NSL Limited

NSL Northampton

Quality Report

7 Edgemead Close
Round Spinney Industrial Estate
Northampton
Northamptonshire
NN3 8RG

Date of inspection visit: 12 May 2015
Date of publication: 03/08/2015

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focused inspection on 12 May 2015 to review the service's arrangements for the safe transport of patients as we have received information of concern about this service. As this was a focused inspection, we did not inspect every key line of enquiry under the five key questions.

Are services safe at this service

Not all staff were enabled to complete incident report forms according to NSL policy and there was no process in place to ensure wider learning took place from incidents which had been reported. The staff we spoke with were not able to fully recognise safeguarding issues. We identified some safeguarding issues which had not been reported and appropriate immediate action was not always taken when safeguarding concerns were identified. Incidents which must be notified to the Care Quality Commission had not always been notified to us.

Arrangements for transporting patients who may have an infection were not adequate. We were told that reliance was placed on the discharging clinician to make decisions about whether a patient should travel without other patients on board.

Are services effective at this service

We identified concerns regarding the Do Not Attempt Resuscitation arrangements for the service. We asked NSL Northampton to take immediate action to address our concerns which they did promptly.

Are services caring at this service

This was a responsive inspection and we did not consider this as part of the inspection.

Are services responsive at this service

We were told that the policy for Ambulance Care Assistants to work in pairs for some patient journeys was followed.

Complaints were not always responded to in a timely manner, although lessons learned were recorded.

From the performance reports provided, we saw that a significant proportion of patients waited more than 90 minutes for collection after their appointment or discharge and some patients were late for their appointment.

Are services well led at this service

Suitable arrangements for staff to provide feedback about the service were not in place. Staff meetings were held but not accessible to all staff and staff were not paid for attendance at meetings. Team leader meetings were held and standard agenda items were discussed each week, although actions being taken was not always documented or owned.

We identified areas of poor practice where the provider needs to make improvements.

Importantly, the provider must take action to ensure compliance with regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014).

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We found that a significant proportion of patients were subject to a long wait for collection and it was unclear from the information provided whether staffing arrangements were adequate to meet demand. Staff training was not adequate and procedures for supporting staff to raise concerns needed improvement. Arrangements for reporting incidents and safeguarding concerns were not sufficiently robust to ensure all incidents were reported or acted on appropriately and regulatory requirements were not being met. We found that vehicles were not always repaired or taken off road promptly. Governance arrangements, including acting on concerns raised at meetings, were not sufficient and some policies and procedures needed updating. Infection control arrangements failed to ensure patients were adequately protected. Do Not Attempt Resuscitation arrangements were not robust; we asked the service to take immediate action which they duly did.

NSL Northampton

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to NSL Northampton

NSL Northampton is part of a NSL Limited, a nationwide provider of patient transport services.

We undertook a focussed inspection in response to information of concern that we had received about this service.

We inspected elements of four out of the five key questions including whether the service was safe, effective, responsive and well led.

Our inspection team

Our inspection team comprised of an Inspector and a Specialist Advisor.

How we carried out this inspection

We undertook an unannounced inspection at NSL Northampton on 12 May 2015. We spoke with five members of staff and three managers and inspected some vehicles and reviewed a range of documents including Do Not Attempt Cardiopulmonary Resuscitation records used by NSL Northampton as well as Vehicle maintenance logs. We also requested a broad range of documents both pre and post inspection, including policies and procedures, performance reports, meeting minutes, incidents reported by the organisation, safeguarding referrals and complaints made to NSL Northampton about the service provided.

Facts and data about NSL Northampton

NSL Northampton is registered to provide transport services and triage and medical advice provided remotely.

The service has a fleet of 17 vehicles used to transport patients to and from hospital settings and conducts in excess of 40,000 patient journeys each year.

The service employs 80 Ambulance Care Assistants and shifts run over a 24 hour period.

Patient transport services (PTS)

Safe	
Effective	
Responsive	
Well-led	
Overall	

Information about the service

NSL Northampton are commissioned by the Clinical Commissioning Group to transport patients to and from acute hospitals and their place of residence on a pre-arranged or as needed basis in and around Northamptonshire.

NSL Northampton provides in excess of 40,000 patient journeys each year. Journeys are provided by Ambulance Care Assistants using a private ambulance or car.

We undertook a focused inspection following concerns which were raised with us. Therefore we did not inspect all aspects of the service. We spoke with three managers and four members of staff during the inspection, reviewed some documents on site as well as a range of documents following the inspection, specific to the concerns which had been raised with us as well as some additional concerns identified during the inspection process.

Summary of findings

We found that a significant proportion of patients were subject to a long wait for collection and it was unclear from the information provided whether staffing arrangements were adequate to meet demand.

Staff training was not adequate and procedures for supporting staff to raise concerns needed improvement.

Arrangements for reporting incidents and safeguarding concerns were not sufficiently effective to ensure all incidents were reported or acted on appropriately and regulatory requirements were not being met.

We found that vehicles were not always repaired or taken off road promptly.

Governance arrangements, including acting on concerns raised at meetings were not sufficient and some policies and procedures needed updating.

Infection control arrangements failed to ensure patients were adequately protected.

Do Not Attempt Resuscitation arrangements were not robust, we asked the service to take immediate action which they duly did.

Other concerns have been summarised in the main body of the report.

Patient transport services (PTS)

Are patient transport services safe?

We have not rated the patient transport service for safety. This was a responsive inspection and elements of this standard were not inspected.

Staff had mixed views about the protocol for reporting incidents which was not always in accordance with policy, incidents were not always reported and there was no process in place to ensure wider learning took place from incidents which had been reported.

The staff we spoke with were not able to fully recognise safeguarding issues. We identified some safeguarding issues which had not been reported and appropriate immediate action was not always taken when safeguarding concerns were identified.

Incidents which must be notified to the Care Quality Commission had not always been notified to us.

Arrangements for transporting patients who may have an infection were not adequate. We were told that reliance was placed on the discharging clinician to make decisions about whether a patient should travel without other patients on board.

Adequate personal protective equipment was not available to staff for infection control purposes.

Vehicles were not always taken off the road or repaired on a timely basis.

Not all staff involved in the administration of oxygen had received up to date training.

Fire safety training was not tailored to the specific risks involved with driving vehicles.

Staffing levels could not be reviewed, but a significant proportion of patients were left waiting for long periods of time.

We also observed that confidential information was kept on vehicles longer than necessary.

Incidents

- NSL Limited's incident reporting policy and procedure formed part of the health and safety policy. We were told that the incident reporting policy was currently under review, previously updated in 2012. The extract we were provided with did not specify the anticipated review date. The policy defined an incident as, '"Any incident which has caused, or could have caused injury to persons, or damage to/ loss of property". The policy stated that every employee must report any incident whilst at work to their line manager as soon as possible. The line manager or supervisor should then complete an incident report form.
- We also noted from the review of the policy that it did not make reference to reporting specific incidents to the Care Quality Commission (CQC).
- The staff we spoke with had differing views on the reporting process. Some staff told us they completed the forms themselves, whilst others informed us they reported incidents to the control room and control room staff completed the incident form on their behalf and we saw evidence of this.
- If employees who have witnessed or been involved in an incident do not have responsibility to complete the form themselves, there is an increased risk that an incident may not be reported or that vital information may be lost in translation.
- A total of 46 incidents had been reported during the six month period up to and including 10 May 2015; four of which had been classified as major. We requested a summary report of all incidents to include a summary of the incident as well as lessons learned. The summary report provided included the incident category but did not include a description of the incident or details of lessons learned. We were told that this level of detail is not reported on and that there were no mechanisms in place at NSL Northampton for shared learning from incidents.
- We also saw from the summary information provided that there was one incident which had been reported to the police which had not been reported to the CQC. Regulation 18 (2)(f) of the Registration Regulations 2009 require any incident which is reported to, or investigated by, the police to be notified to the Commission without delay.

Cleanliness, infection control and hygiene

- NSL Northampton followed NSL Limited's infection control policies and procedures. We asked about patients who may need to be transported separately, particularly patients who may have an infection, for example Methicillin Resistant Staphylococcus Aureus MRSA or Clostridium difficile (C.difficile). We were told

that there were no specific requirements for these patients to be transported separately and that the control room sought guidance from the discharging clinician at booking.

- NSL's own policies did not stipulate that patients who may have an infection be risk assessed prior to transporting with other patients. For example, we asked about patients with C.difficile who may need to travel without other patients on board or without other 'at risk' patients. NSL had produced a compliance safety notice for staff to refer to. With regards to C.difficile, the notice stated, 'Clostridium difficile is transmitted by clostridium spores capable of surviving for long periods of time in the environment and which are shed in large numbers by infected patients'. The guidance did not state that these patients should be transferred alone or without other 'at risk' or elderly patients on the vehicle. Therefore there is an increased risk that infection may spread if suitable measures are not in place when transporting elderly or 'at risk' patients.
- We inspected four vehicles during our visit and found all vehicles to be visibly clean on the day of our inspection. All vehicles were subject to a regular deep clean and we observed that this had been recorded. We noted that one vehicle was overdue its deep clean by one day but had not been taken out of use
- We noted that staff did not have access to a full complement of protective equipment for infection control purposes. Each vehicle had a supply of disposable gloves and vomit bowls but there were no spillage kits, aprons, sleeve protectors or face masks available for staff to use. NSL's Infection Control Policy makes reference to protective equipment; the policy states when gloves should be used but does not make reference to other forms of protective equipment for infection control purposes.
- We also noted that vehicles had yellow clinical waste bags tied to the inside of the vehicle. All bags were open and only clinical waste bags were available which meant that waste could not be separated.
- The main clinical waste bin on the NSL Northampton premises was locked and stored away from public access.

Environment and equipment

- We were told that Ambulance Care Assistants completed daily checks of their vehicles using a standard checklist, although this was not the case for all vehicles. The checklist was a duplicate form which was sent to the team leaders responsible for maintenance of vehicles. The same form was used to report problems with the vehicles. In most cases concerns reported were acted on promptly and the vehicle was taken 'off road' for repair.
- However, we saw examples for three vehicles where the same fault had been repeatedly reported and there had been delays in taking the vehicles off road, faults and timeframes varied. For example, one related to the handbrake and the time taken was from a few days to a few weeks to be repaired. This meant that both staff and patients may have been placed at risk because there had been a delay in responding to concerns about the safety and suitability of a vehicle.

Medicines

- NSL Northampton Ambulance Care Assistants do not administer medication to patients; however oxygen cylinders are on board each vehicle and can be used if deemed appropriate.
- We were told that staff were required to complete a training session on the administration of oxygen. There was no specified frequency for which training should take place.
- We were provided with a statement that 69% of staff who were eligible to complete oxygen training had done so and that this included all Ambulance Care Assistants.
- One of the staff members we spoke with told us that they can prescribe low levels of oxygen in accordance with pre-determine levels to a patient if required.
- NSL Limited guidance states that patients that have an oxygen saturation of below 94% should be put on emergency oxygen and only the supplied oxygen mask must be used by non-high dependency unit staff (Ambulance Care Assistants in the case of NSL Northampton). If emergency oxygen is given then this must be documented as it is a Prescription Only Medicine (POM). NSL vehicles do not have saturation monitors and therefore this cannot be monitored so the service was not able to safely administer oxygen according to the provider's own guidance.
- Through a review of an incident form, we saw that one patient had been administered oxygen during transportation. An oxygen administration form had been completed which recorded the percentage of oxygen delivered at 2% but it did not state the litres per minute. The form did not record the patient's saturation levels or the name of the person who had administered the

oxygen (although the name of the person who administered the oxygen had been recorded on a separate incident form). There was no evidence the forms were subsequently checked to ensure the oxygen has been administered correctly. We also noted that the member of staff who administered oxygen had not received training since 2012, which is not in accordance with the provider's policy that stated staff were to receive this training annually.

Records

- We did not specifically review records maintained by the service. However, during our inspection of the vehicles used to transport patients, we observed three of the vehicles had patient information related to journeys which had occurred months or years prior to our inspection. This included some personal information and was not locked away securely and therefore there was a risk a patient or member of the public could access this confidential information.

Safeguarding

- We were provided with a statement that all staff had completed their mandatory training on safeguarding vulnerable adults and children by completing a NSL Limited workbook. The workbook provided information about how to recognise abuse and to report concerns to their manager or the local authority using a referral form. The workbook stated that staff can access further information from NSL policies although was not explicit about which policies to access or where the local authority's safeguarding contact details could be obtained.
- There were separate policies in place for safeguarding adults and children. It was noted that guidance within the main policies and their supporting appendices offered conflicting advice about when to make a referral. The main section of the policy for safeguarding adults advised staff to make referrals even when a patient was handed over to another service. However, the flowchart in the appendices informed staff that where a patient was handed over to another service, NSL staff were to report their concerns to the service receiving the patient for them to make a referral.
- Each vehicle had a sticker placed in it with contact numbers for the NSL safeguarding telephone line and we observed these were in place in each of the vehicles we inspected.
- We talked to staff who worked in the control room and had experience of working as Ambulance Care Assistants about safeguarding referrals, who had an understanding of the types of incidents which may cause them concern and prompt a safeguarding referral. However, the staff we spoke with, including management, told us that if patients had been left for a long time waiting to be collected and had not been cared for by hospital or other care service staff, for example by meeting basic toileting needs or providing food and drinks, that this would not be reported as a safeguarding concern and instead addressed with the hospital directly.
- We saw an example of a complaint received from the relative of a patient as well as three separate incidents reported internally at NSL Northampton where concerns had been raised regarding the possibility of neglect. Safeguarding referrals had not been made by NSL Northampton which further demonstrated that staff lacked understanding of the referral process and patients were at further risk of neglect.
- A total of four safeguarding referrals had been reported in the past six months to the local safeguarding authority. We had concerns regarding three of the four safeguarding referrals made because immediate action had not been taken to ensure the patients' welfare; one safeguarding concern had been dealt with appropriately by the crew.
- Two of the safeguarding related to concerns about the safety and suitability of discharge arrangements. The crew for one patient took the decision to transport the patient back to hospital. The crew for a second patient, despite identifying the environment was not safe for the patient and that the patient appeared confused and lacked capacity, decided that the patient was not in immediate danger and they were left at their home. Two other safeguarding referrals required other professionals to be contacted but were not. In one case, the police should have been contacted and in another mental health services should have been contacted; contact was not made by NSL Northampton staff.
- This demonstrated that processes, procedures and training arrangements were not adequate to ensure staff were equipped with the correct skills and competencies to take appropriate action to keep patients safe.

Mandatory training

Patient transport services (PTS)

- Ambulance Care Assistants were required to complete mandatory training for the following: safeguarding, conflict resolution, capacity of consent, infection prevention and control, greener driving and Carbon Footprint, fire and Safety awareness, CQC essential standards, information governance, equality and diversity, stress management, basic life support update, CPR, oxygen, equality, safer moving, unconscious and haemorrhaging and manual handling.
- We were provided with a statement and supporting spreadsheet confirming that 100% of staff had completed the workbook during 2014 and that workbooks had been issued to all staff for 2015.
- Additional Continuous Professional Development training was provided to staff for manual handling, oxygen and basic life support. We were provided with a statement that 72% of eligible staff had completed manual handling training and 69% of eligible staff had completed training oxygen and 60% CPR. We were told that of the 31% not yet trained in oxygen that these were office based staff.
- This meant that not all staff had received the training they required and there was therefore a risk they would not be competent to deliver the care that patients using the service required.
- We were told that additional face to face training was being considered for other elements of mandatory training.
- We also noted that fire safety training included within the workbook did not relate the risk of fires to the service provided by Ambulance Care Assistants or the regulated activity being provided.

Assessing and responding to patient risk

- We did not gather evidence for this as part of the inspection.

Ambulance Care Assistant staffing

- We were told that the staffing of vehicles and the shifts that Ambulance Care Assistants worked was based on historic rotas and if there was variation to this due to sickness or leave, replacements were not always sought and crews were rearranged to manage the daily activity based on demand.
- We were told that this was reviewed regularly by the control team as part of the daily planning, although there were no documented guidelines to agree the number of staff who worked based on activity or acuity of patients.
- We were told that NSL Northampton were in the process of reviewing staffing and activity levels in relation to an anticipated increase in activity as a result of a new renal unit being opened in the local area.
- NSL Northampton employs 88 members of staff (71 whole time equivalents) and there were no permanent vacancies. There were vacancies for three bank members of staff and we were told NSL were in the process of recruiting to these vacancies; sickness rates were on average below 5% each month.
- We were told by management and the staff that we spoke with that staffing arrangements were adequate. However, the performance data provided demonstrated that a significant proportion of patients had a long wait (in excess of 90 minutes) to be collected following their appointment or discharge and some patients arrived 30 minutes after their appointment time..
- We were provided with copies of the staffing rotas although we were subsequently informed that this would not reflect sickness or last minute changes to the rota, which meant they could not be relied upon or used as evidence for this inspection. We were told that additional staff were not usually sourced at short notice and that the shift would be managed accordingly during the day; there were no escalation plans in place to determine when the service reached a critical level.
- Minutes for the team leader meeting held in April 2015 recorded that there were concerns regarding bank staff agreeing to work shifts but withdrawing their offer at short notice. There was no data available for the meeting to determine the number of shifts affected or how this impacted on patients and actions were not agreed to improve this.
- We were told that staff were required to take an 11 hour break between shifts. NSL did not have a policy on working hours and we were told that the working time directive guidance was followed and adhered to.
- We were told that the Ambulance Care Assistants are entitled to a 30 minute meal break (this was one hour for some members of staff who worked according to their previous contract) as well as two 15 minute tea-breaks and stand down time.

Patient transport services (PTS)

Major incident awareness and training

We did not gather evidence for this as part of the inspection.

Are patient transport services effective?

We have not rated the patient transport service for effective. This was a responsive inspection and elements of this standard were not inspected.

We identified concerns regarding the Do Not Attempt Resuscitation arrangements for the service. We asked the provider to take immediate action to address our concerns which they did promptly.

Evidence-based care and treatment

- We did not gather evidence for this as part of the inspection.

Pain relief

- We did not gather evidence for this as part of the inspection.

Nutrition and hydration

- We did not gather evidence for this as part of the inspection.

Patient outcomes

- We did not gather evidence for this as part of the inspection.

Competent staff

- We did not gather evidence for this as part of the inspection.

Multidisciplinary working (in relation to this core service)

- We did not gather evidence for this as part of the inspection.

Access to information

- We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not consider the Mental Capacity Act or Deprivation of Liberty Safeguards as part of this inspection.
- At the time of our inspection NSL Northampton transferred patients who may have had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place. The protocol the service used was complex and failed to evidence the correct paperwork was in place.
- For patients who were recorded on NSL's booking system as having a DNACPR order in place, Ambulance Care Assistants were expected to view the patient's original DNACPR form and there was no requirement for the DNACPR form to travel with the patient.
- This process differed if the patient was not on NSL's booking system as having a DNACPR in place. For these patients, Ambulance Care Assistants were still expected to view the patient's DNACPR order, but in addition to this an NSL Transfer DNACPR form was completed by a member of staff from the hospital or other care service as well as the member of staff from the hospital involved in the patient's discharge. This process was outlined in the provider's DNACPR policy.
- Where an NSL Transfer DNACPR form was required, it was NSL Limited's policy for the form to be signed by the member of NSL staff transporting the patient as well as a senior clinician from the hospital or care service confirming a DNACPR order was in place. Some of the staff we spoke with told us that forms only needed to be signed by the member of staff they liaised with who could be non-clinical.
- We reviewed a sample of these forms and found that they had not always been completed or signed in line with the provider's policy. Some of the forms had not been signed by NSL staff and it was not possible to identify the job role of the member of staff from the hospital or care service in most cases and where job titles had been recorded, they were not senior clinicians.
- Following the inspection, we requested the service to provide evidence of all patients who had a DNACPR order in place and had been transported and whether NSL staff had been able to check the original DNACPR order. NSL were unable to provide this information as the service did not record this information.
- There was a risk that patient's choices regarding their DNACPR decisions would not therefore be respected during patient transport journeys.

Patient transport services (PTS)

- We raised our concerns with the provider immediately after the inspection, who took prompt action to address the concerns.

Are patient transport services responsive?

We have not rated the patient transport service for the service being responsive. This was a responsive inspection and elements of this standard were not inspected.

We were told that the policy for Ambulance Care Assistants to work in pairs for some patient journeys was followed.

Complaints were not always responded to in a timely manner, although lessons learned were recorded.

From the performance reports provided, we saw that a significant proportion of patients waited more than 90 minutes for collection after their appointment or discharge and some patients were late for their appointment.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Meeting people's individual needs

- We were told that patients who were receiving end of life care were transported without any other patients on board the vehicle. We reviewed a sample of patients who were receiving end of life care and found that this was complied with.
- We were told that some patients could be transported by a single Ambulance Care Assistant whilst others required support of two Ambulance Care Assistants. We asked for details of any incidents where this policy had not been followed and we were told that there had not been any such reported incidents.

Access and flow

- NSL Northampton monitored their performance by the length of time a patient waited after their appointment or discharge, as well as the number of patients who arrived after their appointment. Performance data provided demonstrated that some patients had a long wait to be collected following their appointment or discharge. During April 2015, 14% of patients waited longer than 90 minutes and 8% of patients waited longer than 150 minutes.
- We were told by management that performance could be improved if the hospitals or care service provided sufficient notice regarding a patient's discharge. However, we saw little difference between the time patients were left waiting whether they had a pre-booked discharge or if the discharge had been arranged on the day.
- We also observed from the performance reports that some patients arrived after their appointment time; this was 3% for April 2015. We were told that patients who missed their appointment due to being late were not recorded or reported on separately compared to patients who had cancelled their appointment for other reasons.
- For the purpose of inspection, we were provided with a statement that between January and May 2015, 18 patients had missed their appointment due to arriving late. The service told us that they were working with staff to report this as an incident, but this had not been embedded at the time of inspection.
- Overall, this demonstrated that patient demand was not always being effectively met.

Learning from complaints and concerns

- NSL had a complaints policy in place. A complaints leaflet was also placed in each vehicle which provided contact details should a patient wish to make a complaint; however, there were no leaflets available for a patient to take home with them.
- A total of four complaints had been received during the six months prior to inspection; not all of these had been responded to in a timely manner.
- All complaints recorded related to long waits following appointments or discharge. Lessons learned were recorded and details of improvements planned or in progress detailed.

Are patient transport services well-led?

We have not rated the patient transport service for the service being well-led. This was a responsive inspection and elements of this standard were not inspected.

Patient transport services (PTS)

Suitable arrangements for staff to provide feedback about the service were not in place. Staff meetings were held but not accessible to all staff and staff were not paid for attendance at meetings. Team leader meetings were held and standard agenda items discussed each week, although action being taken was not always documented and where actions had been recorded they were not always assigned to a member of staff to ensure responsibility was taken for taking the agreed action.

Vision and strategy, innovation and sustainability

- We did not gather evidence for this as part of the inspection.

Governance, risk management and quality measurement

- Team leader meetings were held every fortnight and standard agenda items discussed included staffing and performance. We observed from a review of the meeting minutes that actions were not always clear. For example, an issue around bank staff cancelling shifts at short notice was minuted but there was no clear action or ownership for how this would be carried forward.
- There were discussions around vehicle maintenance at several meetings. Minutes recorded that the fleet management team were looking into this, although no immediate remedial action was recorded and it was unclear from the minutes whether this affected performance.
- NSL Northampton monitored their performance by the length of time a patient waited after their appointment or discharge as well as the number of patients who arrived after their appointment.
- Minutes recorded discussions around performance and that in depth analysis was ongoing. The most recent set of minutes provided reporting that performance was improving, although this was not observed from the data we were provided with. The minutes also recorded that delays would continue to be monitored for breach (breach of agreed time frames for collection of patients) reasons. Breach reasons were not reported on as part of the key performance reports.

Monthly contract monitoring meetings with commissioners were also held each month. It was noted from the March 2015 minutes that NSL Northampton had completed a detailed review of breach reasons and that a specific crew had been identified as being responsible for a number of late patients and that this was being addressed with them.

Leadership/culture

- We were told that staff had the opportunity to discuss concerns at monthly team meetings. However, we were told that team meetings were not well attended and not minuted. We were told that staff on shift during the meeting time were unable to attend as they were transporting patients and that staff were not paid to attend meetings if it was there day off.
- We were told that there was an open door policy should staff have concerns they wished to raise.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include - (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. NSL Northampton failed to ensure that patients who used the service were safely transported at all times This is because • Adequate arrangements were not in place to ensure that patients were transported in accordance with their physical and medical needs.

This section is primarily information for the provider

Requirement notices

- Adequate arrangements were not in place to ensure vehicles were maintained and fit for purpose, because vehicles were not always repaired promptly once a defect had been identified and reported by staff.
- Appropriate arrangements were not in place to ensure that staff who administered oxygen were trained to do so.
- Appropriate arrangements were not in place to ensure that whilst transporting patients with an infection that other patients were adequately protected from the risk of this infection.
- Timely care planning did not always take place and a significant proportion of patients were left waiting for transport in excess of 90 minutes.

Adequate arrangements were not in place to ensure patients with a DNACPR in place were transported with a valid copy of their DNACPR

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to - (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

This section is primarily information for the provider

Requirement notices

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to be kept in relation to —

(ii) the management of the regulated activity;

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services

NSL Northampton failed to meet this regulation because

- Adequate arrangements were not in place for the recording, reporting, investigation and taking appropriate action in relation to incidents which may occur during the carrying on of the regulated activity.
- Actions taken in relation to issues discussed at management meetings were not consistently documented or followed up.
- Patient records were not always stored securely. We identified some patient records stored in an unlocked area of the vehicle.
- Staff were not given appropriate opportunity to provide feedback about the service which was conducive to their working arrangements

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must - (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

This section is primarily information for the provider

Requirement notices

NSL Northampton failed to meet this regulation because there were inadequate staff numbers to ensure patients were not waiting for collection for long periods and because staff had not received adequate training to perform their role in the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment (1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. (6) For the purposes of this regulation "abuse" means - (11) (d) neglect of a service user. NSL Northampton were failing to meet this regulation because staff did not always recognise or make appropriate safeguarding referrals when there were clear signs of abuse or neglect from another provider. The Safeguarding Adults policy had areas of ambiguity around reporting arrangements and training provided to staff was not sufficient to ensure they were competent in recognising and reporting abuse.