Ambuline Limited

Ambuline Chesterfield

Quality Report

Ambulance desk
Outpatient department
Chesterfield Royal Hospital
Chesterfield
Derbyshire
S44 5BL
Tel: 01915 204000
Website: www.arrivatransportsolutions.co.uk

Date of inspection visit: 05 October 2017
Date of publication: 29/11/2017

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Ambuline Chesterfield is operated by Ambuline Limited, which is a subsidiary of Arriva Transport Solutions Ltd.

Ambuline Chesterfield provides a non-emergency patient transport service (PTS) in North Derbyshire. They have a 'control desk', which operates from the NHS hospital's outpatients department. The service has a base approximately two miles from the hospital where the vehicles are stored and crews start their shifts. The service operates to transport patients to and from neighbouring NHS hospital outpatient departments, and to and from the patients' home address.

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

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

The full report of this inspection can be found on the CQC website: https://www.cqc.org.uk/location/1-202455260

As a result of our findings we issued a warning notice served under Section 29 of the Health and Social Care Act 2008 in June 2017. In order to follow up on progress against this warning notice we carried out a short notice announced focused inspection on 5 October 2017.

At this inspection we visited the control desk, which was located at the NHS hospital and the service's ambulance station at Chesterfield. We spoke with 10 members of staff including managers, control staff and PTS drivers.

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

Services we do not rate

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

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

- The supervisors, control patient transport drivers had not had updated adult and children's safeguarding level two training as recommended in national guidance.
- Staff were not consistent in their knowledge of how to recognise or report a safeguarding concern in order to protect people from avoidable harm and abuse.
- Information was not provided in all ambulance vehicles to assist in making safeguarding referrals.
- Ambulance staff had no computer access to current policies stored on the web based portal.

However we also found the following areas of good practice:

- Senior managers and supervisors had undertaken incident management training and were able to identify, investigate and review themes in order to fully address incidents within specific timelines.
- A 24 hour, seven day a week incident reporting telephone number had been provided to all staff.
- A quality bulletin was available for all staff to read highlighting incidents and learning points identified.

Summary of findings

- Management staff had received updated training in line with safeguarding level three as recommended inNational guidance from the Intercollegiate Document for Healthcare Staff (2016)

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

Heidi Smoult

Deputy Chief Inspector of Hospitals(Central), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Ambuline Chesterfield

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Ambuline Chesterfield

Ambuline Chesterfield is operated by Ambuline Limited, which is a subsidiary of Arriva Transport Solutions Ltd, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Ltd is part of an international transport group Deutsche Bahn (DB).

Since December 2013, Ambuline Chesterfield has provided non-emergency patient transport for the Derbyshire area. The service covers a mix of urban and rural areas including Derby City, towns such as Mansfield and Chesterfield and rural areas such as Derbyshire. 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, oncology, palliative care, intermediate care, mental health and bariatric (patients over a certain weight).

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

Our inspection team

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

How we carried out this inspection

During the inspection we visited the control desk, which was located at the NHS hospital and the service's ambulance station at Chesterfield. We spoke with 10 members of staff including; control staff, patient transport drivers and management.

Detailed findings

Facts and data about Ambuline Chesterfield

Ambuline Chesterfield undertakes approximately 2,600 patient journeys a month. The service employs 26 members of staff who are employed for a total establishment of 23 full time equivalent posts. The service provides transport services 12 hours a day, seven days a week and the ambulance control operates from 8am to 6pm, five days a week Monday to Friday. At the weekend, the discharge lounge at the neighbouring NHS hospital coordinates the transport services. The service has a fleet of 15 vehicles.

Ambuline Chesterfield is registered to provide the following regulated activity:

• Transport services, triage and medical advice provided remotely.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Ambuline Chesterfield is operated by Arriva Transport Solutions Ltd. We carried out this inspection in order to follow up on enforcement action we had issued in June 2017. We have not rated patient transport services (PTS) for Ambuline Chesterfield Ambulance Services because we were not committed to rating independent providers of ambulance services at the time of this inspection. PTS was provided from a base in Chesterfield with the control desk based within the main entrance of a neighbouring NHS hospital. All of the vehicles were kept and maintained at the Chesterfield base and this was where we undertook our inspection. All of Ambuline Chesterfield Ambulance PTS Services were contracted by the neighbouring NHS hospital trust

Summary of findings

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

- The supervisors, control patient transport drivers had not had updated adult and children's safeguarding level two training as recommended in national guidance.
- Staff were not consistent in their knowledge of how to recognise or report a safeguarding concern in order to protect people from avoidable harm and abuse.
- Information was not provided in all ambulance vehicles to assist in making safeguarding referrals.
- Ambulance staff had no computer access to current policies stored on the web based portal.

However we also found the following areas of good practice:

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

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- At the last inspection in March 2017 we issued the provider with a warning notice as there were no effective procedures and processes in place for staff to report incidents to protect people from the risk of avoidable harm or abuse. There was also limited understanding amongst staff about the processes to follow for managing incidents
- At this inspection we found a new incident reporting system had been implemented. A 24 hour, seven day a week telephone number had been provided to all staff. All staff we spoke with were aware of the new reporting line and the telephone number was available to them at all base areas and on a key fob for each vehicle. Some staff had yet to use the new system but reported that a dedicated helpline would address the long waits to report incidents they previously encountered.
- The use of the new reporting line meant that incidents were reported accurately into one system. Should a safeguarding concern also be identified there was a dedicated section of the incident report to add this. This directly linked the two for improved reporting and follow up.
- At the time of the inspection there were 68 closed incidents and one open incident for the Chesterfield location. We reviewed three incidents and found they had been appropriately investigated. Key tasks had been undertaken in the allotted timeframes and they had been reviewed by a safeguarding lead to ensure safeguarding concerns had been acted upon and had not been missed.
- At our March 2017 inspection we saw no evidence of learning from incidents.The staff we spoke with were not able to give examples where learning had taken place or where they had been given any feedback from incidents they had reported.
- During this inspection staff were aware of the incident reporting policy and said that if they had reported any incidents they did receive feedback. However, this was isolated to the individual reporting the incident and was not routinely shared with other staff.
- Three staff could recall learning being shared in relation to a wheel chair incident and we saw the quality bulletin available for all staff to read relating to this at the base.

Safeguarding

- At the last inspection in March 2017 we issued the provider with a warning notice as there were no effective procedures and processes in place to safeguard people from the risk of avoidable harm or abuse. There were also no effective systems to allow ambulance staff to report safeguarding incidents. Overall, whilst we found some progress had been made to systems of reporting and training of senior staff there was still work to do to ensure that staff were trained and knowledgeable in what to report.
- At this inspection Ambuline managers had renewed their policies in relation to safeguarding of adults and children. A new flow chart had been provided with guidance relating to the company safeguarding leads and contact numbers. Staff were directed to Arriva net (a web based portal) to access these policies as required.
- We asked seven staff where policies were available. They all reported that they were kept in a folder at the ambulance base. However, the folder had been removed as it had contained out of date policies, all policies were available on Arriva net.
- The seven staff told us they were aware of Arriva net but had never used it. We asked one member of staff to access the safeguarding policies on the portal. Policies were available however; they were not the current policies.
- Patient transport drivers told us as there was no computer access for them at base therefore they would not have any access to the policies. This was also a concern at our initial March 2017 Inspection.
- We spoke with the operational manager at Chesterfield base who confirmed the policies on Arriva net were out of date and all new policies were on an internal computer drive. Patient transport drivers and control staff did not have access to the drive, as there was no computer at the base.
- The new safeguarding flow chart and a poster detailing safeguarding contacts for Ambuline were on the noticeboard at the Chesterfield base. This identified who the safeguarding leads were.

- However, staff we spoke with could not recall seeing the poster and said they would discuss any concerns with the operational manager. The operational manager had not received the updated safeguarding training.
- We looked at information available on four vehicles and on three of them this did not contain all of the new safeguarding referral information. This was raised with the operational manager and we were told it would be rectified.
- The safeguarding policy and the safeguarding flowchart stated that staff should contact local authorities directly if they needed to raise a safeguarding concern.
- At our March 2017 inspection we found all staff had undertaken annual mandatory training including safeguarding but we were not assured about the quality of this training.
- At this inspection we found there had been improvements in the training being provided for staff but there was still more work to be done for the provider to be compliant with this regulation. The provider had reviewed the safeguarding training being provided to staff.They recognised the training was not in line with NHS England or the Intercollegiate Document for Healthcare Staff recommendations.
- The safeguarding training package had been updated to meet the intercollegiate guidelines. A delivery programme for the training had been planned to cover management, control staff and patient transport drivers. Projected completion for management and control staff was November 2017 and patient transport drivers April 2018.
- We spoke with four members of road staff who were able to demonstrate a good understanding of their responsibilities to report safeguarding concerns and had received some safeguarding training previously though not to the correct level.
- Control staff we spoke with during the follow up inspection still could not consistently describe how they would make a safeguarding referral and were not always aware of the situations when they would be required to do so. All staff told us they would contact their manager or area manager, for advice.
- A network of locally based designated safeguarding officers and champions had been identified to support staff within their locations. The organisational lead for safeguarding had oversight of this team.
- Senior managers had undertaken updated training in relation to Safeguarding adults and children in line with the Safeguarding children and young people: roles and competences for health care staff Intercollegiate DocumentMarch 2014 or the Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document (2016).
- Documentation showed the four safeguarding leads had undertaken level three safeguarding training, which is the requirement for this role under the national guidelines for safeguarding, specifically the Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document (2016) and Safeguarding children and young people: roles and competencies for healthcare staff – Intercollegiate document (2014).
- The leads were due to undertake train the trainer training for safeguarding within the next few weeks.
- At our March 2017 inspection we were not assured the safeguarding lead for the service had links with the local authority safeguarding teams. At this inspection, one of the safeguarding leads was in the process of initiating regular contact with the community social care leads, since our last inspection, the provider had commenced a quarterly safeguarding group meeting for the executive team. The meeting reviewed all reported safeguarding incidents, policies and procedures, training for staff and any other safeguarding issues that were appropriate.
- We found the provider had improved safeguarding reporting processes and oversight practice. The new safeguarding management system had made it easier for the provider to track trends in safeguarding incidents and monitor actions to ensure any learning was implemented.

Are patient transport services effective?

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

Patient transport services (PTS)

Are patient transport services caring?

- Although this was not an area covered by the focused inspection, during our inspection we saw staff had a good rapport with patients. They spoke with patients using everyday language rather than medical terminology and were polite and kind.
- The health care assistant provided fresh water for patients waiting for transport and assisted them as necessary.

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

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

Are patient transport services well-led?

Leadership of the service

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

Governance, risk management and quality measurement

- At our inspection in March 2017 we found the governance processes were ineffective. There was a lack of oversight of incidents and the learning from those incidents to prevent them happening again.
- At this inspection we found the governance framework had undergone a review and had been changed in order to strengthen the incident and safeguarding reporting and review systems for the senior management team.
- A compliance and quality steering group had been formed. This group planned to meet quarterly reporting directly to the senior leadership team. Further changes had taken place with the formation of an operational quality performance group. This group discussed the challenges locally to feed into the quarterly compliance and quality steering group.
- We saw minutes from the first two of these meetings which identified monthly discussion of incidents, safeguarding and complaints. Where actions had been identified they had been addressed. For example to ensure incidents were managed in a timely way when managers were on leave the group discussed and agreed an action to manage this.
- We saw two provider critical compliance reports which were produced monthly to identify all serious incidents, who they are reported to stakeholders for example, NHS commissioners, CQC etc. and all coroners' enquiries. These were produced to share information across the country at all locations
- The provider had also developed a quarterly incident and complaint summary.This provided assurance that the senior team were sighted on all of the current complaints and incidents. With more focus in relation to management of incidents, complaints and safeguarding the senior leadership team had greater oversight of the risks facing the service at patient level.
- Governance and quality notices were made available to staff at an operational level during our March 2017 inspection. However there was no evidence that staff were reading and understanding them. During this focussed inspection a signature sheet had been provided with each governance and quality notice for staff to sign. We saw the signature sheets at the base and were assured the operations manager had discussed these with staff. However, some staff had refused to sign the sheet as they remained unsure of the rationale from the senior leadership team.

Patient transport services (PTS)

- Additional training for all management staff from operational supervisors upwards had been undertaken. This was to ensure there was improved oversight of the incident management process.
- Incident review meetings took place in order to share progress and support managers to review and complete investigations.
- Since the March 2017 inspection, the provider have reported incidents to CQC as required by the Health and Social Care Act.
- To ensure all staff were aware of the new incident reporting line all staff had been given a key fob with the telephone number on. This had served as a reminder to staff when working remotely.
- The provider had developed an 'on the road pocket guide' for operational staff although this had not yet been distributed. This contained information for staff to remind them what to do in certain circumstances. For example assessing risk, preventing infection, and how to report safeguarding concerns.

Innovation, improvement and sustainability

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure safeguarding adults and children's level two training is delivered in a timely manner.
- The provider must ensure staff are consistent in their knowledge of how to recognise or report a safeguarding concern.
- The provider must ensure Information provided to assist in making the referrals is present and is current in all of the ambulance vehicles.
- The provider must ensure all staff have access to current policies stored on the web based portal.

Action the hospital SHOULD take to improve

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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