Ambuline Limited

Ambuline Leicestershire

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 know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambuline Leicestershire is operated by Ambuline Ltd, which is a subsidiary of Arriva Transport Solutions Ltd. The service provides patient transport services.

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.

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 the service provider needs to improve:

- The incident reporting procedure was not effective. Some staff did not know the procedure and the organisation did not share feedback and learning from incidents.
- Staff did not know about or understand the principles of duty of candour.
- Staff did not always follow infection control procedures. Audits identified some infection control issues. Vehicles and equipment were not always clean.
- Bases did not store highly flammable liquids in in accordance with the Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR).
- Staff did not receive training which supported them in their roles. The inspection team had concerns regarding the effectiveness of the organisation's moving and handling, safeguarding and mental health training.
- Staff knowledge of the safeguarding pathway was inconsistent. Staff did not have access to the organisation's safeguarding policy.
- The organisation's safeguarding trainer was not qualified to train staff in safeguarding. The trainer did not know what level of training they delivered to staff.
- We reviewed nine staff training files and saw there was no assurance staff had successfully completed safeguarding training and understood what constituted abuse.
- The safeguarding lead could not articulate knowledge or oversight of the safeguarding incidents within the service.
- Staff had challenges with vehicles off the road. Between November 2016 and February 2017, the number of vehicles off the road for Leicestershire was constantly over 30 per month (almost 50%).
- At our previous inspection we identified patients were waiting long periods for transport. Data from the organisation showed they were not meeting contractual response time targets. We saw a number of patients waiting long periods for transport during this inspection.
- In addition, data from the organisation showed the organisation was not meeting its targets regarding the transport of renal dialysis patients.

Summary of findings

- We saw the control room was consistently not meeting contractual targets for call answering times. We also saw call abandonment (a call ended before any conversation occurs) rates were high meaning callers were waiting longer to speak to staff on the phone.
- Staff did not assure the inspection team they knew their roles and responsibilities regarding mental capacity consent and the restraint of patients.
- The organisation did not have aids for patients with visual impairments. Vehicles did not have any signage in languages other than English or for patients living with dementia.
- The organisation did not share feedback or learning from complaints with staff.
- The majority of staff were not aware of the strategy and vision of the organisation and could not describe how they would apply them to their role.
- We saw there was a lack of discussion and oversight of risk, safeguarding and incidents at leadership meetings.
- We saw managers had not appropriately identified some risks. The management of risks was not timely or effective. Where risks had been identified there were either no actions or actions had been slow to be completed.
- We found staff morale to be low because of pay and conditions, organisation culture and unrealistic targets. Staff perceived a blame culture within the organisation.
- Staff felt senior managers did not communicate or engage them effectively. Managers had processes to communicate with staff using briefings however, it relied on staff finding the time to read them.

However, we found the following areas of good 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.
- Staff used electronic devices to conduct daily vehicle checks. We observed staff conducting daily checks prior to shifts.
- All equipment had been tested and checked with stickers stating test and retest dates.
- Oxygen was securely stored on vehicles and at bases.
- Patient records were stored securely both on ambulances and in the control room. The control room had procedures to dispose of confidential waste.
- Staff used an electronic patient record system, which identified possible risks to patients and staff. The system helped staff to assess and plan care.
- The organisation had a vision and strategy underpinned by values and objectives linked to staff personal development reviews.
- All staff we spoke with had received an appraisal. All three bases had positive staff appraisal rates.
- We observed positive relationships and coordination between staff and with other health and social care providers.
- Staff had access to important information or special notes. The electronic patient record system alerted staff to any special notes or requirements for patients.
- Staff ensured where patients had them, do not attempt cardio pulmonary resuscitation (DNACPR) orders were up to date.

Summary of findings

- 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.
- The organisation had different ways transport could be booked including online and by phone. Any carer, patient or health professional could book appointments.
- Local managers were visible and staff said they were supportive. We found local leaders had a greater understanding of staff concerns, risk and performance than some senior managers did. Staff said there was a positive team working culture amongst colleagues.
- Staff demonstrated a culture and commitment to good patient care.

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 in relation to their patient transport service. Details are at the end of this report.

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

Heidi Smoult
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Ambuline Leicestershire is operated by Ambuline Ltd, which is a subsidiary of Arriva Transport Solutions Ltd. We inspected the service on the 13, 14, 15 and 27 March 2017. We have not rated patient transport services (PTS) Ambuline Leicestershire Ambulance Services because we were not committed to rating independent providers of ambulance services at the time of this inspection. The organisation provided PTS from three service bases in Leicestershire with the control room based at Imperial House, Leicester. We inspected all three bases and the control room.

Ambuline Leicestershire

Detailed findings

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Patient transport services (PTS)

Detailed findings

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Background to Ambuline Leicestershire

Ambuline Leicestershire is operated by Ambuline Ltd, 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 Leicestershire clinical commissioning groups (CCGs) commissioned the service in 2012 to provide non-emergency patient transport to the communities of Leicestershire.

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 including urgent transfers, renal, oncology, palliative care, intermediate care, mental health, paediatric and bariatric (patients over a certain weight).

We undertook an announced and unannounced inspection and inspected the five key questions whether the service was safe, effective, responsive, caring and well led. We inspected the control room at Imperial House, Leicester and the ambulance stations at Loughborough, Whetstone and Thurmaston. We inspected these locations in order to speak to patients and staff about the ambulance service.

Our inspection team

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

How we carried out this inspection

During the inspection, we visited the control room at Imperial House and ambulance bases at Loughborough, Thurmaston and Whetstone. We spoke with 49 members of staff including; ambulance staff, control room staff, managers and members of the senior leadership team. We spoke with 15 patients and two relatives. We also received information from staff and patients prior to inspection. During our inspection, we listened to 11 calls, reviewed seven sets of patient records and ten 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

Detailed findings

inspected four times and the most recent inspection took place in November 2014. The service had one outstanding compliance action regarding the care and welfare of patients. This was because patients experienced long delays in waiting for patient transport.

Facts and data about Ambuline Leicestershire

The service is managed from a control room in Leicester (Imperial House) which is also the location registered with the Care Quality Commission. The ambulance bases are located in Loughborough, Whetstone and Thurmaston. The service conducts an average of 14,000 patient journeys per month in Leicestershire and has 64 vehicles (a mixture of stretcher ambulances, seated ambulances, wheelchair vehicles and cars). The service employed 111 full time equivalent staff in Leicestershire.

The service is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

The service has had had a registered manager in post since July 2013.

The service provides transport services 24 hours a day, seven days a week. The control room in Leicester operates daily from 7am to 11pm with out of hours cover provided by the Bristol control room between 11pm and 7am.

Ambuline Arriva are contracted to provide patient transport services until July 2017. The organisation were negotiating with commissioners an extension to provide services until August/September 2017. After which the contract will cease and another provider contracted to provide non-emergency patient transport services.

Track record on safety for the period December 2015 and November 2016

- Zero never events were reported.
- One hundred and seven clinical incidents were reported but not categorised.
- No serious injuries were reported.
- Four hundred and five complaints were received.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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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:

- The incident reporting procedure was not effective. Some staff did not know the procedure and the organisation did not share feedback and learning from incidents.
- Staff did not know about or understand the principles of the duty of candour.
- Staff did not always follow infection control procedures. Audits identified some vehicles and equipment were not always clean.
- Bases did not store highly flammable liquids in in accordance with the Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR).
- The inspection team had concerns regarding the effectiveness of the organisation's moving and handling training. Between April 2016 and January 2017 there had been four complaints about injuries to patients.
- Staff knowledge of the safeguarding pathway was inconsistent. Staff did not have access to the organisation's safeguarding policy.
- The organisation's safeguarding trainer was not qualified to train staff in safeguarding. The trainer did not know what level of training they delivered to staff.
- We reviewed nine staff training files and saw there was no assurance staff had successfully completed safeguarding training and understood what constituted abuse.
- The senior leadership team could not articulate knowledge or oversight of the safeguarding incidents within the service.
- Staff said they were not confident in managing or supporting violent or aggressive patients. Staff expressed concerns at the level of training they received to prepare them for emergencies.
- We saw staff had challenges with vehicles off the road. Between November 2016 and February 2017, the number of vehicles off the road for Leicestershire was constantly over 30 (almost 50%).

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

- Staff used electronic devices to conduct daily vehicle checks. We observed staff conducting daily checks prior to shifts.
- All equipment had been tested and checked with stickers stating test and retest dates.
- Oxygen was securely stored on vehicles and at bases.
- Patient records were stored securely both on ambulances and in the control room. The control room had procedures to dispose of confidential waste.
- Data from the organisation showed 98% completion rate for mandatory training.
- Staff used an electronic patient record system, which identified possible risks to patients and staff.
- The control room had emergency procedures in the event of a power cut or system failure.

Are services effective?

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:

- Staff had limited access to policies and procedures while at work.
- At our previous inspection we identified patients were waiting long periods for transport. Data from the organisation showed they were not meeting contractual response time targets. We saw a number of patients waiting long periods for transport.

Patient transport services (PTS)

- In addition, data from the organisation showed the organisation was not meeting its targets regarding the transport of renal dialysis patients.
- We saw the control room was consistently not meeting contractual targets for call answering times. We also saw call abandonment rates were high meaning callers were waiting longer to speak to staff on the phone.
- Staff did not receive the level of mentoring, support and development opportunities as identified in organisational policy. Managers did not check staff competencies unless an incident occurred.
- Staff did not receive training which supported them in their roles. Staff raised concerns about driver training and the level of mental health training.
- Staff did not assure the inspection team they knew their roles and responsibilities regarding mental capacity, consent and the restraint of patients.

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

- Staff provided transport to patients in line with national and local guidelines usingcriteria on an electronic system.
- Staff could assess and plan care using an electronic patient record system. It enabled staff to identify what type of vehicle and crew were needed.
- The organisation met their targets for patient time spent on vehicles. This meant patients were not spending too long in vehicles.
- All staff we spoke with had received an appraisal. All three bases had positive staff appraisal rates.
- We observed positive relationships and coordination between staff and with other health and social care providers.
- Staff had access to important information or special notes. The electronic patient record system alerted staff to any special notes or requirements for patients.
- Staff ensured where patients had them, do not attempt cardio pulmonary resuscitation (DNACPR) orders were up to date.

Are services caring?

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

We found the following areas of good practice:

- The organisation had positive patient survey results concerning staff care and consideration. Patients were positive about the care they received.
- We observed staff preserve patient's privacy and dignity.
- We observed positive interactions between staff and patients. Staff made patients feel at ease and checked their comfort levels during travel.
- Staff understood and involved patients in their care and treatment. Staff ensured patients understood what was happening and gave them the opportunity to ask questions.
- We observed staff support patients to walk and reassure patients who may have been anxious.

Are services responsive?

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

We found the following areas of good practice:

- The Loughborough base had training facilities. Staff attended the Loughborough base for their mandatory training. The facilities were comfortable and spacious and were appropriate for training staff.
- Staff identified individual needs of patients at the booking stage. Staff used an electronic system, which prompted staff to ask callers about patient 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.
- The organisation had policies and procedures to handle complaints. We saw an example of a change in policy because of a complaint.

Patient transport services (PTS)

- The organisation had different ways transport could be booked including online and by phone. Any carer, patient or health professional could book appointments.

However, we found the following issues that the service provider needs to improve:

- We saw ambulance crews faced challenges with their base environments. We saw there was no temperature control in some bases and poor lighting for vehicle checks and cleaning at night.
- 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.
- Journey planning was not patient focussed. Staff had challenges with demand and therefore had to book journeys that could fit in the most patients. This affected patient pick up times meaning some patients arrived too early or too late for appointments.
- We observed patients requiring stretchers waited the longest for transport. During the inspection, we observed five patients waiting between 52 and 215 minutes (three hours and 35 minutes) over their target pick up times.
- The organisation did not share feedback or learning from complaints with staff.

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 majority of staff were not aware of the strategy, vision and values of the organisation and could not describe how they would apply them to their role.
- We saw there was a lack of discussion and oversight of risk, safeguarding and incidents at senior leadership meetings.
- We saw managers had not identified or responded to some risks. The management of risks was not timely or effective. Where risks had been identified there were either no actions or actions had been slow to be completed.
- We found staff morale to be low because of pay and conditions, organisation culture and unrealistic targets. Staff perceived there was a blame culture within the organisation.
- Staff said senior managers were not visible or supportive.
- The organisation had overall poor staff satisfaction in the staff survey results.
- The organisation had a lone working policy. However, staff did not know about the policy or lone working procedures. Staff did not have processes in place to make immediate alerts if they were in danger.
- Staff felt senior managers did not communicate or engage them effectively. Managers had processes to communicate with staff using briefings however, it relied on staff finding the time to read them.

We found the following areas of good practice:

- The organisation had a vision and strategy underpinned by values and objectives linked to staff personal development reviews.
- Local managers were visible and staff said they were supportive. We found local leaders had a greater understanding of staff concerns, risk and performance than some senior managers did.
- Staff said there was a positive team working culture amongst colleagues.
- Staff demonstrated a culture and commitment to good patient care.
- The organisation had processes to receive compliments, complaints and concerns. Staff had friends and family test questionnaires in vehicles and posters about how to feedback in vehicles.

Patient transport services (PTS)

- The organisation had a commitment to innovation. They developed electronic processes for vehicle checks, staff communication and vehicle monitoring.

Are patient transport services safe?

Incidents

- There were no never events reported in this service between December 2015 and November 2016. 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.
- For the period December 2015 to February 2017, staff reported 143 incidents in Leicestershire. The most frequent patient incidents were injury, abuse/abusive behaviour and issues around transportation, admission and discharge.
- The service had not reported any serious incidents. We requested the investigation reports including root cause analysis for all incidents that had been reported in the previous six months. The registered manager told us they had no incidents that had required an incident investigation or a root cause analysis to be undertaken. However, reviewed the submitted incidents and saw incidents (for example, injuries to patients) that could be classed as a serious incident. Therefore, we were not assured staff and the incident reporting system could recognise serious incident.
- 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. Four out of 14 staff we spoke with did not know the incident reporting procedures. Staff we spoke with during the inspection were unaware of the policy and six out of 14 staff did not know what constituted an incident.
- The organisation used an electronic reporting system to report incidents, accidents and near misses. However, not all staff had direct access to this system. The organisation required staff to telephone the control room. Control room staff were responsible for raising an incident, accident or near miss. This presented a risk of incident details being misinterpreted and not recorded

correctly. Staff gave examples of when they had reported an incident but the details were different on the electronic reporting system or they had not had sight of what had been written.

- Operational staff told us that control staff made decisions whether they recorded incidents on the electronic reporting system or on a daily log list. The daily log list was a list of minor issues raised by staff. Control staff we spoke with said they had to determine whether the information they received had to go on the electronic reporting system or on a daily log. Staff gave examples of when staff raised safeguarding alerts, which control staff had put on the daily log list. Organisational policy stated staff should record safeguarding alerts on the electronic reporting system. This highlighted the organisational incident and safety systems were not always followed and were not effective.
- The service had a timescale of 14 days for investigating incidents. Assistant general managers (AGMs) investigated incidents. However, AGMs said processes were not flexible and they received incidents to investigate despite annual leave commitments. This affected investigation timescales and AGM workloads and AGMs said it could affect the quality of investigation.
- Managers said as part of the investigation process they would talk to staff, organise training and feedback to all affected teams. Staff said AGMs were supportive when incidents occurred.
- The service did not systematically learn from incidents. The majority of staff said they received no feedback or learning from incidents. Staff could not give examples of learning from incidents.
- We were not assured the organisation's manual handling training was effective. We observed on inspection staff appropriately moving and handling patients. However, between April 2016 and January 2017 the Leicestershire service had received four complaints regarding injuries to patients. We reviewed 36 incidents for the period December 2016 to February 2017. Out of the 36 incidents11 were related to moving and handling errors.

Duty of candour

- The duty of candour is a regulatory duty requiring 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.
- All operational staff and one manager we spoke with did not have understanding about duty of candour and could not explain its principles. Staff said they had not received any training on the duty of candour. Staff did not understand the need to open and honest with patients and their relatives when things went wrong.
- Senior management staff had knowledge of when duty of candour should be applied. However, there had been incidents, which would have triggered the duty of candour, but no evidence managers had followed it.

Cleanliness, infection control and hygiene

- The organisation had an infection prevention and control policy and procedures addressing all relevant aspects including decontamination of medical devices, vehicles and workwear.
- Staff completed infection control training on induction and at their annual mandatory training day. 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. All staff we spoke with knew their responsibilities regarding infection prevention and control. However, staff did not always have the capacity and time to clean vehicles and equipment.
- Staff did not always follow infection prevention and control practices. We saw evidence of lack of adherence to provider policies such as not regularly changing mop heads daily. We saw from base records at Whetstone and Thurmaston staff did not change mop heads daily. At Thurmaston, between 20 February 2017 and 14 March 2017 staff had not recorded changing mop heads on six occasions. At Whetstone between 14 February 2017 and 15 March 2017, staff had changed the mop head on nine occasions. Therefore, there was evidence staff had not followed organisational policy.

Patient transport services (PTS)

- We saw there was a system of using colour coded mops and buckets with different cleaning products. Staff used this system to clean different areas of the ambulance for example, inside and outside to avoid cross contamination. At Whetstone, we saw different coloured buckets stored on top of each other so dirt from yellow buckets ended up in red buckets. This meant there was a risk of cross contamination.
- 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 did not keep vehicles consistently clean. We viewed nine vehicles and saw five were not clean. On two of the vehicles, we saw the stretcher was visibly dusty underneath. Managers expected staff to clean vehicles themselves daily with a full clean once a week. Staff were not allocated time to clean and we were told by staff some vehicles were not cleaned to an acceptable standard because staff were not paid overtime to clean their vehicles. Staff told us they had seen deterioration in the overall appearance and cleanliness of vehicles in the last year.
- Infection control data between April 2016 and November 2016 showed vehicle infection control practices fell below the organisational standard of 95% at Thurmaston (88%) and Loughborough (92%). Whetstone data highlighted 98% compliance with infection control standards. In addition, vehicle equipment also scored below organisation standards (95%) with audits highlighting issues with the cleanliness of equipment at all three bases.
- We reviewed the Legionella risk assessment for the Thurmaston base. Legionella is a bacteria causing Legionnaires' disease. It is a potentially fatal form of pneumonia and everyone is susceptible to infection. We saw the assessment took place in March 2015. The assessment highlighted two high risks and one medium risk. The assessor recommended the organisation addressed high risks within 28 days and medium risks within three months. We saw managers had not completed actions in a timely manner. Managers had signed off the actions in November 2016, 20 months after the assessment.
- Staff had access to cleaning sprays, cloths, wipes and disposable gloves. Staff could replenish stock at the bases when required. Staff kept cleaning products on ambulances in storage lockers. Vehicles were equipped with appropriate equipment including spillage kits, antibacterial wipes and personal protective equipment for staff. We observed staff cleaning vehicles in between patients, before and after shifts.
- Safety information and instructions for use of the cleaning products were on display to ensure staff safety when using the products. Sluice areas at most stations were visibly clean and tidy. However, at Whetstone, staff used the male toilet as the station for filling containers with cleaning chemicals. Staff used a bespoke dispenser to ensure mixtures were correct but the concentrate chemicals were stored on the floor.
- Bases had posters providing information on effective hand hygiene. Alcohol hand gel was readily available and allocated to staff. We observed staff using this appropriately.
- All staff we spoke with had correct uniform with name badges in accordance with the uniform policy. Staff were responsible for laundering their own uniforms.

Environment and equipment

- Staff used electronic vehicle checklists to record any issues with vehicles prior to shifts. Staff used the devices daily to conduct vehicle checks. This allowed the organisation to capture any vehicle issues on a central database. Managers would check this daily to identify any issues with vehicles requiring repair and action this as appropriate. However, at Loughborough crews had one device between them meaning each staff member had to sign in and conduct checks separately. This could cause delays in leaving the base.
- We inspected two ambulances working from the emergency department (ED) at a local NHS hospital. The ambulances working from ED and performing inter-hospital transfers were equipped with additional equipment. For example, a defibrillator and machines for taking blood pressure and monitoring oxygen levels

in the patient's body. The organisation had serviced all equipment on both ambulances regularly and had stickers to confirm the next service. Other equipment such as the first aid kit and fire extinguishers were all in date.

- Highly flammable liquids were not stored safely. At Whetstone and Thurmaston we saw the screen wash, (classed as a highly flammable liquid), not stored in lockable flameproof cabinets in accordance with the Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR). The DSEAR regulations require the organisation to control risks from the indoor storage of dangerous substances 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 stored in suitable cabinets or bins of fire-resisting construction.
- At Whetstone base there was increased risk as highly flammable liquids were stored in a storeroom exposed to direct sunlight. We escalated this risk to the base AGM. On our unannounced inspection, we saw the AGM had taken appropriate action to address this.
- Drivers could call out a vehicle recovery service to attend if there was a breakdown. If this did not work, then a vehicle went to a local garage for repair. All staff and managers we spoke with said they carried out minor repairs on vehicles, for example changing headlight bulbs to try to keep vehicles roadworthy.
- Clinical waste was kept in a locked area and taken away monthly by a contractor. Each vehicle also had the correct bags for the safe disposal of clinical waste. There was a local agreement with the local NHS hospital and staff told us of the correct procedure for disposing of their clinical waste.
- The service had arrangements to ensure they maintained vehicles and Ministry of Transport (MOT) annual vehicle safety tests were completed. There was a fleet list which showed the MOT due date and the road fund licence due date. We saw completed and up to date vehicle maintenance schedules. All vehicles had an up to date MOT, annual service and were insured.
- 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.
- Bases had systems to ensure staff could replenish stock on the ambulances at the start or end of a shift. For example, staff could replace aprons, gloves, hand gel and water potentially required during a journey.
- The service had a local agreement with the local NHS hospital to use their blankets and sheets as required and they had the correct linen bags to enable them to use the hospital laundry system.
- We checked 14 pieces of equipment including trolleys and wheelchairs. The organisation had tested and checked all equipment we inspected. Equipment had stickers on which showed the test date and when the piece of equipment was due to be retested.
- Staff in the control room wore double-ear headsets to ensure they could hear the caller and not be distracted by outside noise.

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 four vehicles, which all had cylinders stored securely. All cylinders had appropriate levels of oxygen. Each ambulance was equipped with oxygen, which staff administered to patients if prescribed by a doctor. Staff did not alter the flow rate of the oxygen, if a patient required more the hospital provided a nurse escort.
- Staff stored oxygen securely at bases in lockable cabinets. Managers kept a record of stock and ordered new stock as and when required.

Records

- The organisation kept patient records on an electronic patient record system. Control centre staff generated records by using the patient's NHS number. Crews received patient records through their hand held electronic devices. Control staff collected relevant information during the booking process and recorded

the information regarding patient's health and circumstances. The process enabled crews to receive information about patient needs or requirements during their journey on their electronic devices.

- We observed all patient records were stored securely on vehicles. Staff locked vehicles when they were unattended. Staff kept confidential patient information in sealed envelopes.
- When booking patient transfers, staff asked for and recorded details of any patients with do not attempt cardio pulmonary resuscitation (DNACPR) documentation. Staff said they would not take a patient with a DNACPR unless it was accurate and up to date.
- Staff used paper checkpoint forms to evidence their vehicle stock and equipment checks. These checks were separate to the electronic device checks. Staff kept the same checkpoint form with the same vehicle for the week so managers could monitor stock levels or raise any issues.
- The control room area was secure and required keypad access. This meant public access was restricted ensuring records were kept confidential and secure. The control room had processes for the disposal of confidential waste.

Safeguarding

- The organisation had safeguarding policies and procedures for adults and children. The policy was available on the organisation's online system. The organisation displayed the referral pathway on notice boards in the control centre and in bases. Ambulance staff had access to the pathway in the majority of vehicles along with the relevant local authority contact details.
- Staff knowledge of the safeguarding pathway was inconsistent. Organisational policy stated staff should contact local authorities directly if they had concerns regarding patient safety. Staff should ensure they logged their concerns on the electronic incident reporting system. Staff described several different processes. Some described contacting local authorities directly, some contacted their manager and some staff contacted control. Staff could not tell us whether safeguarding concerns were reported through the organisation's electronic reporting system. Some control staff said they did not report safeguarding alerts through the electronic reporting system. This was not organisational policy.
- The organisation's safeguarding trainer did not have safeguarding training to enable them to be competent to teach safeguarding to healthcare staff. The safeguarding trainer did not know what level of training they had received or had delivered to staff.
- Staff received safeguarding training at staff induction and annual one-day mandatory training sessions. Data from the organisation showed 98% of staff had completed their safeguarding training. The training was a short session, which was delivered in addition to eight other topics, such as manual handling and basic life support.
- We reviewed nine staff training files and saw the trainer had signed staff off as having completed the training even if the staff had not answered all the questions or had answered them incorrectly. We were therefore not assured of the validity and effectiveness of the training, or whether it equipped staff in identifying abuse or adhering to organisational policies.
- The majority of staff could tell us what constituted abuse and harm to patients. Some staff gave us some examples of action they took to safeguard patients. They gave us an example of a patient living in dirty conditions when they called social services. However, they received no feedback about action taken.
- Although the safeguarding lead had knowledge of the processes for raising a safeguarding alert, they were unable to articulate knowledge or oversight of the safeguarding incidents within the service.

Mandatory training

- Staff undertook yearly mandatory training updates. The training was delivered during a one-day training session. The one-day session included safeguarding update (including deprivation of liberty safeguards (DoLS) and Mental Capacity Act (MCA) 2005 training), basic life support/oxygen update, vehicle cleaning and infection control, patient handling update and practical, incident management, operational updates, information governance update and fire safety update

Patient transport services (PTS)

- Control staff and non-operational managers attended half a day mandatory training, which included safeguarding update (including DoLS and MCA), dealing with incidents, operational updates, information governance update and fire safety update.
- Staff said they were given time at work to complete mandatory training. Data from the organisation showed 98% staff attendance. This was more than the organisational target of 85%. However, we were not assured the training waseffective because of the inspection team's concerns regarding staff knowledge of safeguarding, manual handling and mental health.
- The organisation recorded driving level qualifications and revalidation dates of driving level training on a central training spreadsheet. This was 100% compliant. The driver training handbook covered defensive and emergency driving.

Assessing and responding to patient risk

- The organisation had policies and procedures to manage violent or aggressive patients. The majority of staff felt the organisation did not train or equip them to deal with aggressive patients. Staff were unclear on protocols they would follow to meet the demands of challenging behaviour.
- All staff working on the ambulances said they received training in basic first aid as part of their induction or annual mandatory updates. This gave them basic skills to notice and act if a patient was deteriorating. This included basic life support (BLS) training for children and babies. In addition, all staff said they would call 999 for the emergency services to attend. Data from the organisation showed 98%staff had received BLS training.
- However, staff received limited training in first aid. In particular, staff said they would like training to enhance their job role. Staff described incidents such as managing and treating patients who may deteriorate or become unwell. . Staff working from local NHS hospital EDs and conducting urgent hospital transfers had received emergency medical technician training. Specialist nursing staff employed by the hospital accompanied any patients who were seriously unwell. The organisation had crews who had trained to conduct 'blue light runs' or urgent inter-hospital transfers.
- Ambulance staff received details from the control on any potential risks to patients. All ambulance staff we spoke with described using a dynamic risk assessment (a real-time and continuous assessment of risk), in relation to moving and handling each patient. However, while staff described the assessment they did not document it.
- Control staff used an electronic patient record system, which identified any risks to patients for example falls and pressure damage. This enabled control staff and crews to provide appropriate responses to patients and assess any risks.

Staffing

- There was enough staff to deliver the service. Data from the organisation showed for the period January 2017 to March 2017 actual against planned staffing levels ranged between 91% and 94%. The organisation had planned staffing levels of 118 full time equivalents (FTE). Actual staffing levels dropped from 111.8 FTE in January 2017 to 107.8 FTE in March 2017. Leicestershire had 10.2 (8.7%) FTE vacancies.
- 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 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 277 hours of bank staff, 381 hours in February 2017 and 208 hours in March 2017.
- For the period January 2017 to March 2017, data from the provider showed a fluctuation in sickness rates, In January2017 the sickness rate was 1.8% of the total establishment hours. This rose to 3.9% in February 2017 and down to 1.6% in March 2017. This equated to 333.3 hours lost to sickness in January 2017, 656.5 hours lost in February 2017 and 294 hours lost in March 2017.
- The staffing rota was over a period of seven weeks. Different bases had different rota arrangements and shift patterns. Staff said line managers were flexible with the rota and staff could get time off for personal circumstances and events.
- Staff did not know whose responsibility it was to ensure ambulance crews got breaks on time. Ambulance staff

told us they were often late getting their breaks and this was due to allocation of jobs from control. Both control and ambulance staff knew when the break period should be. Both control and ambulance described different processes and responsibilities for allocating breaks. Some said it was down to control to allocate breaks and others said it was the crew's responsibility.

- Control staff conducted handovers at shift changes. We observed a handover and staff discussed resources, journey lists and availability of crews. The handover was clear and concise. Staff used paper lists and notes to pass on any ongoing information.

Anticipated Resource and Capacity Risks

- Vehicles were often unavailable. There were a number of vehicles off the road and this had an adverse impact on resource and journey planning. Staff told us they did not record an 'off the road' vehicle on the incident reporting system. During our inspection, we saw 10 out of 27 vehicles (37%) were unavailable for use at Thurmaston. During out unannounced inspection this had increased to 12 vehicles (44%).
- Data from the organisation for the period November 2016 to February 2017 emphasised this issue. The number of vehicles off the road was constantly over 30 per month, peaking at 35 vehicles in November 2016 and February 2017. Between one and nine vehicles had been off the road three times or more during this period and the service lost 300 transport days for three out of four months. In November 2016, seven vehicles had been off the road for over 20 days and this reduced to three vehicles in February 2017. Data from the organisation showed a daily average of 8.7 vehicles off the road. The Leicestershire service had a total of 64 vehicles.
- The organisation used hired vehicles to fill gaps in resources. We observed four hire vehicles in use due to large numbers of vehicles off the road in Thurmaston. In addition, managers arranged for staff to use vehicles from other bases. Staff said some hire vehicles were not fit for purpose or delivered in an unclean condition. We observed during our inspection an unclean hire vehicle with a defect. The base manager reported the issue to the hire company. A base manager returned another vehicle to the hire company, as it was not fit for purpose.
- The control room had a system to manage and respond to demand and capacity. The control room had an electronic list for patient journeys they had not yet allocated to crews 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. Control staff did not allocate crews who were transporting high priority patients.
- The control room had procedures in the event of a power cut and electronic software failure. If the Leicestershire 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 Leicestershire 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 resource allocation and communication with crews.

Response to major incidents

- The staff had received 'prevent' training Prevent training is the counter-terrorist programme, which aimed to stop people from becoming terrorists or supporting terrorism.
- Managers told us they did not have a service agreement with local NHS trusts to be involved with their major incident policies. However, if a trust requested them to provide services they would endeavour to meet those demands.
- All bases we visited had clear fire evacuation procedures. Procedures were clearly visible on the walls of bases. Staff briefed visitors on fire procedures on arrival at bases.

Are patient transport services effective?

Evidence-based care and treatment

Patient transport services (PTS)

- 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. Staff had access to hard copies of policies and procedures at their bases. Managers kept policies and procedures in folders located in visible areas
- The organisation had given staff access to policies and procedures on the organisation's online system. There were no computers at bases except for the manager's so they had to access policies from home. Staff we spoke with had not used this system and either did not want to or did not have internet connections at home. Therefore, staff access to policies was limited.
- 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.

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 suitable for the needs of the patient for example, a vehicle with a stretcher. 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 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.
- 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.
- Control staff had electronic lists for inward and outward journeys required. Therefore, they could also plan journeys based on shift times and geographical locations. For missed appointments staff conducted welfare calls to check on individual patient's wellbeing.
- Staff had water on board ambulances in case patients required a drink. We saw all bases had stocks of water so staff could replenish stocks on vehicles.
- Staff asked about pain management prior to journeys in and out of hospital. This was to ensure they had all the necessary information to handover to staff or carers at the other end of the journey.

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 appointment 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 July 2016 to February 2017. Between 60% and 70% of patients arrived within 60 minutes of their appointment. The organisation collected between 40% and 60% of patients from their appointment within 60 minutes of being booked ready. 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. Data showed an overall deterioration with 58.6% of patients arriving 30 minutes before and 81.9% arriving before their appointment in February 2017.

- 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 for February 2017 showed 63.8% of journeys were 30 minutes or below and 74.2% of patients had departed on time after treatment.
- The service monitored performance against call centre contractual target (all calls answered within 10 seconds) and call abandonment rates (a call ended before any conversation occurs). 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 organisation had targets for patient time on vehicles. For journeys within a radius of 10 miles, 95% of patients should be on vehicles no longer than 60 minutes. Between 10 and 35 miles, the target was 90 minutes for 95% of patients and between 35 and 80 miles, the target was 120 minutes for 90% of patients. The organisation consistently met these targets between July 2016 and February 2017.
- Staff monitored response time performance against targets 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.

Competent staff

- The service did not comply with the organisation supervision policy. This specified performance development reviews (PDR) with six monthly interim PDRs, observed practice twice yearly and monthly one to ones. The policy included guidance for managers. Staff said these did not happen with their managers. Only the yearly PDRs took place.
- All staff we spoke with had received an appraisal or performance development review in the last year. Data from the organisation showed 100% of PDRs at Loughborough were complete, 96.5% at Thurmaston and 90.9% at Whetstone. The organisational target was 85%. Therefore, the majority of staff had received an appraisal in the last year.
- Staff had limited development opportunities and career progression. The majority of staff we spoke with said there were no additional training opportunities. The organisation had recently introduced lead driver roles to develop a limited number of ambulance staff to support the work of assistant general managers. The organisation's 2016 staff survey also highlighted this as a key area of concern and priority with 28% of staff satisfied with career development opportunities.
- Organisational training did not comprehensively support staff to fulfil their roles. For example, staff training for dealing with patients who were living with dementia was a short section as part of staff safeguarding training. This section also included patients living with mental ill health.
- The organisation provided a training programme 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. The training policy stated mentors would support new staff during the first six weeks of employment. However, most new members of staff said they did not get a mentor or the mentorship did not last for six weeks.
- Managers did not routinely review staff competencies, for example blue light driving or driving skills in general. Senior managers advised us all crews had six-monthly observed practice by a mentor, team leader or manager. Staff said this did not happen and managers did not have records to demonstrate this happened. Managers reviewed competencies on a reactive basis when

incidents occurred. Data from the organisation between January 2016 and December 2016 showed no observed practice had taken place at Loughborough, 3.5% at Thurmaston and 21% at Whetstone.

- The organisation electronically monitored the driving performance of each vehicle, including ambulances and cars. This included speed and braking. These aspects of driving had a direct impact on patient comfort during the journey. Each driver received scores, which managers could access at any time. The organisation monitored the scores and if the driver's score exceeded a maximum score of one, staff employed on a bonus scheme would lose their monthly bonus.
- Some staff raised concerns about driver training for new drivers. Driver training consisted of a one-day course but staff said trainers took three or four drivers with them. This meant the time spent driving was limited for new staff.
- Managers could monitor call handler performance through an electronic telephony system. Managers could see real time call answering times, the length of time spent on calls and logged off. Managers used this information to address any individual poor performance.
- Control staff said they received regular monthly one-to-one meetings. Managers used them to support staff and discuss any performance related issues.

Coordination with other providers and multi-disciplinary working

- When staff transferred a patient's care to another healthcare provider such as a local NHS hospital or hospice, they ensured the handover at pick up was clear and precise to enable a thorough handover to staff receiving the patient. We observed positive relationships between staff and other NHS trust healthcare staff.
- Managers and staff said they had a good working relationship with the local NHS hospital trust and could call to discuss any concerns. In addition, the organisation had staff based at local NHS hospitals to coordinate the provision of transport. At one hospital, the organisation had a discharge coordinator who liaised between the hospital and crews directly. At another hospital, a coordinator based at the renal unit liaised with patients, the unit and control.
- We observed good communication amongst the control staff, with callers and the crews. We observed the call takers clarifying information and working to ensure the quick transportation of priority patients. We saw constant communication with crews via a messaging system.
- However, ambulance staff said it was difficult to get through to control over the phone and this caused some delays. This did create tension at times between ambulance and control staff. We did not see this during our inspection but observed control staff were busy. We observed crews experiencing small delays because of the time taken to contact control.
- Some crews worked at night or late into the evening. The organisation had procedures for 24-hour control room cover. At 11pm each night a control room in Bristol took over the control functions for crews working overnight. This meant crews could continue to communicate and speak to control out of hours.

Access to information

- Each vehicle had an allocated electronic hand held device. The electronic hand held device enabled the crew to see the patient record, provide information to dispatch as to their status during their shift, for example if they were mobile or waiting to pick up a patient. The crew could also use the tablet to telephone and/or send messages to the control centre.
- Operational staff received full patient handovers when collecting patients from providers.
- The electronic patient record system alerted staff to any special notes or requirements for patients. For example, the system highlighted if two staff were required because of concerns of falls or specific moving and handling requirements. The system also highlighted patients who had mental health conditions or learning disabilities.
- The organisation had procedures with local NHS emergency departments (EDs) regarding patients requiring transport home or to other hospitals from ED. Department staff contacted control and control staff

sent the information electronically to crews. However, we observed delays in crews receiving information when emergency department staff had already instructed staff to take patients from ED. This caused delays for crews and emergency departments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The organisation had alerts on the electronic patient record system if patients had a do not attempt cardio pulmonary resuscitation (DNACPR) order. Staff also discussed and checked DNACPR orders with hospital staff prior to leaving. Staff discussed any concerns with the nurse and doctor to ensure documentation was legal and appropriate prior to transferring the patient.
- Half the staff we spoke with said they were not sure or they had not received training in the Mental Capacity Act 2005 and dementia. The other half said they had. Staff told us the training was too short and had not given them enough information for them to judge people's capacity to give consent.
- All staff we spoke with could not describe how to undertake basic mental capacity assessments, or knew what to do with agitated patients or patients experiencing a mental health crisis.
- Four members of staff we spoke with gave examples of trying to prevent patients leaving the ambulance or preventing patients from physically harming staff. Staff did not know about deprivation of liberty safeguards (DoLS) and unlawful restraint. This presented a risk to both staff and patients.
- Staff used forms to record when patients refused transportation or for when they could not enter the patient's home. We saw staff respect patient's decisions and staff reported the refusal to the control room.
- Crews asked patients for consent before they carried out any moving and handling.

Are patient transport services caring?

Compassionate care

- The organisation conducted a patient survey between November 2016 and January 2017. An average of 88% of patients were either satisfied or very satisfied with staff care and consideration. Whetstone and Loughborough stations scored 97% and 100% respectively. Patient comments included, "drivers were brilliant, helpful and kind" and, "very caring and professional."
- Staff gave patients and their relatives or carers opportunity to feedback through the complaints process or through the friends and family test (FFT) questionnaire cards. We saw completed FFT cards at bases and posters in vehicles explaining how patients could feedback.
- For the period January 2016 to December 2016, the service FFT scores fluctuated between 71% and 93% of patients likely or highly likely to recommend the service to others. The service scored above 85% for six months out of 12. This meant most patients who used the service would recommend it to others.
- We observed crews preserving patient's dignity when transferring them from trolleys or beds to wheelchairs and stretchers. We saw crews drawing patient's privacy curtains to ensure privacy and fastening seat belts carefully in the vehicle.
- Call handling staff preserved patient confidentiality by not referring to patients by name when speaking to other health and care professionals until they confirmed patient details.
- Crews were caring and compassionate towards patients. Staff checked patient's comfort and welfare and helped them, for example adjusting wheelchairs so they were comfortable for travel.
- Staff did not rush patients. We observed one patient eating and drinking in a local NHS emergency department. Staff politely waited and said they would take the patients once they had finished. They told the patient not to hurry and to take their time.
- Staff driving ambulances drove with care to ensure the patient's ride was comfortable and smooth. Staff drove over speed bumps and road surfaces carefully and slowed down to ensure patients felt comfortable.
- We observed call handlers responding to patients in a helpful and reassuring manner. Call handlers were friendly and made additional calls on behalf of patients and relatives to take worry and anxiety away from them.

Patient transport services (PTS)

- Relationships between people who used the service, those close to them and staff were strong, caring and supportive. Patients told us staff were kind and very professional. Staff welcomed relatives and carers travelling with patients.
- Staff talked to patients during their journey to help them feel at ease and comfortable. Staff used humour where appropriate and showed an interest in patient's welfare and social background.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us staff explained everything to them and they could ask questions at any time, nothing was too much trouble for the staff. Staff talked to patients about their needs and requirements prior to journeys. Staff talked to patients to understand and involve them in their transport requirements. Where possible staff provided patient's choices in terms of where they sat to ensure the most comfortable method of travel.
- We observed excellent communication from the staff to the patients and their relatives or carers. It was evident they knew some of the patients very well. Staff took the time to explain what was happening to both patient and relatives.
- Staff discussed whether patients could receive transport with patients, carers and healthcare professionals. Staff used prompts on the electronic patient record system in order to identify whether patients were appropriate to receive transport. Staff were kind, polite and sensitive to any patients not eligible for transport.
- Staff provided information to patients prior to their journey about the service. Staff explained the service over the telephone. The organisation's patient survey conducted between November 2016 and January 2017 showed an average of 62% of patients across Leicestershire were satisfied or very satisfied with the information staff provided prior to their transport. On average, 17% of patients were less than satisfied. This meant most patients were happy with the information provided by staff.

Emotional support

- We observed staff reassuring patients and communicating in a meaningful manner to alleviate fears patients may have had. Staff used eye contact and physical contact to reassure patients.
- The organisation's patient survey conducted between November 2016 and January 2017 showed 88% of patients said staff reassured them during their journey.
- We observed staff supporting patients to walk independently where appropriate.

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

Service planning and delivery to meet the needs of local people

- Local commissioners contracted the organisation to provide transport to meet the needs of patients. The organisation carried out journeys to and from outpatient appointments, hospital discharges, hospital admissions, hospital transfers, oncology, palliative care and bariatric (patients over a certain weight) patient transfers.
- The organisation had reviewed their fleet in August 2016 and September 2016 to allocate the correct type of vehicle to locations where they were needed. They adjusted staff rotas as part of this service planning.
- The Loughborough base had training facilities. Staff attended the Loughborough base for their mandatory training. The facilities were comfortable and spacious and were appropriate for training staff.
- We saw ambulance crews faced challenges with their base environments. Staff told us and we observed ambulance base environments did not enable staff to deliver a quality service. we saw evidence of issues raised in station staff meetings. Staff said there was no temperature control therefore bases were too hot in the summer and too cold in the winter. Staff said they did not return to base for breaks because they were either too cold or they had poor facilities.

- The outside lighting was not appropriate for cleaning vehicles in the dark and there was no covered space to vacuum inside vehicles. This contributed to crews not cleaning vehicles directly after their shifts especially in winter months.
- Staff had a breakout room and kitchen at the control room in Leicester, which they used for lunch or breaks. Staff had access to water coolers in the control room.

Meeting people's individual needs

- 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.
- Staff identified individual needs of patients at the booking stage. Staff used an electronic system, which prompted staff to ask callers about patient needs. We observed staff had systems to identify patients who were vulnerable including patients living with dementia and learning disabilities. Staff could also allocate single or double crew vehicles depending upon the transportation needs of the individual patients.
- Staff identified and booked vehicles with wheelchairs if patients were disabled or had mobility difficulties.
- 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.
- We observed the control room had a type talk system to support patients with hearing impairments.
- The organisation did not have aids or materials for patients with visual impairments. Vehicles did not have any signage available in languages other than English. Vehicles did not have signage suitable for patients living with dementia or patients with learning disabilities.

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. This 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.
- Journey planning was not patient focused. Staff told us control adjusted patient pick up times so they could fit in more runs, for example picking a patient up three hours before their appointment instead of two hours before. We saw staff in the control room faced challenges because of high demand.
- 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 schedules. 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. During the inspection we observed there were five patients (three transfers and two discharges) waiting between 52 and 215 minutes (three hours and 35 minutes) over their target pick up times.
- We observed one situation where local NHS hospital staff had given the crew the wrong address. Staff advised the patient and their relatives of this issue. This resulted in the crew taking the patient to the wrong location. Call handling staff obtained the correct

address however, the crew returned the patient to the hospital to wait for another crew to take them to the correct address. Staff arranged for another crew to collect the patient. This caused the patient a significant delay and some concern for relatives.

- 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 69% of patients across Leicestershire were happy with the timeliness of crews. Twelve percent of patients were neither satisfied nor dissatisfied. This meant most patients were happy with timeliness.
- However less than half the patients asked in the survey (for the same period November 2016 to January 2017) were satisfied with the timeliness of their pick up from hospital. Data showed 47% of patients were happy with the timeliness of crews. This highlights capacity and 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.
- Between December 2015 and November 2016, there were 405 formal complaints (a rate of one complaint every 440 journeys). The most common complaints were about late outbound journeys (157), missed inbound journeys (94), late inbound journeys (40) and care standards (19). Managers discussed complaints at the weekly managers meeting.
- Between December 2015 and November 2016, 100% of complaints were acknowledged within three working days. Between the same timeframe, 74% of complaints were completed within 25 days, and 95% were completed within 40 days.
- Patient Advisors reviewed and triaged complaints. They were part of the Quality and Standards team and escalated complaints to senior management via the Quality and Standards manager.
- We saw evidence of learning and a change of practice resulting from complaints. For example, we saw the organisation had introduced a policy on key safe guidance to ensure staff knew their roles and responsibilities in accessing properties. Staff did not recognise this had resulted from a complaint. However, managers did not actively share learning from complaints across the organisation.
- Managers told us they received information about numbers of complaints but not details. All staff we spoke with said they did not receive feedback about complaints.
- We saw posters in all of the vehicles advising patients how to feedback or raise concerns about the service.
- One member of staff gave a positive example of quickly dealing with and responding to a complaint. A manager went to visit the complainant to apologise and listen to the patient's concerns.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The organisation delivered non-emergency patient transport services across the country. Therefore, leadership existed at a local and national level. The national leadership team of the service consisted of a managing director, national head of patient transport services, and head of quality and standards. Locally the service had a registered manager who was also head of contacts, a general manager and four AGMs who managed the service and bases day to day. Operational staff saw their manager on a daily basis at their base station.

- Local leaders, including the general manager and AGMs, were visible. Staff said their local leaders and managers were supportive. The 2016 staff survey data showed 62% were satisfied overall with their manager. These were similar results to the previous year.
- We found local managers knew about the issues raised by staff. However, some senior managers at the national level in the organisation did not know about the issues which were important to staff. We saw positive local leadership with managers supporting staff and enquiring about their welfare. All AGMs demonstrated a commitment to staff welfare.
- Staff told us morale was low. Staff had to stay longer than their shift time to clean and check vehicles. The majority of staff (27) we spoke with said workload, organisational culture and lack of information were key factors in their morale. Staff said senior managers did not thank them or told them they were doing a good job.
- Most staff felt their managers treated them inconsistently during investigations about incidents and damage to vehicles. Staff perceived a blame culture existed around reporting incidents. The organisation displayed information about 'blameworthy' incidents at bases. Staff told us if they damaged a vehicle or were involved in an incident which caused harm to a patient, they were financially penalised and lost their driver initiative bonus. The majority of staff (27) said the organisation was more concerned about finance than staff.
- Two members of the senior management team told us they were not aware that staff felt there was a blame culture, and told us that staff were responsible for their standards of driving and that all incidents involving vehicles were investigated by the AGMs. The company was intent on decreasing the number of accidents involving vehicles. We therefore observed there could be a potential disconnect between the senior management team and operational staff.
- The organisation monitored driver and vehicle performance data. If a vehicle had the engine running but not moving, the organisation called it idling. Staff felt this was unfair due to the time some frail elderly people took to board the vehicle and in the winter months, it was required to heat the vehicle to ensure the windscreens were clear and safe to drive.
- Staff we spoke with felt the electronic monitoring of driving was unfair. Staff said heavy braking could be due to emergencies and managers did not consider them when they removed bonuses from staff pay.
- Staff undertaking the same role had different conditions attached to their employment. This was due to different inherited contractual arrangements. This caused disharmony within the teams and resentment towards the company. Staff we spoke with told us they felt devalued by the company.
- The organisation had a lone working policy. However, the majority of staff we spoke with said they had not read the policy or knew it existed. Most staff could not describe what they would do if they felt at risk or in danger. Some staff said they would call 999 or contact control, as per organisational policy. However, if control were busy there may be a delay in reporting their concerns. This presented a risk to staff safety. This meant procedures described in the policy were not effective.
- All staff we spoke with described a positive team working culture across all bases. Staff said their colleagues were friendly and supportive and all staff felt they worked well together with their AGMs. The organisation's 2016 staff survey highlighted supportive colleagues and positive team working amongst staff.
- Staff were extremely passionate about providing good experiences for patients and building relationships with patients using the service regularly. Every member of staff we spoke with said patients were the main reason they did their job.
- The organisation gave staff free bus passes to use on specified bus routes. Staff we spoke with appreciated this and said it made getting to work cheaper and more accessible, especially those working in Leicester city centre.

Vision and strategy for this this core service

- The organisation had a vision and strategy. The vision was to provide 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 change brings opportunities. However, we found out during our inspection commissioners had extended the Ambuline Arriva contract to provide services for Leicestershire to run until August/ September 2017, after which the contract will cease and another provider will be contracted to provide non-emergency patient transport services in Leicestershire.

- The organisation had four values: teamwork; great customer experience; doing the right thing and thinking beyond (to be curious and inspired). Most staff had heard of and understood the values.
- There were four key objectives to provide an effective and safe service with consistent quality. Senior managers acknowledged progress was required in a number of areas. Senior managers promoted the vision in a booklet provided to staff and highlighted their role in achieving the organisational aims and objectives. Managers had also incorporated the objectives into staff appraisals.
- The majority of staff were not aware of the strategy, vision of the organisation and could not describe how they would apply them to their role.

Governance, risk management and quality measurement

- Operational quality performance group meetings took place on a monthly basis. This group had manager representatives from all the service's areas. There was a standing agenda for these meetings and this group reported to the senior leadership team. We reviewed minutes the from this group between September 2016 and February 2017 and saw risk, incidents, safeguarding, complaints and performance were standing agenda items. However, the minutes showed little discussion and learning from complaints and risks. We reviewed the minutes from the senior leadership team meetings and found there was no discussion relating to the risks identified at the operational quality performance group meetings.
- Governance processes were not always effective, for example, there was no oversight of the quality of training that was being delivered despite staff raising concerns that they felt the training was rushed and did not equip them to effectively undertake their role.
- The service had a local risk register. We reviewed the local risk register for non-emergency patient transport services, which included risks such as failure to meet key performance indicators (KPIs), adverse publicity, call centre performance and staffing and competence.
- 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.
- 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.
- The general manager and assistant general managers (AGMs) discussed risks. Assistant general managers said some risks were resolved locally but they raised others at weekly meetings. The general manager escalated risks and added them to the Midlands risk register. Where managers identified risks we saw no actions taken or delays in addressing risks. Not appropriately managing risks could potentially cause harm to staff working at bases.
- We saw each base used generic risk assessment templates. The templates were risk assessment templates used by bus services. Managers had not changed them to account for base or ambulance specific risks. Each of the risk assessments we viewed were the same across each base. We saw managers had not clearly identified risks identified on the risk assessments for example the storage of flammable liquids.
- Data from the service showed they were continually not meeting their contractual response time targets and patients were either late or missing hospital appointments. We saw from minutes of operation quality performance group meetings between

November 2016 and February 2017 managers had recognised this issue. However, managers had not implemented any actions, which contributed to improving performance. Data showed late and missed appointments were still a key performance issue.

- The provider used several dashboards to monitor the safety of their service. The provider monitored performance on control room performance (talk time, allocation time, aborted journeys), inward and outward journeys, infection control practices, capacity and demand. The provider monitored performance using observational, manual and electronic audits. The provider used specific electronic audit software to monitor and analyse results.
- Results demonstrated high demand, sometimes over and above service capacity. Audits demonstrated teams were not meeting some key performance indicators (KPIs), including inward and outward journey times. We saw from minutes of quality performance meetings in November 2016 managers had introduced procedures to record missed appointments to improve monitoring where performance was poor. However, data from the organisation showed they continued to perform poorly regarding journey times.
- Managers displayed and shared performance at bases using notice boards. The boards were clearly visible to staff and contained relevant performance information. Managers compared performance with the previous month. The electronic audit software created reports for managers to discuss at monthly and quarterly management performance reviews.
- The organisation had key performance indicators for crews and staff. For example the organisation monitored response times, times patients spent on vehicles, waiting times and call handling targets such as time to answer. Staff knew and had access to performance data through bulletins, notice boards or electronic systems. Managers regularly reviewed and received feedback on performance data and shared this with staff.
- Staff told us the targets they had to achieve were unrealistic. Staff found it difficult to collect a patient or a number of patients and take them to a local NHS community or acute hospital in the time allocated. Staff said this was because the times allocated to complete these journeys did not take into account patient frailty, mobility and the time needed for them to board the ambulance.
- The service did not record or audit calls to the control centre. This meant managers could not use them for monitoring performance or as part of any complaint or incident investigation.
- All staff we spoke with knew their role responsibilities. Some AGMs said they were accountable and responsible for a disproportionate amount of operational delivery. They had raised concerns regarding workload and senior managers' expectation of them. We saw AGMs had a greater understanding of delivery, risk and performance than some senior managers did.

Public and staff engagement

- 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.
- Managers created an action for Leicestershire in response to FFT and patient survey comments. We reviewed an action plan from June 2016 and July 2016. We saw managers had increased wheelchair capacity and staffing establishments for crews and the control room. These actions were in response to long waits and concerns regarding poor communication. We observed during inspection communication and long waits were still concerns for patients meaning actions put in place did not have an impact.

Patient transport services (PTS)

- Staff said senior managers did not listen to their requests and suggestions. Staff across all bases gave examples where senior managers had not listened to them.
- Staff said local managers listened to them and we saw evidence of local team meetings (station surgeries). We saw minutes from three such meetings at Loughborough and Thurmaston between March 2016 and March 2017. We saw evidence of discussion, identifiable actions and feedback.
- Managers held monthly base meetings. Staff found it difficult to attend base meetings as they were often on shift. In general, base meetings were not well attended at Loughborough and at Thurmaston. This was because staff worked shifts and they found it difficult to attend.
- Managers had flip charts in bases where staff could write down questions, issues or concerns. We saw managers responded on the flip charts and reacted to suggestions. This meant staff could read the manager response and see any action taken next time they were on shift.
- 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.
- Most staff we spoke with said it was hard to keep up to date with changes to the service or changes to policies and procedures. Staff said due to a minimum time spent on bases and having other duties prior to their shift starting meant it was hard to keep up with changes. We observed this at one base where two members of staff were unaware of recent changes to the layout of their base.
- The majority of staff we spoke with said they did not feel informed or involved regarding contract changes to the service. Some staff knew about a briefing circulated in December 2016 regarding the organisation's intentions for the Leicestershire service. Some staff told us managers had asked for staff representatives and arranged a meeting. We saw managers had cancelled this meeting and staff had received no further information.
- 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. However, the majority of staff we spoke with had not used this group.
- The organisation conducted a quarterly patient survey. Results for the period November 2016 to January 2017 showed patients were mostly happy with the services they received. However, it highlighted patient concerns regarding waiting for transport out of hospital. An average of 65% of patients were happy with the overall quality of the service. Staff could not tell us any changes to services resulting from patient feedback.

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

- The patient transport service contract to provide services for Leicestershire had been extended to run until August/September 2017, after which the contract will cease and another provider will be contracted to provide non-emergency patient transport services in Leicestershire. The organisation had not taken part in the tendering process for the new contract. Senior managers had engaged in high-level discussions however, operational staff did not feel they knew what was happening. One base manager said they knew they were leaving their base when their property owner told them he was putting the base back up for lease. Senior managers had not informed the base manager.

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 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 staff follow infection, prevention and control procedures to assure themselves vehicles and equipment are clean.
- The provider must ensure ambulance bases are clean and suitable for the purposes for which they are being used.
- The provider must ensure it adheres to relevant regulations regarding the storage and management of highly flammable liquids.
- 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 including lone working and safeguarding.
- The provider must review lone working arrangements for staff and ensure staff can access immediate help and support.
- The provider must improve its performance against contractual targets to ensure patients arrive for their appointments on time.
- The provider must ensure staff are supported in their roles by effective supervision, competency monitoring, mentoring and appraisal systems.
- The provider must ensure staff know their responsibilities regarding the mental capacity act, consent and the use of restraint.
- The provider must ensure that timely and effective governance and risk management systems are in place and where risks are identified, timely and appropriate action is taken.
- The provider must ensure learning from complaints and concerns is shared with staff.

Action the hospital SHOULD take to improve

- The provider should work to reduce the numbers of vehicles off the road to ensure staff and patients have access to appropriate vehicles.

Outstanding practice and areas for improvement

- The provider should assure themselves staff are competent in dealing with patients with mental illnesses. Any incidents of restraint of patients should be reported through the organisational incident reporting system.
- The provider should consider using written materials suitable for patients with visual impairments and for patients whose first language is not English.
- The provider should ensure effective communication and engagement methods with staff are in place.
- The provider should review and act on comments regarding morale and organisational culture.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: Premises at Whetstone were not suitable for maintenance and cleanliness of vehicles. We found staff used the male toilet as the station for filling containers with cleaning chemicals. Lighting was not sufficient for staff Issues were raised on the cleanliness of vehicles and equipment on infection control audits. Deep clean schedules were not in place to ensure regular thorough cleans of vehicles. There were ineffective infection control practices in place to ensure vehicles were clean and prevented the spread of infection. Staff did not follow infection control procedures therefore compromising the cleanliness of vehicles and equipment. Flammable liquids were not always stored and managed in line with legislation. Regulation 15 (1)(a)(c)(2)

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: Procedures to protect staff who were lone working were not effective. The organisation was not meeting response time targets for collecting patients and call answering.

This section is primarily information for the provider

Requirement notices

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)

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

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

This section is primarily information for the provider

Requirement notices

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

Regulation 20 (1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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

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

This section is primarily information for the provider

Enforcement actions

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

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

Staff did not receive feedback about incidents they had reported

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

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

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