Ambuline Limited

Ambuline Nottinghamshire

Quality Report

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

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 and Derbyshire.

We inspected patient transport services (PTS) using our comprehensive inspection methodology, in March 2017 which resulted in enforcement being taken against the provider for two regulations of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. These were:

- Regulation 13 Safeguarding service users from abuse and improper treatment
- Regulation 17 Good governance

The full report of this inspection can be found on the CQC website:

https://www.cqc.org.uk/location/1-425787954.

As a result of our findings we issued a warning notice served under Section 29 of the Health and Social Care Act 2008 in June 2017.

In order to follow up on progress against this warning notice we carried out a short notice announced focused inspection on 5 October 2017.

At this inspection we visited Ashville and Quorn Road ambulance stations at Nottingham. We spoke with 12 members of staff including managers, control staff and PTS drivers.

As this inspection was a focused inspection, we looked at the safe and well-led domains only.

Services we do not rate

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 provider had met the requirements of the warning notice but there were still some areas that required further improvement:

- The supervisors, control patient transport drivers had not had updated adult and childrens safeguarding level two training as recommended in national guidance.
- Information was not provided in all ambulance vehicles to assist in making safeguarding referrals.
- Ambulance staff had no computer access to current policies stored on the web based portal.

However we also found the following areas of good practice:

- Senior managers and supervisors had undertaken incident management training and were able to identify, investigate and review themes in order to fully address incidents within specific timelines.
- A 24 hour, seven day a week incident reporting telephone number had been provided to all staff.
- A quality bulletin was available for all staff to read highlighting incidents and learning points identified.
- Management staff had received updated training in line with safeguarding level three as recommended inNational guidance from the Intercollegiate Document for Healthcare Staff (2016)

Summary of findings

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 one requirement notice that affected patient transport services. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals(Central), on behalf of the 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 have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Ambuline Nottinghamshire

Detailed findings

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Patient transport services (PTS

Detailed findings

Contents

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 and Sheffield in South Yorkshire. The Sheffield contract is no longer active and the Nottinghamshire contract has been renewed for a further two years. 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).

The service had a registered manager since 2012. However, at the time of the inspection, a new manager was in the process of being appointed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Yin Naing, Inspection Manager.

How we carried out this inspection

During the inspection we visited the control room, which was located at the Ashville base and the service's ambulance station at Quorn Road. We spoke with 12 members of staff including; control staff patient transport drivers and management.

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. This was extended this year for a further 2 years the service is managed from a control room in Ashville, which carries out planning and dispatch functions. It has four ambulance bases in the county, which are Ashville, Quorn Road , Mansfield and Carlton Forest, North Nottinghamshire. 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.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Ambuline Nottinghamshire is operated by Arriva Transport Solutions Ltd. We carried out this inspection in order to follow up on enforcement action we had issued in June 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 four service bases in Nottinghamshire with the control desk based at Ashville station in Nottingham.

Summary of findings

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Patient transport services (PTS)

Are patient transport services safe?

Incidents

- At the last inspection in March 2017 we issued the provider with a warning notice as there were no effective procedures and processes in place for staff to report incidents to protect people from the risk of avoidable harm or abuse. There was also limited understanding amongst staff about the processes to follow for managing incidents.
- Staff in the control room took the calls and made a decision if it was a reportable incident or not.
- At this inspection we found a new incident reporting system had been implemented. A 24 hour, seven day a week telephone number had been provided to all staff. All staff we spoke with were aware of the new reporting line and the telephone number was available to them at all base areas and on a key fob for each vehicle. Some staff had yet to use the new system but reported that a dedicated helpline would address the long waits to report incidents they previously encountered.
- The use of the new reporting line meant that incidents were reported accurately into one system. Should a safeguarding concern also be identified there was a dedicated section of the incident report to add this. This directly linked the two for improved reporting and follow up.
- We observed the key performance indicator (KPI) for call answering on the incident line was for calls to be answered within 30 seconds. The evidence provided showed an average call answering time of 12 seconds. The longest wait so far had been two minutes. This had reduced the time for crews to report an incident and ensured incidents were accurately recorded according to the organisations policy.
- At the focussed follow up inspection there were 265 closed incidents and 4 open incidents for Nottinghamshire. We reviewed four incidents and all had been appropriately investigated. Key tasks had been undertaken in the allotted timeframes and they had been reviewed by a safeguarding lead to ensure safeguarding concerns had been acted upon and had not been missed.
- The registered manager had a statutory duty to report incidents, to the Care Quality Commission; however, we found incidents our March 2017 inspection that had been incorrectly graded and closed without information being reported.
- As a result of the section 29 warning notice of the Health and Social Care Act 2008 senior and local managers have attended updated incident and root cause analysis training. The provider had also informed CQC and the NHS commissioners of notifiable incidents and we saw evidence of this during our focussed inspection.
- We also interviewed three operations managers and all were clear about their responsibilities relating to incident reporting and management.
- At our March 2017 inspection we saw no evidence of local learning or local actions being undertaken in relation to these incidents. Staff we spoke with were not able to give examples where learning had taken place as a result of incidents. In addition, staff told us they did not receive feedback about the incidents they had reported. Lessons were not learned and potential for improvements were not identified when things went wrong. Staff we spoke with during the inspection were unaware of the incident management policy and were not able to give examples where learning had taken place as a result of incidents.
- During this inspection staff were aware of the policy and said that if they had reported any incidents they would receive feedback.

Safeguarding

- At the last inspection in March 2017 we issued the provider with a warning notice as there were no effective procedures and processes in place to safeguard people from the risk of avoidable harm or abuse. There were also no effective systems to allow ambulance staff to report safeguarding incidents.
- The service had safeguarding policies for adults and children. The safeguarding policies were not accessible to ambulance staff whilst they were conveying patients at work. However, in the ambulance stations there was a safeguarding flowchart which was displayed on a notice board.
- At our focussed follow up inspection Ambuline managers had renewed their policies in relation to

safeguarding of adults and children. A new flow chart had also been provided with guidance relating to the company safeguarding leads and contact numbers. Staff were directed to Arriva net (a web based portal) to access these policies as required.

- However, 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. This remained the same during our focussed follow up inspection.
- The staff we spoke with could describe the new safeguarding pathway. However, there was no information on the noticeboard at Quorn Road station identifying who the new safeguarding leads were.
- We were informed each vehicle had a list of safeguarding contact numbers in a folder for staff to refer to if necessary. However at this follow up inspection we reviewed five vehicle folders, of these four contained out of date information.
- This was raised immediately with the operations supervisor and rectified whilst we were present.
- At our previous inspection staff did not have access to the computerised reporting system and had to contact control to report a safeguarding incident. This had been addressed with the new 24 hour incident reporting system. Staff we spoke with were aware of the contact number and felt this was a much quicker way of reporting accurately.
- A network of locally based designated safeguarding officers and champions had been identified to support staff within their locations. The organisational lead for safeguarding had oversight of this team.
- Senior managers had undertaken updated training in relation to Safeguarding adults and children in line with the Safeguarding children and young people: roles and competences for health care staff Intercollegiate DocumentMarch 2014 or the Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document (2016).
- Documentation showed the four safeguarding leads had undertaken level three safeguarding training, which is the requirement for this role under the national guidelines for safeguarding, specifically the Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document (2016) and Safeguarding children and young people: roles and competencies for healthcare staff – Intercollegiate document (2014).
- The leads were due to undertake train the trainer training for safeguarding within the next few weeks.
- At our March 2017 inspection we were not assured the safeguarding lead for the service had links with the local authority safeguarding teams . At this inspection, one of the safeguarding leads was in the process of inititating regular contact with the community socil care leads, Since our last inspection, the provider had commenced a quarterly safeguarding group meeting for the executive team. The meeting reviewed all reported incidents, policies and procedures, training for staff and any other safeguarding issues that were appropriate.
- We found the provider had improved safeguarding reporting processes and oversight practice. The new safeguarding management system had made it easier for the provider to track trends in safeguarding incidents and monitor actions to ensure any learning was implemented.
- We saw documentation and staff told us there was an improved procedure for communication and protocols for safeguarding referrals with the local authority safeguarding authority. Staff now had telephone access to a computerised system to report safeguarding incidents. All the front line staff we spoke with were aware of how to report alleged safeguarding incidents to the local safeguarding authority. The executive team told us safeguarding training was part of the induction for all staff.
- We reviewed the updated safeguarding training package, this had been updated to meet the intercollegiate guidelines.
- During this inspection we spoke with four members of the front line staff .None of them had received updated training on safeguarding to level two. However, they demonstrated a good understanding of their responsibility to report safeguarding concerns and had received some safeguarding training previously though not to the correct level.
- A delivery programme for the training had been planned to cover management, control staff and patient

transport drivers. Projected completion for management and control staff was November 2017 and patient transport drivers April 2018. New staff received this training during induction.

- One of the safeguarding leads was in the process of initiating regular contact with the community social care leads.
- Overall, whilst we found progress had been made to systems of reporting and training of senior staff there was still work to do to ensure that staff were trained and knowledgable in what to report.

Are patient transport services effective?

- We did not inspect the effectiveness of PTS as there were no warning notices identified in this area during our March 2017 inspection.

Are patient transport services caring?

- We did not inspect the caring aspect of PTS as there were no warning notices identified in this area during our March 2017 inspection.
- We did not see any patients or relatives during this focussed unannounced inspection.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

- We did not inspect the responsiveness of PTS as there were no warning notices identified in this area during our March 2017 inspection.

Are patient transport services well-led?

Leadership

- The governance framework prior to this focussed inspection had been reviewed in order to strengthen the reporting and review systems for the senior management team.This included patient advisors,quality managers ,an improvement manager and the head of quality . With more focus in relation to management of incidents, complaints and safeguarding the senior leadership team had greater oversight of the risks facing the service at a patient level.
- Additional training for all management staff from operational supervisors upwards had been undertaken. This was to ensure there was imporved oversight of the incident management process.

Governance, risk management and quality measurement

- At our inspection in March 2017 we found the governance processes were ineffective.There was a lack of of oversight of incidents and the learning from those incidents to prevent them happening again.
- At this inspection we found the governance framework had undergone a review and had been changed inorder to strengthen the incident and safeguarding reporting and review systems for the senior management team.
- A compliance and quality steering group had been formed. This group planned to meet quarterly reporting directly to the senior leadership team. Further changes had taken place with the formation of a operational quality performance group. This group discussed the challenges locally to feed into the quarterly compliance and quality steering group.
- We saw minutes from the first two of these meetings which identified monthly discussion of incidents, safeguarding and complaints. Where actions had been identified they had been addressed. For example to ensure incidents were managed in a timely way when managers were on leave the group discussed and agreed an action to manage this.
- We saw two provider critical compliance reports which were produced monthly to identify all seriousincidents,who they are reported to stakeholders for example, NHS commissioners, CQC etc and all coroners enquiries. These were produced to share information across the country at all locations
- The provider had also developed a quarterly incident and complaint summary.This provided assurance that the senior team were sighted on all of the current

complaints and incidents. With more focus in relation to management of incidents, complaints and safeguarding the senior leadership team had greater oversight of the risks facing the service atpatient level.

- Governance and quality notices were made available to staff at an operational level during our March 2017 inspection. However there was no evidence that staff were reading and understanding them.During this focussed inspection a signature sheet is now provided with each governance and quality notice for staff to sign. We saw the signature sheets at the base and were assured that the operations manager had discussed these with staff. However some staff had refused to sign the sheet as they remained unsure of the rational from the senior leadership team.
- 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. This had not changed at this focussed inspection. This meant that we were not assured actions were taken forward and discussed for the operational teams.
- Incident review meetings took place in order to share progress and support managers to review and complete investigations.
- Since the March 2017 inspection, the provider have reported incidents to CQC as required by the Health and Social Care Act.

Innovation, improvement and sustainability

- To ensure all staff were aware of the new incident reporting line all staff had been given a key fob with the number on. This had served as a reminder to staff when working remotely.
- The provider had developed an 'on the road pocket guide' for operational staff although this had not yet been distributed . This contained information for staff to remind them what to do in certain circumstances. For example assessing risk, preventing infection, and how to report safeguarding concerns.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure safeguarding adults and childrens level two training is delivered in a timely manner.
- The provider must ensure Information provided to assist in making the referrals is present and is current in all of the ambulance vehicles.
- The provider must ensure all staff have access to current policies stored on the web based portal.

Action the hospital SHOULD take to improve

- The provider should ensure any feedback and learning from incidents is shared with staff.
- The provider should ensure that effective governance and risk management systems are in place and understood by all staff.
- The provider should ensure all staff are aware of the importance of acknowledging governance bulletins for the safety of all patients.
- The provider should ensure a set agenda and action log for minutes of local base meetings to evidence completion of any issues raised.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) The service failed to meet this regulation because: • Ambulance and control staff had not undertaken the updated level two safeguarding adult and children's training. • Information provided to make the referrals was not present or was not current in all of the ambulance vehicles. • Staff did not have access to current policies stored on the web based portal.