents; they did not have direct access to the electronic system. Staff were not able to give examples of when lessons were learned when incidents occurred or things went wrong.
- Infection prevention and control processes were in place however, the cleaning of vehicles was not to a consistent standard. Staff did not have time allocated within their working hours and vehicles were cleaned in their own time.
- Staff we spoke with could not describe the meaning of the process concerning duty of candour.
- Staff received annual mandatory training; the majority of staff we spoke with did not feel that the training provided them with all of skills and knowledge required for their role.
- Road staff did not make operational decisions in relation to faults on a vehicle check. However, they were sometimes told to take the vehicle on the road despite a fault being identified, which caused conflict and disagreements.
- Staff we spoke with were not able to confirm that they had received mentorship when they started their employment.

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

- Staffing levels were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Equipment storage and suitability had been reviewed and all items of single use equipment were in date and stored correctly on vehicles.
- All vehicles had an up-to-date MOT, annual service and were insured.
- All staff working on the ambulances had been trained in basic first aid.
- Staff had received anti-terrorist training and were aware of how to respond to a major incident.

Are services effective?

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

We found the following areas of good practice:

- Policies for care and treatment reflected relevant research and guidance.
- Patients were assessed using national evidence based guidance.
- Staff, teams and services worked together effectively to deliver effective care and treatment.
- Hospitals receiving patients from the service told us that they had effective handovers from staff.
- Patient's consent to care and treatment was obtained in line with legislation and guidance.

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

- Some staff we spoke with did not have supervised observational practice sessions with their manager.
- The service had not completed staff appraisals to meet the service target.

Are services caring?

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

We found the following areas of good practice:

Patient transport services (PTS)

- Staff positively interacted with patients; we observed staff communicating effectively with patients.
- Staff treated patients with kindness, compassion, dignity and respect at all times.
- Staff responded compassionately when patients needed help and supported patients emotionally. This was reflected in patient feedback of their care and treatment.

Are services responsive?

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

We found the following areas of good practice:

- Staff took the needs of different patients into account when providing transport services.
- There was a shared understanding between staff that every patient had individual needs.
- Services were planned and delivered in a way which met the needs of the local population.
- There was a system to support staff to communicate with non-English speaking patients.
- Complaints were investigated in accordance with the service's policy.

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

- The organisation did not have aids or materials for patients with visual impairments. Vehicles did not have any signage or materials available in languages other than English or for patients living with dementia.

The complaints dashboard did not include information, which explicitly benchmarked between areas or listed actions taken because of complaints. Learning from complaints was not always shared across the organisation.

Are services well-led?

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

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

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

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

- Staff we spoke with were extremely proud of the care that the frontline staff gave to the patients in their care.
- Staff were very positive about their local line manager who was visible and approachable for any concerns they had.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- There were no never events reported in this service between December 2015 and February 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no serious incidents reported between December 2015 and February 2017. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to ensure a comprehensive response (NHS England, March 2015). However, when we looked at incidents we raised concerns with members of the senior leadership team that there were some incidents that should have been investigated as serious incidents.
- From December 2015 to February 2017 there were 264 incidents affecting patients in Nottinghamshire. Most of the incidents were related to injury, abuse or abusive behaviour from patient to staff and between staff, and injury or illness where staff had to administer first aid to patients.
- The service had a national Arriva incident management policy, which had been approved August 2014 and reviewed February 2016. This outlined the type of incidents to be reported, whether adverse event or near miss, and the process to follow. The incident management policy stated that incidents should be reviewed within 48 hours and an investigation completed within 14 days.
- Staff we spoke with during the inspection were unaware of the policy and were not able to give examples of learning that took place as a result of incidents.
- Incidents were reported using an electronic incident reporting system, which was not directly available to operational staff who had to call control to have an incident reported. During our inspection, ten staff we spoke with told us this was extremely difficult to do and caused delays in reporting incidents. We could not be assured that all incidents were recorded on the electronic incident reporting system as staff told us they could not always get through to control.
- Staff in the control room took the calls and made a decision if it was a reportable incident or not. This led to a secondary reporting system being used in the daily log on the control management system. Incidents that were not officially recorded were recorded in a daily log, which was not audited or used for developing themes. Incidents within the daily log included vehicle downtimes, communication problems and access issues, all of which were documented in the policy as reportable incidents.
- This meant we could not be assured lessons were learned as not all incidents were reported and reviewed consistently.
- Assistant general managers and managers did not always follow the organisation's incident reporting policy when reviewing and investigating incidents. The policy stated that incidents should be reviewed within two days and an investigation should be completed within 14 days. On the first day of our inspection, we saw a number of incidents were still waiting to be reviewed and had gone past the two days key performance indicator.
- We were not assured that all incidents were being graded correctly or had been investigated appropriately. We reviewed one incident that had been graded as a moderate incident. When we looked at the detail of the incident, we felt this should have been investigated as a serious incident due to the nature of the patient's injury. We asked to see the investigation report for this patient as it looked as though the case had been closed without being investigated on the organisation's electronic incident reporting system. The incident took place in July 2016 and was closed in August 2016. It was not until the patient's advocate contacted the service in October 2016 to establish the outcome of the investigation, that a root cause analysis investigation was undertaken. The report was concluded on 4 March 2017.
- Another incident, which had resulted in a patient sustaining an injury, was being dealt with through the complaints process rather than the incident reporting

Patient transport services (PTS)

process because the patient had raised the incident after the event. The incident was serious and should have been investigated as a serious incident with a root cause analysis completed.

- The registered manager had a statutory duty to report incidents, such as the ones mentioned in this report to the Care Quality Commission; however, we found these incidents had not been reported.
- Assistant general managers informed us that if an incident was reported then they would talk with individual crew members, organise training for the staff member if needed and feedback to all teams if they were affected.
- The majority of staff said they received no feedback or learning from incidents. Staff received feedback if there was a complaint but not if they reported an incident on the electronic incident reporting system.
- Frontline staff we spoke with identified safeguarding and patient safety concerns were something they would report as an incident but had not considered other concerns, for example staffing and recurrent vehicle problems.
- All staff we spoke with told us there was no training in relation to incidents or incident management.

Duty of candour

- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- Managers we spoke with had an understanding about duty of candour; they talked of being open and transparent with the public. However, there had been incidents, which would have triggered the duty of candour, but no evidence managers had followed it.
- Operational staff's awareness of the duty of candour was limited. Staff told us they were not aware of or had any specific training on this.

Cleanliness, infection control and hygiene

- An infection prevention and control policy and system addressed all relevant aspects of infection prevention and control including the decontamination of medical devices, vehicles and workwear.
- Staff completed four hours of infection control training on induction. An update was provided at their annual mandatory training day. Information provided by the service indicated that 97% of staff had undertaken this training against the provider's target of 85%. Although this indicated staff had attended this training, we were concerned about the quality of the training staff received given the annual update covered vehicle cleaning and infection control and was delivered in a time frame of 30 minutes.
- Staff had access to cleaning sprays, cloths, wipes and disposable gloves. These could all be replenished at the bases when required. Cleaning products on ambulances were kept

in an overhead storage locker.

We saw there was a system of using colour coded mops with different cleaning products to avoid cross-contamination. Safety information and instructions for use of the cleaning products were on display to ensure staff safety when using the products. Sluice areas at stations were visibly clean and tidy.

- The service audited compliance with infection prevention and control. It audited premises, vehicles and staff. The September 2016 audit of premises showed Ashville was 97% compliant as it was not cleaned daily. Carlton Forest was 89% compliant and Quorn Road was 95% compliant; they were not fully compliant because mops were incorrectly stored. The target was 100%.
- During our inspection, colour coding guidance was available at all stations and mops were stored as per policy. However, best practice guidance is that disposable mop heads should be changed after each use to reduce risk of possible cross contamination. (The national specifications for cleanliness in the NHS: A framework for setting and measuring performance outcomes in ambulance trusts 2009). Ambulance policy instructed staff to change them daily. This meant wet mop heads were reused, potentially increasing the risk of contamination.

Patient transport services (PTS)

- Staff audits at ambulance stations showed 95% compliance with vehicle cleaning between patient episodes and staff completion of daily/weekly vehicle checklist was 95.5% at Carlton Forest, this did not meet the target of 100%. Hand gel availability at Quorn Road and Carlton Forest was audited to be 90% against a target of 100%.
- During our inspection, stations were visibly clean and tidy.
- All staff we spoke with had correct uniform with name badges in accordance with the uniform policy. However, staff we spoke with told us that badges were often expired and replacements were difficult to get. One badge we saw was dated as expired in September 2016. This meant that patients could not be assured the staff transporting them were still legally employed by the service.
- Staff were provided with uniforms, which they were responsible for laundering themselves. Uniforms appeared visibly clean and in good repair.
- Each vehicle had the correct bags for the safe disposal of clinical waste. There was a local agreement with a neighbouring NHS hospital and staff told us of the correct procedure for disposing of their clinical waste.
- A safe disposal of clinical waste vehicle audit was carried out in September 2016. We found 53% of vehicles (56/106) scored below 97% and were not compliant against the provider's target of 100%.
- During our inspection, we saw vehicles were visibly clean; they were equipped with appropriate equipment including spillage kits, antibacterial wipes and personal protective equipment (PPE) for staff.
- The service did not undertake deep cleaning of vehicles. However, in the service's infection control manual, dated December 2014 and overdue for review since May 2016, it was stated that deep cleans should take place every nine weeks and every six weeks for high dependency vehicles. The service was therefore not following its own guidance for the deep cleaning of vehicles.
- Staff were expected to clean vehicles themselves daily, with a full clean once a week. Staff told us they were not

allocated time to clean and some vehicles were not cleaned to acceptable standards. This was because staff were not allocated time during or after shifts to clean their vehicles.

- The vehicles only had a deep clean if there was an event, which resulted in a significant contamination. Staff requested this through their manager; the clean included the steam cleaning a vehicle to reduce the presence of bacteria. The service did not keep a record or monitor how often a vehicle was deep cleaned. Assistant general managers (AGMs) told us the company could provide a deep clean at short notice. Staff we spoke with said, "Scheduled deep cleans had been withdrawn last year to save costs." They could not remember when the vehicles had last been deep cleaned.

Environment and equipment

- Staff were not always protected from avoidable harm. Control of Substances Hazardous to Health (COSHH) practice was not always in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. All COSHH information was available at the station including data sheets. However, the information in them was not widely understood. For example, we found lubricants, including waste oil, degreasing fluids and cleaning products including hand cleaners, were not always stored in locked cabinets. We raised this concern with the AGMs during our announced inspection. Throughout our unannounced inspection, we saw that action had been taken to address this issue.
- Highly flammable liquids were not stored safely. At two bases, we saw flammable liquids not stored in lockable flameproof cabinets in accordance with the Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR). The DSEAR regulations require risks from the indoor storage of dangerous substances to be controlled by elimination or by reducing the quantities of such substances in the workplace to a minimum and providing mitigation to protect against foreseeable incidents. When not in use, containers of flammable liquids needed for current work activities should be kept closed and stored in suitable cabinets or bins of fire-resisting construction. This had been addressed by the time of our unannounced inspection on 27 March 2017.

Patient transport services (PTS)

- Storage of unused spare tyres and old ambulance seating potentially increased the risk of fire at two bases. We raised this as a risk with the AGMs who told us they had asked for them to be removed but were still waiting. This issue had not been resolved when we undertook our unannounced inspection. However, we did not review the fire risk assessment at each site and we were not provided with it.
- Staff were responsible for responding to minor repairs on vehicles, for example undertaking light bulb replacements. Tools for minor repairs to ambulance vehicles were available at stations. However, staff told us they had not received training in carrying out these repairs.
- Daily vehicle safety checks were carried out by operational road staff who used electronic tablets assigned to each individual vehicle to record them. A new electronic format had been introduced where information was recorded and individually stored for each vehicle on a database. Managers would check this daily to identify any issues with vehicles, which required repair and action this as appropriate.
- The operational road staff reviewed the safety checks and equipment they used to ensure they were safe. Staff we spoke with told us that if the vehicle check identified a fault they would report this to the manager and not take the vehicle out. However, we were given examples by staff where they had been told to continue to take the vehicle and staff had to stand by their decision and refuse to drive a faulty vehicle.
- Each ambulance was fitted with a tracking system, which performed several different functions. When staff logged in, the system enabled managers and control staff to view the status of the ambulance for example, its location, whether they were driving or stationary so work could be allocated more efficiently and it also monitored the performance of the driver.
- The service introduced a hand held device to provide management information about vehicles such as fuel usage, fault reporting and vehicle maintenance. It recorded the weekly management audits, which were reviewed by the AGM.
- The service had arrangements to ensure that vehicles were maintained and Ministry of Transport (MOT) annual vehicle safety tested. There was a fleet list which showed the MOT due date and the road fund licence due date. The service had a checklist to ensure that the driver checked the roadworthiness of the vehicle before leaving stations; this was called the 'Checkpoint/first user' form.
- We saw completed and up to date vehicle maintenance schedules. All vehicles had an up-to-date MOT, annual service and were insured.
- We observed a vehicle being removed from service during our inspection due to a faulty ramp. The AGM reported the vehicle for repair immediately.
- Essential first aid equipment was available on all vehicles inspected and was fully serviced and tested. Packages containing sterile supplies were intact and in date. Medical gases on the vehicles we inspected were in date and stored securely.
- We checked eight patient transport service (PTS) vehicles, which were in full working order. However, staff told us that some vehicles were very noisy, due to old ramp fixings. This meant communication between the attendant and patient was affected. Ramps on the eight vehicles we inspected were non-electric. Staff we spoke with told us this was because the electric ones 'kept breaking and were costing too much to repair.'
- Staff we spoke with told us they were not given guidance or advice in relation to pushing the wheelchair of a bariatric patient, (patients over a certain weight), onto the vehicle. Staff we spoke with said they regularly complained of aches and pains after pushing patients up the ramps all day.
- Staff we spoke with told us some vehicles did not have working heaters so sometimes patients travelled in cold vehicles. Some ambulances had heaters, which only worked when the engine was running so if the ambulance made a stop to pick up a second patient, the first patient would have to wait in a cold ambulance.
- During the winter months defrosting and warming up the vehicles was a major concern for staff where vehicles were stored outside. Having the vehicle engine idling to warm up the vehicle has a negative impact on electronic vehicle tracking readings and drivers were marked down in driver scores for idling times. However, to warm up an ambulance and clear the windscreen, the engine needed to be running. If the journey to the hospital was under 10 minutes this did not allow time for the vehicle to sufficiently warm up for potentially frail patients.
- The non-urgent GP ambulances were equipped with additional equipment such as a defibrillator and machines for taking blood pressure and monitoring

Patient transport services (PTS)

oxygen levels in the patient's body. All of the equipment carried on these ambulances had been serviced regularly and stickers were in place to confirm the next service. Other equipment such as the first aid kit and fire extinguishers were all in date. We observed staff checking that patients were safely fastened in prior to the vehicle moving.

- There was a system in place to ensure staff could replenish stock on the ambulances at the start or end of a shift. There was a store at the base, where items such as personal protective equipment (PPE), for example aprons, gloves and hand gel that may be required during a journey could be obtained.
- The service had single patient use blankets and sheets as required and they would leave them with the patient on transfer if used.
- We observed car seats for the transportation of young children. At two stations staff told us they had received no training in the use of these seats. We were therefore not assured that staff were equipped to safely fit these car seats in vehicles when transporting young children. In addition, there were no maintenance records or stickers to identify that they were safe to use. We were therefore not assured there were appropriate processes in place for ensuring damaged car seats, including those that had been involved in any sort of collision or were possibly beyond a certain age were retired from service. Staff told us they would transfer children on average twice a week.
- Day to day station management was the remit of the AGM, at one station the environment had been improved to ensure safety around vehicles by clear marking out of the parking bays. A separate seating and rest area had also been marked out for staff in order for them to have breaks on base with the use of a kettle and microwave if required.
- During our inspection, all staff wore high visibility jackets at stations and ensured all visitors followed this policy.

Medicines

- No medicines were stored on any of the vehicles or within the office buildings.
- Oxygen was stored safely for use on vehicles; we checked eight vehicles, which all had cylinders stored securely and were at least half-full. Each ambulance was equipped with oxygen which staff were able to

administer to patients if a doctor had already prescribed it. Staff were not allowed to alter the flow rate of the oxygen, if a patient required more a nurse escort was provided.

- Stocks of oxygen cylinders in the bases at the time of inspection were stored in a secure cabinet in a ventilated space. However, guidance from the British Compressed Gases Association states that 'means shall be provided to secure cylinders to prevent them falling over; for example, pallets, chains, lashing, etc.' (Code of practice 44 the storage of gas cylinders 2016 BCGA). Cylinders were not secured to prevent falling as staff opened the door of the cabinet. This was raised during our inspection with the AGMs. This had been addressed at our unannounced inspection.
- One base stored nitrous oxide for use with the emergency GP transfers. This was stored safely and tracked safely.
- During our inspection, we found cylinders were not separated into empty and full. This was raised on day one and rectified immediately at all bases.
- NHS Business Service Authority (NHS BSA) 2014 Guidance on the security and storage of medical gas cylinders states that 'suitable arrangements should be put in place for tracking cylinders from point of receipt into the organisation to their return empty to the supplier.' One base had records indicating tracking of cylinders. The other four bases were unaware which cylinders were on which vehicles and would have difficulty identifying which crew had taken cylinders as we were told sometimes crews from other bases might remove stock.
- At two bases, staff were surprised to see only one full oxygen cylinder in the store as no one had reported that they were running out. We were told stock replenishment relied on managers checking levels but there was not a set procedure at all stations. This is not in line with Guidance on the security and storage of medical gas cylinders NHS BSA 2014 However, one station kept a log of all cylinders to ensure ordering was completed in a timely manner.

Records

- Patient records were created from the control room and received by ambulance crews on an electronic tablet

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associated with each particular vehicle. Control room staff collected relevant information during the booking process so that they recorded the information regarding patient's health and circumstances. For example any information regarding access to property or illness issues. The process ensured crews were informed about any needs or requirements the patient may have during their journey.

- All records were managed and disposed of correctly and they were stored in a locked filing cabinet.
- Confidential waste was disposed of at each station into a locked cabinet. At one station, the waste was overflowing and documents could be removed without unlocking the receptacle. This could potentially cause a breach in data protection, as it was stored at the main entrance to the station. However, on reaching into the bin several forms were removed with no patient identifiable information on. This had financial implications for the service due to the unnecessary disposal of non-confidential waste. This was escalated to the AGM at the time. On our unannounced inspection, we saw that appropriate action had been taken and the bin was not overflowing.
- We observed that all patient records kept on vehicles were stored electronically and vehicles were kept locked when they were unattended.
- When booking patient transfers, details of any patients with 'do not attempt cardio pulmonary resuscitation' (DNACPR) documentation in place would be recorded against the job, if this information was available at the time of booking.
- Staff we spoke with told us they would not take a patient without a DNACPR that was dated and completed accurately. They explained that they would ensure a member of hospital staff reviewed them prior to transportation.

Safeguarding

- The provider had a flowchart for safeguarding concerns dated April 2016 and a local safeguarding of adults policy approved in February 2016, which included basic details of Mental Capacity Act (MCA) information. The provider also had a local safeguarding of children policy dated February 2016, which included how to spot signs of abuse and how to report.

- The organisation's safeguarding policies were not easily accessible to staff whilst on duty, as they were stored electronically and staff did not have regular computer access.
- The majority of staff we spoke with could describe the safeguarding pathway. However, some staff received conflicting advice from their general manager so were confused about which was the correct way to report safeguarding incidents.
- Each vehicle had a list of safeguarding contact numbers in a folder kept on board vehicles for staff to refer to if necessary.
- We reviewed folders at three out of five bases; all had up to date safeguarding referral contact details in.
- Staff did not have access to the computerised reporting system and had to contact control to report a safeguarding incident on the electronic incident reporting system. Delays in getting through to control could potentially result in staff not reporting a safeguarding incident.
- The provider's safeguarding trainer did not have safeguarding training qualifications or expertise and experience to enable them to be competent to teach safeguarding to healthcare staff.
- We were unable to establish the level of safeguarding training although the provider told us it was level two.
- We reviewed nine staff training files, which indicated that staff were being signed off as having completed the safeguarding training even if the staff member had not answered all the assessment questions or answered them incorrectly. We were therefore not assured of the validity of the safeguarding training or whether it adequately prepared staff to identify abuse or adhere to the organisation's policies. Staff told us the safeguarding training was rushed and was delivered as a short session on the mandatory training day where all mandatory topics were covered.
- The lead for safeguarding did not have regular contact with the social care leads for the locations that they provided care to the public.
- The senior leadership team were not able to articulate knowledge or oversight of the safeguarding incidents within the service.
- During induction, staff completed an introduction to safeguarding training course. Training compliance was 90%, which achieved the service target of 85%.

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- We were not assured that the safeguarding lead for the service had links with the local county council safeguarding teams to allow for good working relationships.

Mandatory training

- All staff undertook annual mandatory training which included; first aid and emergency situations, administration of oxygen, infection prevention and control, communication, effective reporting, dignity and care, consent, mental capacity act, equality and diversity, health and safety, whistle blowing, duty of candour, complaints and moving and handling.
- Staff told us that they were given time at work to complete mandatory training, staff attendance was reported as 97%. This was more than the organisational target of 85%. However, we were not assured the training was effective because of the inspection team's concerns regarding staff knowledge of safeguarding, manual handling and mental health.
- However all staff said that the training was not effective because it was carried out over one day and it was rushed. Staff we spoke with did not feel that the first aid training assisted them during their day-to-day work. They said it was not comprehensive enough.
- The provider had a Driving Licence policy issued January 2017, which included checks of driving licences for correct category and that drivers must inform management immediately if they commit an offence or have a medical condition which may affect their driving.
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Driving level qualifications and revalidation dates of driving level training were recorded on the provider's training spreadsheet. This was 100% compliant.
- Mandatory training included carry chair training with a 12 stone dummy and the use of stretcher and patient transfer boards. However, there was some confusion in relation to staff using transfer sheets with patient transfer slides at some local hospitals. We were told that staff should not be using slide sheets, as Ambuline had not provided training. This information had not been communicated in a timely way by management teams which meant staff were potentially putting patients at risk by using a piece of equipment they had not been trained to use.

Assessing and responding to patient risk

- Staff were trained during their induction to provide the skills and knowledge required for their role. The senior team told us of a mentoring programme, some staff we spoke with did not recall being allocated a mentor after they started work these staff may have been employed prior to the mentorship programme commenced. However, we spoke with a new member of staff who felt well supported by their team and identified a number of senior crew as mentors.
- If a patient had a specific medical condition the service ensured that staff were trained and competent to care for the condition they had, otherwise they requested a nurse escort.
- Policies and procedures were in place to manage violent or aggressive patients but not all staff felt they were trained and equipped to deal with aggressive patients or relatives. Staff we spoke with were not clear on the protocols they would follow to meet the demands of challenging behaviour.
- All staff working on the ambulances had been trained in basic first aid, which gave them initial skills to notice if a patient was deteriorating. All staff we spoke with told us if a patient deteriorated, they would call 999 for the emergency services to attend.

Staffing

- All staff we spoke with said they were able to request leave in advance and it would usually be granted.
- Staff we spoke with told us they had enough staff. They qualified this by saying that if they had any more staff they would not have enough vehicles.
- The service had a human resource dashboard, which showed for the period January 2017 to March 2017 actual against planned staffing levels ranged between 95% and 98%. The organisation had planned staffing levels of 142 full time equivalents (FTE). Actual staffing levels dropped from 138.8 FTE in February 2017 to 134.3 FTE in March 2017. Therefore, Nottinghamshire had 7.7 FTE vacancies in March 2017.
- Station managers managed anticipated staffing shortages by scheduling rotas in advance, managing pre-planned holidays and other leave. Staff employed by the organisation could work extra shifts through bank

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work. Managers used bank staff to cover leave or sickness. Between January 2017 and March 2017, the number of bank hours varied. In January 2017, managers used 451 hours of bank staff, 404 hours in February 2017 and 396 hours in March 2017. For the same timeframe, the service also used bank staff and third party providers. Between January 2017 and March 2017, the number of agency hours varied. In January 2017, managers used 778 hours of agency staff, 770 hours in February 2017 and 812 hours in March 2017.

- For the period January 2017 to March 2017, data from the provider showed a fluctuation in sickness rates, In January 2017 the sickness rate was 3.9% of the total establishment hours. This decreased to 3.5% in February 2017 and further decreased to 3.2% in March 2017. A process was in place with manager reviews and occupational health referrals where staff had taken sick leave where appropriate.
- The staffing rota was over a period of seven weeks, the first five weeks were a mixture of early shifts and middles shifts and the last two weeks were variable. The organisation had a flexible working policy to ensure staff could work flexibly where required.
- Ambulance staff told us they were often late getting their breaks and this was due to allocation of jobs from control.

Anticipated Resource and Capacity Risks

- The Nottinghamshire service had 82 vehicles in total.
- Vehicles were often unavailable. There were a high number of vehicles off the road and this had an adverse impact on resource and journey planning. For example, at Ashville three weeks before our inspection, 19 out of the 26 (73%), at Mansfield 14 out of 20 vehicles (70%) were off the road during part of the month. Staff told us they did not record an 'off the road' vehicle on the incident reporting system.
- Monthly data provided by the organisation for the period November 2016 to February 2017 emphasised this issue. The number of vehicles off the road monthly was constantly over 30 peaking at 48 vehicles in January 2017 and February 2017. Between one and 14 vehicles had been off the road three times or more during this period. In February 2017, five vehicles had been off the road for over 30 days.

- The organisation used hired vehicles to fill gaps in resources. We observed two hire vehicles in use due to numbers of vehicles off the road in Nottinghamshire. In addition, managers arranged for staff to use vehicles from other bases.
- The control room had a system to manage and respond to demand and capacity. The control room had an electronic list for patient journeys that had not yet been allocated or when there were no vehicles available for patients. Control staff then worked to allocate crews to patient journeys in addition to their scheduled jobs. We observed controllers taking into account the location and planned jobs.
- The control room had procedures in the event of a power cut and electronic software failure. If the Nottinghamshire control experienced issues, other control rooms within the organisation could pick up the control function ensuring the service could continue to run. Staff had laptops, mobile phones and paper systems as backups. Staff said they had practised using these systems.
- The Nottinghamshire service had allocated control staff who undertook numerous roles including helping crews manage breaks, filling in electronic incident reports and allocating work to crews. Staff we spoke with said it was difficult to undertake all their tasks because of demand and resource issues. This affected on resource allocation and on communication with crews.

Response to major incidents

- There was no Ambulance major incident policy, however the provider had a business continuity plan and staff were able to give us an example of when this had been put into place. Managers told us they did not have a service agreement with local NHS trusts to be involved with their major incident policies. However if a request to provide services was made they would endeavour to meet those demands.
- The staff had received prevent training. Prevent training is the counter-terrorist programme, which aimed to stop people from becoming terrorists or supporting terrorism.
- The staff and managers addressed adverse weather or traffic delays collectively. We were given an example of

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when a serious accident caused traffic problems, routes were reorganised in order to ensure patients reached appointments and hospital staff were informed in order to maintain communication.

Are patient transport services effective?

Evidence-based care and treatment

- Staff we spoke with knew about local guidance relevant to their practice. Managers encouraged staff to read the station staff notice board for new or updated policies.
- Throughout our inspection, all staff we spoke with told us they were unable to access workplace policies because they did not have access to computers in the workplace. In addition, agency staff and third party providers were unable to access policies because they did not have access to computers. Senior managers told us that staff were given a personal identification numbers to enable them to access the policies at home. This meant there was a reliance on staff accessing policies in their own time; in addition, staff did not have instant access to their policies if they needed to refer to them.
- Staff assessed and provided transport to patients in line with national and local guidelines. This happened through staff assessing whether patients were appropriate to receive transport using a specific set of questions based on the Department of Health guidelines.
- Patients had to confirm they were registered under a General Practitioner (GP) in the commissioning area and that they required transport to or between NHS funded providers before they were allocated transport.
- Patients with no GP were transported if in agreement with the clinical commissioning group (CCG) for their area.

Assessment and planning of care

- The organisation had planning and control staff to assess the demand and levels of care for patients. Staff would plan routes or allocate crews dependent on the needs of the patient for example, a vehicle with a stretcher, or a vehicle that was suitable for a heavier

person. Staff used an electronic system, which identified patient care requirements and automatically scheduled journeys. However, staff could override this to plan in additional journeys.

- Staff we spoke with were confident to handover to the receiving party. This meant that systems were in place to enable the continuity of care and treatment.
- Staff were involved in planning the care for individuals. For example if a piece of equipment was required to improve transportation needs, they would be consulted to consider their views. There were stretcher vehicles, wheelchair assisted vehicles and seated ambulances available depending upon the patient's individual need.
- Staff completed risk assessments for complex patients for example patients with bariatric needs. Bariatric patients are patients over a certain weight and considered obese. Bariatrics is a branch of medicine dealing with the study and treatment of obesity, including prevention. The World Health Organisation (WHO) describes people who have a body mass index greater than 30 as obese and those having a body mass index greater than 40 as severely obese (WHO, 2000). Bariatric patient needs make supporting patient's mobility, moving and handling needs hazardous to staff and patients. However, there was only one trolley suitable for use with this category of patients and not all ambulances were fitted with a winch in order to facilitate transportation of this group of patients.
- All Ambulance crew staff we spoke with described use of a dynamic risk assessment, in relation to moving and handling, carried out for each patient. (A dynamic risk assessment is: 'The continuous process of identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing, in the rapidly changing circumstances of an operational incident.') However whilst staff could describe the assessment, it was not documented therefore we could not be assured that it was completed on all patients or in a timely way to prevent risk to patients or staff.
- Staff identified mental health needs of patients using the electronic booking form. Staff had prompts to ask if the patient had any mental health conditions, which may affect the delivery of care and patient transport needs. The electronic form had specific boxes to tick to alert crews to conditions such as dementia.

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- All staff we spoke with were aware of the extra information section within the electronic booking although five staff told us that the information was not always accurate. Food for patients was not carried on vehicles and where possible, journeys were planned to take into account meal times for patients. However, there were arrangements in place to provide drinks for those patients that were on a vehicle for a long period of time. Water was available at each ambulance station for the crews to take on the ambulances and bottles were carried on ambulances and could be provided if required on long journeys or hot days. Water bottles could be replenished at the ambulance bases.

Response times and patient outcomes

- The organisation monitored key performance and outcomes data. The organisation measured these against contractual response time targets. At our previous inspection in 2014 we identified patients were waiting long periods for transport. The organisation did not meet the majority of their key performance outcomes. We saw limited discussion and little action regarding actions taken to address these outcomes.
- The organisation had response time targets for patient pick up and drop off. Ninety five percent of patients were expected to arrive within 60 minutes of their appointment, 90% patients were expected to be collected from their care setting within 60 minutes of being booked ready and 90% of discharged hospital patients collected within two hours of being booked ready. The organisation consistently did not meet these targets for the period February 2016 to February 2017. In January 2017, performance was at its lowest level of 70%. This meant patients waited longer for crews, which affected them being late for appointments or late back to their care settings.
- The organisation had separate response targets for patients undergoing renal dialysis. Dialysis is a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly. The organisation had a target of 100% patients arriving before their appointment and 95% of patients arriving 30 minutes before their appointment. Data from the organisation showed they had not met these targets for the period July 2016 to February 2017. The most recent data showed performance between 63% and 68% for patients arriving 30 minutes before their appointment and between 75% and 78% arriving before their appointment. This meant a quarter of patients not arriving for renal appointments on time.
- For outward renal dialysis journeys data from the organisation showed they did not meet their target of 95% of patients departing after treatment and 95% of journeys of no more than 30 minutes. We saw the organisation had not met these targets between July 2016 and February 2017. The most recent data between November 2016 and January 2017 showed between 62% and 66% performance against the journey times and a deteriorating picture from 68% to 61% for the same period for departure after treatment.
- The service monitored performance against call centre contractual target (calls answered within 10 seconds) and call abandonment rates. Data from the organisation for the period July 2016 to February 2017 showed calls answered within contractual targets ranged between 30% and 60%. Abandonment rates for January 2017 and February 2017 were 22% and 9% respectively. This meant callers waited longer to speak to control room staff to make enquiries or book transport.
- The service had a call handling improvement plan, which included providing more ambulances at busier times of the day and adjusting staff shift patterns.
- The organisation had targets for patient time on vehicles. For journeys within a radius of 10 miles, 95% of patients should not be on vehicles no longer than 60 minutes. Between 10 and 35 miles, the target was 90 minutes and between 35 and 80 miles, the target was 120 minutes for 90% of patients. The organisation consistently met these targets between February 2016 and February 2017.
- Staff could monitor ambulance response time performance against target on screen – green showed no problems completing the journey within target, orange showed getting close to breaching, and red was breaching. Staff prioritised patients waiting the longest when allocating resources.
- Each vehicle had an allocated electronic hand held device that was carried by the ambulance crew during each shift. The electronic hand held device enabled the crew to see the patient record, provide information to

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dispatch (control) as to their status during their shift, for example if they were mobile or waiting to pick up a patient. The crew could also use the hand held device to telephone and/or send messages to the control centre.

Competent staff

- All staff were provided with the training to enable them to undertake their work. Induction training included compliance and governance, customer care, fire safety, equality and diversity, safeguarding, infection control, basic manual handling, bariatric patient handling, emergency first aid, ambulance familiarisation, patient care, driver theory and practical, handheld suction and oxygen administration.
- However, staff who completed the training did not feel that it equipped them with the right skills to carry out their roles. All staff wanted more first aid training to enable them to deal with patients who were at risk of bleeding, such as renal patients. Some staff told us they did not receive the training they required to help them to support patients with a mental health condition or patients who were living with dementia.
- Appraisal rates were variable in Nottinghamshire. Overall, 89% of staff had received an appraisal when we inspected but this varied from no staff appraised at Ashville Control to 94% of staff appraised at Carlton Forest. Only 15.9% of staff at Mansfield received a six monthly review, whereas 96% of staff at Quorn Road had had a six monthly review. This exceeded the organisation's target of 85%.
- All staff we spoke with said they had received an appraisal in the last year with their line manager.
- The supervision policy dated March 2016 outlined performance development review with six month interim professional development review, observed practice twice yearly and monthly one to ones.
- Observed practice was part of the provider's policy for personal development review. Information provided prior to our inspection showed there was no observed practice at Carlton Forest or Mansfield but 38.6% of staff at the Ashville base and 17.2% of staff at Quorn Road had been observed. The target for observation was 100%.
- The management team advised us all crews that worked on ambulances had six monthly observations by a mentor, team leader or manager. Managers we spoke with told us this was happening although it was not consistent at all bases, as it was sometimes difficult to schedule in the observations. The AGM at Quorn Road showed us documentation for the next six months of observations and records to demonstrate that this was embedded in practice despite the low figures we had been provided with.
- The driving of each ambulance was constantly monitored electronically. This took account of the speed travelled and breaking. These aspects of driving had a direct impact on patient comfort during the journey. Each driver received scores, which could be accessed at any time by the team leaders or managers. We were told the scores were monitored and if the driver's score was more than one, those staff employed on a bonus scheme would lose their bonus for that month.
- Staff we spoke with felt this type of monitoring was punitive and unfair because heavy breaking could be due to a vehicle in front breaking harshly, someone stepping out into the road or traffic light changes and these situations were not taken into account when bonuses were removed from staff pay. Managers we spoke to told us the ambulances and cars were set to identify the breaking parameters at the same levels, which meant that the cars would record higher rates of harsh breaking. This meant that staff driving cars, if employed on the bonus scheme of pay, would be continually penalised if they had to drive the single person cars.
- A training programme was provided for new staff. The course lasted two weeks and incorporated driver training, mandatory training, manual handling and two days of being an observer member of staff on a vehicle with the crew.
- Control staff who scheduled routes and timings of patient pick-ups did not go out on the roads regularly with ambulance staff. Neither did they receive training on the road layout or geography of the Nottinghamshire area. This meant that sometimes patient pickups were sequenced inefficiently, leading to delays in service. We saw evidence of this when a crew called in to Nottinghamshire control to ask if there were any other patient transfers at that site. As there were none scheduled, they were told to head back to base for a

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break. On the journey to base, they were contacted by Leicestershire control with a job on the site they had just come from. Staff told us that happened regularly when both controls allocated jobs.

Coordination with other providers and multi-disciplinary working

- When staff transferred a patient's care to another healthcare provider such as a hospital or hospice, they ensured that the handover at pick-up was clear and precise to enable a thorough handover to staff receiving the patient.
- We spoke with staff at other healthcare providers where the service transferred patients to and from. Some were extremely positive and they commented how reliable and professional the staff were. However, it was evident on some ward areas in local NHS hospitals that Ambuline staff were ignored and made to feel 'in the way.' Staff we spoke with said this was a regular occurrence and part of the job. Despite reporting this to managers, nothing had changed.
- We requested minutes of performance meetings that Ambuline managers attended for the local NHS trusts they transported patients to and from. We were not provided with these. However minutes from a contracts meeting held in January 2017 noted that information had previously been shared with stakeholders when the stakeholder meeting had been in place. Due to a lack of attendance these meetings had stopped. Arriva had tried to arrange Transport Working Group meetings at hospital sites, but again, there had been a lack of interest.
- We observed good communication among the control staff, with callers and the crews. We observed the call takers clarifying information with the callers and they received positive feedback from staff about how well the wider team worked together.
- We did not witness any delays in the control staff answering calls.
- Local taxi companies were used to transport some patients to renal dialysis appointments. Ambuline had received complaints about the services provided. Meetings were arranged to discuss the complaints. However, patients we spoke with told us that the service provided by some of the taxi drivers did not meet their

expectations of the Ambuline service. For example, drivers not assisting patients to and from the vehicle if required, drivers not collecting patients from the door and assisting with bags.

- Information provided by Ambuline did not assure us that an effective system was in place for monitoring the quality of the taxi companies.

Access to information

- Operational staff received full patient handovers when collecting patients from providers.
- Patient information was kept secure during transfers and journeys in a sealed envelope.
- Each vehicle had its own individual information box, which was carried by the crew during each shift. The box contained information that crews may have needed when out on the road such as how to contact a translator and important phone numbers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed training on the Mental Capacity Act (MCA) 2005 and Mental Health Act (MHA) as part of their safeguarding training. Compliance was 88% to 97% against the organisation's target of 85%. This did not include training to help with people who were living with dementia or in dealing with challenging behaviour. Although compliance was above the organisation's target, we raised concerns with the provider about the validity of the training provided.
- Staff told us they had received training in the Mental Capacity Act 2005. Staff told us that the training had been useful but was too short and had not given them enough information for them to assess people's capacity to give consent. The majority of staff were not confident to describe how to undertake basic mental capacity assessments.
- Staff told us that when a patient was living with dementia or was confused an escort was usually present. We witnessed this during inspection.
- Patient's consent to care and treatment was obtained in line with legislation and guidance. Staff understood that consent was needed, for example, we observed staff gaining consent when moving patients.

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- Do not attempt Cardiac Pulmonary Resuscitation (DNACPR) orders were discussed with the staff on the wards of local NHS hospitals prior to leaving. If not current, staff discussed DNACPR orders with the nurse and doctor to ensure a current order was written for the patient prior to transferring the patient.

Are patient transport services caring?

Compassionate care

- Staff gave patients and their relatives or carers opportunity to feedback through the complaints process or through the friends and family test (FFT) questionnaire cards. However the provider did not provide any FFT data relating to this service.
- Patient feedback received was extremely positive in terms of patient care, feedback was consistently over 85% from February 2016 to January 2017.
- We observed the staff always maintained the privacy and dignity of patients during transport.
- Patients told us staff were respectful and caring and that they went above and beyond to make sure they were in their homes before driving off. Patients told us crews would make sure lights were on and a cup of tea was made if required.
- Feedback from every patient we spoke with during our inspection was positive about all aspects of the care they received. Information we were given showed Nottinghamshire received 34 formal compliments between February 2016 and February 2017.
- However, we did receive other anonymous feedback that showed that staff were not always caring to patients. For example they did not check that patients left hospital with the right belongings and did not always assist patients who were unsteady on their feet.
- Staff we spoke with were extremely passionate about providing good experiences for patients and building relationships with patients who used the service regularly.
- Overwhelmingly, we observed staff providing care that was compassionate and caring and patients were being treated with respect and dignity and having their privacy respected at all times.
- We observed call handlers responding to patients in a helpful and reassuring manner.

Understanding and involvement of patients and those close to them

- Relationships between people who used the service, those close to them and staff were strong, caring and supportive. Patients who used the service told us staff were kind and very professional. Staff were welcoming to relatives and carers travelling with patients.
- Patients we spoke with told us that, "Crews are very courteous, helpful and friendly", "Very caring, helpful. Willing to wait while we put our coats on", "Very happy with the service. Very professional, staff go beyond their duty to help" and "Crew were very apologetic about being late".
- We observed excellent communication from the staff to the patients and their carers. It was evident they knew some of the patients very well.

Emotional support

- Patients who used services and those close to them received the support they needed to cope emotionally with their care. Patients attending dialysis units at local NHS hospitals were prioritised to ensure they were at their appointments on time. Staff from the units told us patients were not usually late for their treatments only in exceptional circumstances. This meant that the transfer was less stressful for patients attending dialysis treatments.
- We observed staff reassuring patients and communicating in a meaningful manner to alleviate fears that patients may have had.

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

Service planning and delivery to meet the needs of local people.

- The service informed associated providers about the challenges it faced in meeting demand. Senior leaders told us, "We conduct roadshows and information sharing activities across other provider locations as well

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as one-on-one instruction for key transport bookers, in addition to a range of printed literature designed to highlight good patient transport service (PTS) booking behaviour.”

- Monthly and quarterly activity reporting took place, which enabled the service to identify areas in which there was opportunity for improvement to better meet the needs of patients.
- The journey types and categories of patient had been contracted to meet the needs of patients’ journeys carried out, these included; outpatient appointments, hospital discharges, hospital admissions, hospital transfers, oncology, palliative care and bariatric patient transfers.
- The service was able to respond to the needs of patients living with a learning disability, with mental health illness, patients living with dementia and bariatric patients. This was supported by the service’s equality and diversity policy as well as equipment provision.
- Staff told us that the targets they had to achieve meant that they found it difficult to pick up a patient or a number of patients up and drop them to a community or acute hospital in the time allocated. This was because they felt the times given to complete these journeys did not take into account the frailty or mobility of the patient and the time that was needed for them to board the ambulance.

Meeting people’s individual needs

- The service had started to introduce measures to provide a service for patients with complex needs. The service had a system to access interpreters for patients whose first language was not English. Crews and control staff could access a telephone translation service. Staff could use the service for 23 different languages. We saw information about the service in staff vehicle boxes. However, there was mixed staff knowledge about the service.
- The organisation did not have aids or materials for patients with visual impairments. Vehicles did not have any signage or materials available in languages other than English. Vehicles did not have signage suitable for patients living with dementia or patients with learning disabilities.

- The service aimed to take account of the needs of different people, including those in vulnerable circumstances. The service had an equality and diversity policy. The aim of the policy was to define and promote all the company’s employees approach to equality and diversity and to ensure there were defined guidelines for employees to follow if necessary. We observed staff caring for all patients consistently regardless of race, gender, gender identity, religion, belief, sexual orientation, age, physical/mental capability or offending background.

Access and flow

- The service had technology to help allocate crews and vehicles to patients at the time required. The control centre had an electronic system fitted to vehicles, enabling control staff to know the precise location of every vehicle. The helped to allocate the most appropriate resource.
- The organisation had criteria for who was eligible for patient transport. For example, staff checked if the patients were in receipt of mobility allowance. As long as the patient fitted the criteria, any person could book the transport including health professionals, patients, relatives and care staff.
- The organisation had different ways transport could be booked including online and by phone. Most renal dialysis patients booked direct on-line. Outpatients and patient discharges were booked via call handlers.
- Patients we spoke with returning home from outpatient clinic journeys told us they very rarely waited long before being taken home, the longest example we were given was 20 minutes.
- A transport coordinator was employed by Ambuline at one dialysis unit at a neighbouring NHS hospital. This role provided a direct link for patients, hospital and ambuline staff in order to reduce problems with journey times.
- Patients we spoke with undergoing dialysis treatment told us there were delays when the transport coordinator was not on shift, patients told us of delays of, in some cases, two hours. There was no holiday or sickness cover for this position leading to transport delays on these occasions.
- The service used a number of performance tools. The operational measurement tool was used to review

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vehicles off road, sickness and compliance checks. The dispatcher tool measured auto allocation and aborted journeys and the call taker tool to measure ready time, talk time and calls handled.

- Journey planning was patient focused. Control staff told us they adjusted journeys in order to improve patient journey times. Staff told us journeys automatically planned in through the control management system often needed adjusting to ensure they were effective for the drivers and the patients.
- The planner allocated all pre booked patients the day prior to the journey in order that crews could be given a list on commencement of a shift.
- The organisation did not use cut-off times for booking patient journeys. This meant staff found it difficult to plan journeys for the following days. Staff said they had to constantly alter plans and work late because bookings would arrive late in the afternoon or early in the morning. This meant crews had to transport extra patients at the last minute and rarely worked to planned schedule. This sometimes contributed to patients waiting longer for their transport to arrive.
- We observed stretcher patients waited the longest for patient transport. This was due to a shortage of resources capable of transporting patients requiring stretchers.
- The control and crews worked very closely with discharge lounge staff to ensure patients had timely discharges from hospitals to prevent unnecessary delays in hospital stays.
- Delays were not common and the policy was for patients to be ready to leave home two hours before their pickup time. Patients we spoke with did not mind this request because they were waiting in their own homes. Patients who used the service regularly, waiting to be discharged did not experience long delays.
- Throughout our inspection, we did not witness any delays in the control room staff answering calls.
- The organisation conducted a patient survey between November 2016 and January 2017. The survey asked patients about the timeliness of transport crew's arrival. Data showed an average of 80% of patients across

Nottinghamshire were happy with the timeliness of crews. Seven percent of patients were neither satisfied nor dissatisfied. This meant most patients were happy with timeliness.

- More than half the patients asked in the survey (for the same period November 2016 to January 2017) were also satisfied with the timeliness of their pick up from hospital. Data showed 72% of patients were happy with the timeliness of crews. This was despite resource challenges faced by staff with additional ad hoc requests.

Learning from complaints and concerns

- The service had a Management of Complaints, Concerns and Compliments policy agreed nationally in September 2016 and due for review September 2017. This stated that complaints must be acknowledged within three working days, with an investigation and response taking place within 25 working days.
- A regional complaints dashboard recorded complaints within each area of the Midlands region categorised by type of complaint, with response times to the complainant. The dashboard did not include information which explicitly benchmarked between areas or listed actions taken because of complaints.
- All complaints were logged within the electronic incident reporting system so linking could take place between incidents and complaints. The process for dealing with complaints was detailed within the service management of complaints policy.
- Between January 2015 and December 2016, there were 312 formal complaints. Ambuline analysed these by type of complaint and the most common reasons were Outbound journey late (116), Inbound journey missed (63), Inbound journey late (26) and Care standards (21). There were monthly complaint reports, which were discussed at the weekly senior managers meeting.
- Between January 2015 and November 2016, 100% of complaints were acknowledged within three working days. Between the same timeframe, 89% of complaints were completed within 25 days, and 99% were completed within 40 days.
- Complaint analysis identified two areas where practice needed reinforcing; the use of lap and postural belts for wheelchair users (in response to a June 2016 incident)

Patient transport services (PTS)

and techniques for chair to bed transfers using manual handling aids. Ambuline issued Governance and Quality Notices business wide in response. We saw this notice during our inspection and staff were aware of its significance.

- Complaints were handled by patient advisors who were part of the Quality and Standards team, and escalated to senior management via the Quality and Standards manager. The intention was for the Operational Quality and Performance Groups to share complaint information across the organisation.
- Learning from complaints was not always shared across the organisation. Local assistant general managers told us they received information about numbers of complaints but not always details.
- We saw posters in all of the vehicles advising patients how to feedback to the service. Information relating to how a member of the public could make a complaint was displayed on all vehicles. However, this information was only written and displayed in English. This meant that patients who did not speak English as a first language may not have known how to make a complaint.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The majority of staff could not tell us who the senior leadership team for the service was and staff reported the senior leadership team were not visible throughout the service. Operational staff did not have direct access to the senior leadership team.
- The senior leadership team did not appear patient focused. Senior leadership meetings covered operational issues such as mobile telephone functionality, contract issues and communicating values and objectives. They lacked any mention of patients or any analysis of incidents or complaints in order to improve patient experience.
- The local leadership team consisted of a head of contract, supported by a general manager, assistant general managers and a control manager.
- Staff told us that one local manager was not very visible and they were difficult to get hold of. However, we were told another manager was supportive and helpful to all of the team. Staff would have no concerns in raising any issues directly with this manager should the need occur.
- Operational staff were able to see their direct line manager on a daily basis at their base station.
- The majority of staff told us they did not feel there was an open and transparent culture within their service and many staff told us they felt devalued by the organisation. Some staff perceived there was a blame culture around the reporting of incidents. Staff told us that if they had a collision that resulted in damage to a vehicle, they were financially penalised and lost their driver initiative bonus. Staff also expressed concern regarding the process of investigating accidents that resulted in damage to a vehicle. We were told of numerous occasions when headlights or wing mirrors were damaged that staff were required to pay for the damage by loss of earnings and some staff had been taken through disciplinary processes.
- Two members of the senior management team told us they were not aware that staff felt there was a blame culture, and told us that staff were responsible for their standards of driving and that all incidents involving vehicles were investigated by the AGMs. The company was intent on decreasing the number of accidents involving vehicles. We therefore observed there could be a potential disconnect between the senior management team and operational staff.
- Due to some staff undergoing TUPE (transfer of undertakings protection of employment), processes for transfer of their employment to Ambuline from a previous ambulance provider, staff were on varying conditions but were undertaking the same roles. This caused disharmony within the teams and resentment towards the organisation.
- Operational driving staff we spoke with did not always receive their meal breaks. This caused unrest between crews as some staff were on differing contracts, which entitled them to payment for missed breaks.
- The service lacked stable operational leadership. There had been five managers at the Mansfield base over two years.

Patient transport services (PTS)

- At operational level, staff morale was low. Staff told us this was due to uncertainty about the contract arrangements, lack of training and development and management delays, for example in responding to reported collision damage.

Vision and strategy for this core service

- There was a vision and credible strategy to support good quality care. The vision was to provide a safe, compliant and high quality service to customers and to accept and embrace personal accountability for work. The strategy was to acknowledge change as a permanent feature of work and recognise that change brings opportunities.
- There were four key objectives to provide an effective and safe service with consistent quality. Senior managers acknowledged that there was some way to go in a number of areas. The vision had been reinforced in a booklet to be given to all staff detailing their role in achieving the service's set aims and objectives. The objectives had also been incorporated in staff appraisals.
- The majority of staff were not aware of the vision and values of the organisation and could not describe how they would apply them to their role. Some staff did not know that the booklet had been introduced as part of their appraisal. Assistant general managers (AGMs) we spoke with had not given out all of the booklets, as they wanted to introduce them at appraisal meetings.
- Ambulance care assistants who had seen the booklet told us they were upset that objective number one was related to 'not having a blameworthy accident' and nothing at all to do with patient care.
- All operational staff had the same vision to provide the best possible care and service to the patients.

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

- There were governance frameworks in place reporting directly to the managing director. There was a registered manager for this location, who was also the contracts manager. There was a head of quality and standards, head of operations and head of control and planning

who supported the governance framework. A number of general managers, assistant general managers and locality managers were responsible for individual bases within the region.

- Performance was discussed regularly at the leadership operational quality performance group. This group had manager representatives from all the service areas. This group reported to the senior leadership team. Monthly policy performance and senior management meetings took place.
- We reviewed the minutes from the senior leadership team meetings in 2016 and found they did not reflect anything that had been discussed at the operational quality performance group meetings. There was no discussion relating to complaints, incidents or other aspects of the service that affected patients. Discussions were more focused around topics such as mobile telephones and the prodrometer tool, an electronic hand held device which provided performance statistics. We were therefore not assured that the senior leadership team had oversight of some of the risks in the service relating to things such as complaints, incidents and safeguarding.
- Locally monthly team meetings were held and staff told us discussions took place however, set agendas were not in place to enable an oversight of issues discussed. Staff received information from the management at this forum.
- We reviewed three sets of minutes from the meetings September 2016, October 2016 and December 2016 and it appeared there was no set agenda or an action log to evidence completion of any issues raised. This meant that the managers did not have oversight of governance at a local level.
- Governance processes were not always effective, for example, there was no oversight of the quality of training that was being delivered despite staff raising concerns that they felt the training was rushed and did not equip them to effectively undertake their role.
- There was a lack of oversight of incidents and incidents that should have been reported to the Care Quality Commission had not been reported. Although incidents were discussed at the operational quality performance group meetings, there was little evidence to indicate sufficient action had been taken to ensure incidents were being appropriately reported, graded and investigated.

Patient transport services (PTS)

- The service had a local risk register. We reviewed the local risk register for non-emergency patient transport services, which included the incidents and complaints received regarding third party taxi providers and the lack of IT available to lead drivers and AGMs at bases. However, during inspection these risks were still ongoing.
- A risk register review featured on the operational quality performance group meetings agenda. The minutes of these meetings indicated that managers were responsible for monitoring the risk registers for their location. The contents of the risk register were not discussed but it had been identified that the risk register was not being reviewed and updated by managers. When we reviewed this risk register for this location, we saw that some of the risks had gone past their action target completion date but the risk register had not been updated. We also noted the previous registered manager for this location was still named as a 'risk owner' on the risk register, despite no longer being employed by the provider. We were therefore not assured that risk registers were being effectively managed.
- Even though the concerns in relation to incident reporting were known to the attendees of the Operational Quality Performance Group, and the concerns were ongoing, this had not been included on the service's risk register.
- A system called 'checkpoint' was used for each member of staff at the end of their shift. This meant that most staff had conversations with their managers on a daily basis, most on the day they ended the shift. The checkpoint forms were provided at the start of each shift and used to confirm vehicle checks were made, the crews driving scores were recorded and any issues that they had encountered during their shift could be shared.
- As part of the service's annual audit process, we saw feedback was displayed on the staff notice board.
- The provider did not use a clinical dashboard because this was a patient transport service. Staff were not clinically trained. However, the provider used several dashboards to monitor the safety of their service. The provider monitored performance on control room performance (talk time, allocation time, and aborted journeys), inward and outward journeys, infection

control practices, capacity and demand. The provider monitored performance with observational, manual and electronic audits. The provider used specific electronic audit software to monitor and analyse results.

- Results demonstrated high demand, and were sometimes over and above service capacity. Audits demonstrated some key performance indicators not being met including inward and outward journey times and mixed infection control results. Managers displayed and shared performance at bases using notice boards. The boards were clearly visible to staff and contained relevant performance information. Performance was compared with the previous month. The electronic audit software created reports for managers to discuss at monthly and quarterly management performance reviews.
- The service monitored response times to patient pickups. If a vehicle had the engine running but not moving, it was known as idling. Staff were often seen by managers to discuss the length of time their vehicle was idling, staff felt this was unfair due to the time it took for some frail elderly patients to board the vehicle.

Public and staff engagement

- The Arriva Transport Solutions Ltd (ATSL) Midlands 2016 staff survey had a response rate of 71%.
- The organisation's 2016 staff survey highlighted staff concerns regarding engagement and communication from senior management. The survey highlighted this should be a priority for the organisation. The organisation saw a decline in satisfaction for all questions asked about communication and engagement. Data showed in 2016, 26% of staff were satisfied overall with communication, information and involvement.
- The staff survey reflected staff comments and morale. The survey asked staff about their satisfaction and data from the 2016 survey showed decreasing satisfaction for staff working at the organisation from the 2015 survey. Staff were less positive about being proud to work for the company (36% in 2016 from 48% in 2015), enjoying their work (50% in 2016 from 63% in 2015) and 29% of staff said they would recommend their employer to others in 2016. Overall satisfaction with the company had dropped from 40% in 2015 to 35% in 2016.

Patient transport services (PTS)

- Staff told us they did not feel safe to raise concerns and told us they were not involved with their employer in the planning and delivery of their service.
- Managers held meetings with staff but these did not always take place on a monthly basis at all bases.
- Managers communicated with staff through newsletters and briefings. We observed briefing notes and newsletters on walls and accessible areas in local bases. All staff we spoke with knew about the briefings and said if they needed to know anything they would read them if they had time before shifts.
- The assistant general manager at Quorn Road station put all new notices out for staff to read as they signed in to their shift in order to try to keep people up to date.
- Most staff we spoke with said it was hard to keep up to date with changes to policies and procedures. Staff said that unless they wanted to access them in their own time at home it was difficult due to a minimum time spent on bases and no computer access.
- The organisation had recently introduced a private social media group for staff as a way of engaging and enabling staff to discuss a range of topics.
- Staff gave patients and their relatives or carers opportunity to feedback through the complaints process or through the friends and family test (FFT) questionnaire cards.
- The organisation conducted a quarterly patient survey. Results for the period November 2016 to January 2017 showed patients were either satisfied or very satisfied with the services they received.

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

- The organisation promoted the use of technology to improve standards of performance delivery. Staff could monitor real-time performance data, the location of vehicles and any issues found because of vehicle checks entered electronically. Staff could also relay messages to each other via electronic systems.

Outstanding practice and areas for improvement

Outstanding practice

- Staff were without exception kind, caring and compassionate. We saw staff continuously support and reassure patients and callers. Staff demonstrated and told us about their commitment to patient care.

Areas for improvement

Action the hospital **MUST** take to improve

- The provider must ensure safeguarding training is delivered by a qualified trainer and assure themselves all staff know about safeguarding pathways and their responsibilities regarding protecting people from avoidable harm and abuse.
- The provider must ensure there is sufficient oversight of safeguarding incidents and the organisational lead is appropriately qualified.
- The provider must ensure staff receive appropriate training to enable them to effectively carry out their roles.
- The provider must ensure staff have appropriate access to key policies and procedures.
- The provider must ensure incident reporting pathways are effective and staff are aware of them and their responsibilities for reporting incidents, accidents and near misses.
- The provider must ensure any feedback and learning from incidents is shared with staff.
- The provider must ensure staff know about the duty of candour and understand its principles of being open and honest.
- The provider must always follow the duty of candour requirements when significant incidents occur.
- The provider must ensure that effective governance and risk management systems are in place and understood by all staff.

- The provider must ensure all staff receive mentorship when they start their employment.
- The provider must ensure staff are supported in their roles by effective supervision and appraisal systems.
- The provider must ensure learning from complaints and concerns is shared with staff.
- The provider must improve its performance against contractual targets to ensure patients arrive for their appointments on time.

Action the hospital **SHOULD** take to improve

- The provider should have a set agenda and action log for minutes of meetings to evidence completion of any issues raised.
- The provider should ensure effective communication and engagement methods with staff are in place.
- The provider should ensure staff feedback received after annual mandatory training is reviewed and used to ensure training is effective.
- The provider should ensure that if staff identify a fault on a vehicle check they are supported to take the vehicle off the road.
- The provider should ensure there is a safe culture to enable staff to work in a blame free environment and enable them to raise concerns.
- The provider should review processes to promote a workforce to feel valued.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The organisation did not always notify the Care Quality Commission as they were required to do so about incidents that affect the health, safety and welfare of people who use the service. Regulation 18(1)(2)(a)
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The organisation was not meeting response time targets for collecting patients and call answering. The organisation demonstrated poor performance in call abandonment. There was no oversight of the training staff received to ensure it was effective. Managers did not share learning from complaints with staff. Incident reporting pathways were not effective and staff were not aware of their responsibilities for reporting incidents, accidents and near misses. The organisation did not have sufficient oversight to assess, monitor and mitigate risks. Regulation 17 (1) (2) (a)(b)

This section is primarily information for the provider

Requirement notices

Regulated activity

Transport services, triage and medical advice provided remotely

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Staff did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Staff did not have adequate access to policies and procedures.

Regulation 18 (2a)

Regulated activity

Transport services, triage and medical advice provided remotely

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

How the regulation was not being met:

Staff did not know or understand their responsibilities under the Duty of Candour Regulation.

The provider did not always follow the duty of candour requirements when significant incidents occurred.

Regulation 20 (1)

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to meet this regulation because: Staff were not consistent in their knowledge of how to make a safeguarding referral. The person who taught the safeguarding session had no safeguarding training or qualifications to enable them to be a competent trainer. Staff files indicated the trainer was signing staff off as having completed the training even if the staff had incorrectly answered or not answered all the assessment questions. We could not establish the level of safeguarding training although the provider told us it was level 2. The senior leadership team were not able to articulate knowledge or oversight of the safeguarding incidents within the service. The lead for safeguarding was not appropriately qualified and did not have regular contact with all of the social care leads for the locations that they provided care to the public. Regulation 13 (1) (2) (3)
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service failed to meet this regulation because:

Enforcement actions

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

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

Staff did not receive feedback about incidents they had reported

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

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

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