Thames Ambulance Service Limited

Thames Ambulance Service

Quality Report

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	
Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Thames Ambulance Service is operated by Thames Ambulance Service Limited. The service provides urgent care transport services and patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 22 November 2016, along with an unannounced visit to the location on 8 December 2016. We carried out additional unannounced inspections of this service at two local A&E departments on 2 December and 6 December 2016 and at the service's base in Milton Keynes on 9 December 2016.

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.

Where our findings, for example on management arrangements, apply to both urgent care and patient transport services, we do not repeat the information but cross-refer to the emergency and urgent care core service.

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 where the service needs to improve:

- There was a poor culture around reporting, investigating and learning from incidents and a lack of accountability for incidents. There was a lack of systems and processes to ensure lessons were learned and shared.
- There was a lack of oversight of and accountability for safeguarding concerns. Safeguarding referrals were not made appropriately to the local authority and the safeguarding lead was not investigating safeguarding concerns effectively.
- There were widespread issues with infection prevention, cleanliness and hygiene across urgent care transport vehicles including bodily fluids on equipment. These concerns had not been recognised by service managers and were not reflected in local infection prevention and control audits.
- There were widespread issues with equipment including out-of-date equipment and reusing of single-use items. Equipment was not standardised across vehicles; in particular there was a lack of paediatric equipment.
- Records management and documentation in patient records was poor. For example the records documented medicines being administered however, it was unclear who had signed off these medications. Thames Ambulance Service reviewed this with the commissioning trust and stated that these signatures were from the commissioning providers staff.
- There was a lack of systems or support to ensure staff were able to assess and respond to patient deterioration and risk, in particular in the case of children or patients experiencing a mental health crisis.
- Audits were not fit for purpose (in particular, the records audit, infection prevention audit and vehicle equipment compliance audit) as they were not highlighting areas of concern and actions for improvement.
- There was limited support and opportunity for staff to maintain and develop their competencies particularly in relation to First Person On Scene (Enhanced) qualifications. We were not assured driving competency checks, licence checks and blue light refresher training were consistent for maintaining competencies.
- There was no arrangement for staff to access translation services to communicate with patients whose first language was not English.
- There was nothing in place to ensure the specific needs of patients living with dementia or learning disabilities were met, such as pictorial communication cards.

Summary of findings

- There were no formal systems for sharing learning from complaints and concerns among all staff at the service to drive service improvement, and the service did not benchmark its complaints against other providers.
- The service's risk register was not reflective of all the potential risks faced by the service and was not kept up-to-date. There was no evidence of action to minimise risks within the service.
- Meetings were not consistently minuted and the minutes of team and governance meetings that were provided were not sufficiently detailed.
- There was a lack of accountability and responsibility, for example in relation to safeguarding, records management and incident reporting.

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

- Staffing levels and skill mix was appropriate to meet patient need in both core services and staff received sufficient breaks and time off between shifts.
- Staff were up-to-date with appraisals.
- Frontline staff in both core services displayed a patient-focused approach and ensured patients' privacy and dignity were maintained. This was reflected in positive feedback from patients about the care and treatment from frontline staff.
- Services were planned to meet the needs of local people.

Following this inspection, we told the provider that it must take some actions to comply with the regulations, to help the service improve.

We also issued enforcement action against the provider in respect of Regulation 17: Good Governance, Regulation 13 safeguarding and Regulation 5 requirements relating to registered managers.

Following this action, the provider voluntarily agreed to suspend the urgent care aspects of its service until such time as improvements could be made. We will continue to monitor the service and will carry out a further inspection in due course to ensure the necessary improvements are made to protect the health, welfare and safety of people using its service.

Ted Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		Overall we have not rated urgent and emergency care at Thames Ambulance Service because we were not committed to rating independent providers of ambulance services at the time of this inspection. Emergency and urgent care at Thames Ambulance Service was provided by two of the service's nine locations, we inspected the Canvey Island location as part of this inspection. There were no paramedics or technicians employed by Thames Ambulance Service as their contractual obligations to NHS emergency care providers was to provide purely back-up services. This meant that they would attend alongside emergency services and transport patients in an emergency capacity after paramedic attendance in a car or motorbike. It was possible for Thames staff to be first on scene to an adult or child emergency. Staff employed to fulfil the emergency contract were emergency care assistants and under the contracts with NHS ambulance providers were not authorised to administer medicines apart from Entonox and oxygen.
Patient transport services (PTS)		Overall we have not rated patient transport services (PTS) at Thames Ambulance Service because we were not committed to rating independent providers of ambulance services at the time of this inspection. PTS was provided from the service's bases in Milton Keynes, Lincolnshire, Gateshead, Grimsby, Scunthorpe, Sussex and Canvey Island. All of these bases were managed from the Canvey Island Head Office and this was where we undertook the bulk of our inspection. We did not inspect the other registered location for the service. in Ipswich, which also provided PTS services. This was because the service was registered as a separate location. The majority of Thames' PTS services were directly commissioned by Clinical Commissioning Groups, NHS

Summary of findings

trusts and independent health care providers. A small proportion of the service was private; providing transport direct to people who requested and paid for the service themselves.

At the time of our inspection there were 177 PTS vehicles in service and one bariatric ambulance.

Thames Ambulance Service

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS)

Detailed findings

Contents

Background to Thames Ambulance Service

Thames Ambulance Service was founded in 1996 and is part of the Thames Group, a nationwide provider of transport evolved around urgent care transport services and patient transport services and support to health and social care services across both public and private sectors. It is an independent ambulance service with its head office in Canvey Island, Essex, and further bases in Ipswich, Milton Keynes, Lincolnshire, Gateshead, Grimsby, Scunthorpe, and Sussex.

At the time of our inspection, Thames Ambulance Service had been accredited on five of the ten UK NHS ambulance trusts.

The Thames Group incorporates a dedicated training company, Thames Training and Development, which is accredited by awarding bodies such as the Institute of Health Care and Development (IHCD), Edexcel, and FutureQual.

The service's registered manager had been in post since September 2015. The service had last been inspected in November 2013, where it was found that the service was meeting required standards of quality and safety against which it was inspected.

We carried out the announced part of the inspection on 22 November 2016, along with an unannounced visit to the location on 8 December 2016. We carried out additional unannounced inspections of this service at two local A&E departments on 2 December and 6 December 2016 and at the service's base in Milton Keynes on 9 December 2016.

Our inspection team

The team that inspected the service comprised a CQC Head of Hospital Inspections, Inspection Manager, six CQC inspectors including two registered paramedics, a governance specialist and a specialist advisor with a background in patient transport services (PTS) and ambulance operational management.

How we carried out this inspection

We carried out the announced part of the inspection on 22 November 2016, along with an unannounced visit to

Detailed findings

the hospital on 8 December 2016. We carried out additional unannounced inspections of this service at two local A&E departments on 2 December and 6 December 2016 and at the service's base in Milton Keynes on 9 December 2016.

During the announced and unannounced inspections, we visited the Canvey Island head office, the Milton Keynes base and two local A&E departments. We spoke with staff including senior management, the registered manager, operations managers, emergency care assistants, ambulance care assistants, and administrative staff.

We inspected five urgent care vehicles and four PTS vehicles, including equipment within the vehicles, altogether across the announced and unannounced inspections. We also reviewed documents including staff files and policies and reviewed patient records.

Facts and data about Thames Ambulance Service

The service was registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

There were no paramedics or technicians employed by Thames Ambulance Service as their contractual obligations to NHS emergency care providers was to provide purely back-up services. This meant that they would attend alongside emergency services and transport patients in an emergency capacity after paramedic attendance in a car or motorbike. It was possible for Thames staff to be first on scene to an adult or child emergency.

Staff employed to fulfil the emergency contract were emergency care assistants and under the contracts with NHS ambulance providers were not authorised to administer medicines apart from Entonox and oxygen.

PTS services were provided from the service's bases in Milton Keynes, Lincolnshire, Gateshead, Grimsby, Scunthorpe, Sussex and Canvey Island. All of these bases were managed from the Canvey Island Head Office.

We did not inspect the other registered location for the service in Ipswich, which also provided PTS services. This was because the service was registered as a separate location and will be inspected at a later time.

The majority of Thames' PTS services were directly commissioned by Clinical Commissioning Groups, NHS trusts and independent health care providers. A small proportion of the service was private; providing transport direct to people who requested and paid for the service themselves.

At the time of our inspection there were 177 PTS vehicles in service and one bariatric ambulance.

There were 35 urgent care transport vehicles.

We could not be provided with data on the number of transports that the provider undertook in total as this was collected by type and commissioned service.

During the announced and unannounced inspections, we visited the Canvey Island head office, the Milton Keynes base and two local A&E departments. We spoke with staff including senior management, the registered manager, operations managers, emergency care assistants, ambulance care assistants, and administrative staff.

We inspected five urgent care transport vehicles and four PTS vehicles, including equipment within the vehicles, altogether across the announced and unannounced inspections. We also reviewed documents including staff files and policies and reviewed patient records.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Emergency and urgent care at Thames Ambulance Service was provided by two of the service's eight locations, Canvey Island and Ipswich.

There are 35 emergency vehicles at Canvey Island and five at Ipswich. There are 132 emergency staff employed at Canvey Island and 21 at Ipswich.

There were no paramedics or technicians employed by Thames Ambulance Service as their contractual obligations to NHS emergency care providers are to provide purely back-up services. Staff employed by the service are emergency care assistants and under the contracts with NHS ambulance providers are not authorised to administer medicines apart from Entonox and oxygen.

Summary of findings

Overall we have not rated urgent and emergency care at Thames Ambulance Service because we were not committed to rating independent providers of ambulance services at the time of this inspection.

- There was a poor culture around reporting, investigating and learning from incidents and a lack of accountability for incidents. Staff were not given the appropriate support and guidance to be able to report incidents consistently. There was a lack of systems and processes to ensure lessons were learned and shared.
- There was a lack of oversight of and accountability for safeguarding concerns. Safeguarding referrals were not made appropriately to the local authority; safeguarding training was not in line with national guidance; and the safeguarding lead was not investigating safeguarding concerns effectively.
- There were widespread issues with infection prevention, cleanliness and hygiene across emergency vehicles including bodily fluids on equipment. These concerns had not been recognised by service managers and were not reflected in local infection prevention and control audits.
- There were widespread issues with equipment including out-of-date equipment and reusing of single-use items. Equipment was not standardised across vehicles; in particular there was a lack of paediatric equipment.
- We had concerns around records management. Records we reviewed had documentation of

medicines administered and it was not clear who had signed these records. The records audit process was not fit for purpose and service managers were not aware of the issues around records management.

- There was a lack of systems or support to ensure staff were able to assess and respond to patient deterioration and risk.
- Audits were not fit for purpose (in particular, the records audit, infection prevention audit and vehicle equipment compliance audit) as they were not highlighting areas of concern and actions for improvement.
- There was limited support and opportunity for staff to maintain and develop their competencies particularly in relation to First Person On Scene (Enhanced) qualifications. We were not assured driving competency checks and licence checks were consistent for maintaining competencies.
- There was no arrangement for staff to access translation services to communicate with patients whose first language was not English.
- There was nothing in place to ensure the specific needs of patients living with dementia or learning disabilities were met, such as pictorial communication cards.
- There were no formal systems for sharing learning from complaints and concerns among all staff at the service to drive service improvement, and the service did not benchmark its complaints against other providers.
- The service's risk register was not reflective of all the potential risks faced by the service and was not kept up-to-date. There was no evidence of action to minimise risks within the service.
- Meetings were not consistently minuted and the minutes of team and governance meetings that were provided were not sufficiently detailed.
- There was a lack of accountability and responsibility, for example in relation to safeguarding, records management and incident reporting.

Are emergency and urgent care services safe?

Incidents

- All frontline staff we asked were able to explain their responsibilities for reporting an incident and confirmed that any incidents that occurred when providing emergency backup for a commissioning provider would go through the single point of contact for that provider. However, they did not show awareness of who was responsible for managing incidents once they had been reported and we were concerned they did not receive the appropriate support and guidance from managers on this.
- There was a poor culture around reporting, investigating and learning from incidents. We spoke with the registered manager who was responsible for managing incidents reported to the service and had concerns that they did not have awareness of incidents that were taking place and were not investigating them properly.
- We found that incidents were not being consistently and appropriately reported by the service's staff and were instead being reported to the service by the commissioning NHS ambulance service. We were therefore concerned that staff either did not understand the importance of reporting incidents or were unwilling to report incidents; and that there was under-reporting of incidents.
- There was no clear and appropriate investigation process for incidents. There was no standard documentation for the investigation of incidents; for example the registered manager told us about a recent incident where he had called the relevant members of staff in. However, this was not recorded so it was impossible to verify. This also meant there was no action plan or lessons shared among all staff to ensure similar incidents did not reoccur in the future.
- The service reported four serious incidents (SI) between January and October 2016, however because of the issues around incident reporting we were concerned about under-reporting of SIs. There was no clear action plan following these SIs. We did not see data for the previous year for comparison.
- Data submitted by the service showed there were three 'open' incidents on the service's reporting system. One of these was a staff behaviour incident which occurred

in August 2016 and was graded as a serious incident. Two were staff injuries, one of which was graded as a serious incident. However, because of the lack of adequate investigation and documentation around incidents we could not be assured incidents were being appropriately graded. There were 27 further incidents (although one had occurred in November 2014); however, incidents and complaints were recorded in the same document and there was no indication of whether they took place under urgent and emergency services or patient transport services (PTS). The lack of specific incident log heightened our concerns about the lack of oversight of the incident reporting and learning system.

- Staff were unable to give examples of learning from any recent incidents and we were concerned there was no clear procedure for debriefing staff after an incident and ensuring lessons were learned and shared to prevent similar incidents reoccurring in the future.
- We found there was a lack of ownership and accountability on the part of service managers for monitoring incidents and ensuring lessons were learned. For example, we asked the training lead who had responsibility for overseeing driver training, how many driving-related incidents there had been in the previous 12 months and they told us this was the responsibility of operations managers. This meant that training could not be changed in light of incidents.
- We asked the operations manager about their policy on speeding incidents and they confirmed that for blue light driving the limit was 20 miles per hour over the speed limit. We were told the driver could be taken to disciplinary meeting but they were not allowed to hold disciplinary meetings on the basis of data received through the fleet tracker alone.
- We asked about the joint investigation procedure when incidents occurred when carrying out activities under a commissioning provider. We were told that the service's input would depend on the situation but that the commissioning provider would lead the investigation.
- The local clinical commissioning group told us they had attended two of the service's meetings to discuss incidents. They were concerned that no differentiation was made between lower level internal incidents and serious incidents and therefore that the service was giving insufficient attention to serious incidents, which would require a greater amount of focus.
- There was a Serious Incident Review Panel, comprising the medical director, chief executive officer, clinical governance and compliance officer and an executive assistant. The purpose of this panel was to 'provide assurance…that key trends and themes arising from Serious Incidents and complaints are being identified and actions carried out, audited and monitored to completion, in order to ensure that the experience of patients…is improved", as set out in the panel's terms of reference. We saw minutes of the meeting on 27 July 2016, which included a summary of incidents and actions to be taken, such as contacting the relatives of the patient involved. However, there was no evidence of any systems for cascading this information to all frontline staff for learning from incidents.
- The duty of candour is a duty on health care providers to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. There was a duty of candour policy, which was up-to-date and included information for staff on, for example, grading of patient safety incidents and the responsibilities for all staff. However, we were concerned because the six members of frontline staff we asked could not clearly explain the duty and told us they had not been in a situation where they were required to use it.

Mandatory training

- Data submitted by the service prior to inspection showed that mandatory training rates were at 91% overall for the Canvey Island base. However there was no target compliance rate or timeframe specified for this data so we could not fully assess their performance in mandatory training.
- Mandatory training included both e-learning and face-to-face classroom training modules. Staff we spoke with said it was sometimes difficult to find the time to complete refresher training, although they were able to access e-learning training modules at home.
- The service employed one in-house driving assessor who was Institute of Health Care and Development (IHCD) qualified and also used bank staff to carry out driver training including blue light driving, as part of mandatory training.
- D2 (emergency response driving) training rates were 92% for the Canvey Island base and 100% for the Ipswich base. Although this was a high rate of training we were not assured driving competence was

consistently and properly refreshed owing to varying responses on this which we have reported on under the 'effective' domain. There was no target rate for comparison.

- We were concerned that staff were not being trained correctly or consistently in securing a patient on a stretcher using the harness according to manufacturer's recommendations. This training was included in manual handling training. We were told that the harness would go over the shoulders and lap. However, to secure and transport patients safely they should also be strapped in over the chest using a four-point harness where safe to do so.

Safeguarding

- We were not assured that staff were aware of the potential safeguarding situations they may face or received adequate support to deal with them. Three frontline staff were not able to tell us what level of safeguarding training they had completed, even though one of them confirmed they had just completed the refresher safeguarding training. However, they were able to give recent examples of where they had raised a safeguarding concern and what they did in the situation.
- Training compliance data showed that staff had not received children's level three safeguarding training. We also found that the safeguarding lead and named doctor had not received level four safeguarding children training as required by the Royal College of Paediatrics and Child Health's Intercollegiate Document issued in March 2014. This meant we could not be assured staff had appropriate training to enable them to act on safeguarding concerns relating to children and young people. The service had not carried out an assessment of the level of children's safeguarding training required. Although the service did not regularly transport children, we were told that they did on occasion, when no more suitable back up was available.
- We were concerned about the safeguarding escalation and referral arrangements in place at the service. This was because we were given conflicting explanations of how the internal referral process worked. For example, frontline staff told us that they would contact one of three people in the organisation to discuss their safeguarding concerns and report a safeguarding. However, this view was not shared by three senior members of staff who all said that concerns should be discussed with the service safeguarding lead before a referral was made. This was not in accordance with the service's own policy on safeguarding vulnerable adults which stated that 'any member of the Thames Group who may come into contact with vulnerable adults has a duty to share and, if necessary, report or refer concerns regarding suspected abuse or neglect to Social Care'. Nor was it in accordance with their policy on safeguarding children which stated that 'the task for Thames Group staff is to ensure that any suspicion or concern is passed to the appropriate agency, i.e. the police or the appropriate local authority'.
- The service's named safeguarding lead, who was responsible for ensuring all safeguarding referrals and investigations met statutory guidance, did not have oversight of safeguarding concerns taking place during work carried out by Thames staff. This meant we could not be assured that safeguarding investigations were undertaken appropriately or that there was an appropriate level of accountability for safeguarding concerns.
- The safeguarding lead told us that when a potential safeguarding concern was raised, the service would decide internally whether it should be referred to the local authority. We were therefore concerned that actions were not being taken appropriately and promptly and that there was a risk of concerns not being referred. The corporate governance group minutes from November 2016 confirmed that safeguarding concerns were only referred to social care agencies after internal investigations were complete.
- We were concerned that the importance of safeguarding was not highlighted to staff or managed by the safeguarding lead. There was a recent safeguarding incident involving a child with learning disabilities that took place in the presence of Thames Ambulance Service staff which had not been raised as a safeguarding by those staff. It had been raised by the relevant NHS trust. The safeguarding lead told us they had arranged a discussion in four days' time with the members of staff who had been present. This was not sufficient action to address the safeguarding concern.
- The service also did not have a named clinical lead for safeguarding at the time of the inspection, who had received training as recommended by the intercollegiate document.
- The service's Safeguarding Children and Young People policy, dated 2 November 2007 and signed as up to date on 31 October 2016 by the executive management team,

was out of date. It had not been updated to include statutory guidance; namely, Working together to safeguard children, issued by the Department of Education in 2015, or the training and competency requirements of staff as referenced in the Royal College of Paediatrics and Child Health's Intercollegiate Document issued in March 2014.

- We reviewed the service's Safeguarding Vulnerable Adults policy, dated 2 November 2007 and signed by the executive management team as up to date on 31 October 2016.This policy had been updated to reflect the most recent legislative requirements such as those in the Care Act 2014.
- We were not assured the service had adequate measures in place to ensure staff would be aware of potential situations where female genital mutilation (FGM) or domestic violence may be present. In one vehicle we saw an information leaflet on FGM but this was not present in the other vehicles we inspected. However, we asked five members of frontline staff and they showed awareness of FGM and domestic violence, although it was not covered in mandatory training.
- Safeguarding adults level two training was provided to staff and at the time of our inspection 93% of staff had received this training, although the training compliance data gave no target rate for comparison. The service confirmed this was the level required by the NHS commissioning ambulance provider, although there was no target compliance rate specified for comparison.
- The service had plans in place to provide level four safeguarding training to four managers within the next year so they could be safeguarding leads.

Cleanliness, infection control and hygiene

- In all of the five urgent care transport vehicles we inspected on our announced inspection there were issues with cleanliness, infection control and hygiene. For example, in two of the vehicles the mattresses on the trolley were torn with the foam inside exposed which could present an infection risk. The blood pressure cuff for adults inside one vehicle was visibly dirty.
- In one vehicle the cab area was unclean with crumbs and food in the side of the door and there was dirt and dust around the foot pedal used to release the stretcher. On one of the box splints, used for limb fracture immobilisation, the plastic was dirty and broken and another immobiliser in the same vehicle appeared to have bodily fluids on it.
- Appropriate decontamination wipes were seen on four of the vehicles we inspected; however, on one vehicle the wipes were open, dried out and unlabelled with no expiry date visible.
- In two of the vehicles there was no personal protective equipment (PPE) available. This meant in the event of a patient who posed a potential risk of infection, staff would not have the appropriate equipment to adequately prevent or control the possible spread of infection to other patients and themselves.
- In two of the vehicles there was no hand cleansing gel available which meant there was an increased risk of infection and cross-contamination.
- We raised the issues we had found in relation to infection control with a manager at the time of our inspection, who addressed them immediately, by taking those vehicles off the road. However when we returned for the unannounced inspection we found these issues had not been resolved; for example we found a cervical collar and immobilisation head blocks with dried blood on them within vehicles.
- Our concerns were heightened because the results of infection prevention and control (IPC) vehicle compliance audits were good; for example in July 2016 the Canvey Island base scored 93% and the Ipswich base scored 100%. The evidence we saw during our inspection was not represented in or consistent with the service's audit results, so we were concerned managers did not have awareness of the issues. Also these audit results were not split into PTS and urgent and emergency care so it could not be identified from the audits which areas were of concern.
- In all vehicles we inspected on the announced inspection, there was an unlabelled trigger spray bottle with pink fluid, which appeared to be disinfectant; however this should have been labelled and displayed an expiry date. It was not apparent whether the substance was hazardous. We were told that the disinfectant used by the service had recently changed.
- An operations manager was unable to give examples of infections that would require deep cleaning to prevent

contamination after treating a patient but told us they could refer to the infection prevention and control policy. This policy specified examples of where deep cleaning was required.

- We asked staff about the procedure after transporting and caring for a patient who posed a risk of infection. They told us that the 'make-ready' team would carry out a deep clean on the vehicles before they were used again. Staff also said that "some hospitals" allowed them to clean vehicles at the hospital between patients; however the service provided no formal evidence of this.
- Routine deep cleaning was carried out every six weeks and staff and managers said a deep clean would also be carried out after treating and transporting a patient who posed a risk of infection and that staff would also be required to clean and change their uniform in this event.
- The service carried out weekly hand hygiene audits by observing opportunities for handwashing and whether hand washing took place. The audit from May 2016 showed out of 38 handwashing opportunities observed at Basildon Hospital, there were 29 actual instances of hand washing. We were concerned that there were no actions identified in this audit to improve results to minimise the risk of infection, although we did see a reminder to staff in a monthly newsletter from July 2016 about good hand hygiene.
- The service's Occupational Health policy stated, "All staff are required to attend the local Occupational Health department to receive any new immunisations, updates or boosters in a timely manner when requested to do so by Occupational Health or Thames Ambulance Service". Further, "It is imperative that a full immunisation programme is maintained for each individual in order to protect the health of both employees and patients". Staff told us they had not had vaccination cover at induction and there was no evidence to demonstrate this had been followed up by the individual or management to ensure staff were protected. A reminder had been issued to staff about overdue vaccinations.

Environment and equipment

- There were 35 urgent care transport vehicles at the Canvey Island base and five at the service's Ipswich base.
- We inspected a random sample of five urgent care transport vehicles at the station and found safety issues with all of them. For example, in one vehicle the defibrillator had passed its recommended service date (expired June 2016), the two front grill lights were faulty, the fire extinguisher was out of date (expired July 2016) and the four-point shoulder and chest harness for transporting patients securely was missing. On another vehicle, two other fire extinguishers had also expired in July 2016 and we found a laryngeal airway mask, which had gone out of date in November 2014. A laryngeal mask is a medical device that protects a patient's airway during unconsciousness. The provider informed us that the date on the green sticker reflected the date serviced however staff using this equipment were unsure and therefore were not assured that they were using equipment that was fit for use.
- We were also concerned that single-use items were potentially being reused. For example, on the announced part of our inspection we found a single-use neck collar which had evidently been reused.
- We raised these issues relating to environment and equipment with a manager at the time of inspection, who took the relevant equipment and vehicles out of use immediately to address the concerns. When we returned for our unannounced inspection we found there were still issues in relation to this, such as a cervical collar which had evidently been reused and had bodily fluids on it. Therefore, there had been no action since the announced inspection to prevent this from happening.
- Equipment was not standardised across urgent care transport vehicles. For example they did not all have specialist paediatric masks and harnesses which were used to safely transport paediatric patients. This was a concern because frontline staff told us they "sometimes" transported children, so we were not assured children were being transported securely and safely. At the service's Milton Keynes location we found there were no paediatric defibrillator pads on vehicles, although paediatric harnesses were available. Staff at this base confirmed they did not regularly transport children but did on rare occasions. However, there was no data on how many children had been treated or transported by the service.
- The layout of the vehicles was not standardised and there were no labels on cupboards indicating where equipment should go. Staff confirmed this meant different staff members had different places for storing equipment, although they said they familiarised themselves with the vehicle at the start of each shift.

- Staff recognised equipment was not standardised across urgent care transport vehicles. We were concerned there was a lack of risk management and oversight of this by operational managers in the service. There was no indication that the service was working towards standardisation.
- Our concerns were heightened because an internal vehicle compliance audit for the Canvey Island base, completed in June 2016 showed 91% compliance. For the Ipswich base it was 100%. Managers relied on the results of these audits and these results did not match our findings on inspection, so we were concerned the service did not have sufficient awareness of the issues in relation to equipment in vehicles.
- We did not see evidence of any risk assessments for the vehicles to ensure they were appropriate and safe.
- There was a vehicle daily checklist document which crew members and two managers confirmed were completed each morning by the crews who were going to use the vehicles, to ensure they had sufficient equipment and supplies. Emergency operations staff confirmed that they were required to document any vehicle damage and hand in the completed sheet to control before leaving the base. However, the checklist did not indicate the exact numbers of each piece of equipment. There was only a column to tick 'yes', 'no' or 'N/A' and no indication of what would be applicable or not applicable. The checklist did not specify whether it was for urgent care transport vehicles, PTS vehicles, or both.
- On the unannounced inspection we found the same issues in relation to the lack of standardised equipment on vehicles. Although we saw a new more appropriate equipment checklist in place which included the numbers and sizes of all items required on each vehicle, there was no evidence this was consistently being adhered to across the fleet.
- We asked staff how they would deal with faulty equipment or vehicles. They said they would immediately tell the commissioning provider and their own operational managers. They would then either go straight to the mechanic or go back to the ambulance base to take the faulty equipment out of service and replace it.

Medicines

- The service did not keep their own medicines on vehicles or at stations. When a Thames Ambulance Service crew was providing emergency back up under their contractual arrangements they would use the medicines stored and transported by the commissioning provider from that provider's vehicle and crew. These arrangements were included in the service's Management of Medicines procedure.
- Under the contract with the regional commissioning NHS ambulance service, Thames Ambulance staff were not authorised to administer medicines even though some members of staff had First Person on Scene (FPOS) enhanced qualifications.
- We reviewed patient report forms (PRFs) from the previous four weeks and found several had documentation of medicines being administered. These included paracetamol, salbutamol, ipratropium bromide and oral morphine (oramorph). The registered manager told us that in these instances it would be the paramedic or technician from the commissioning provider administering the drugs. However, it was unclear who had signed off these medications. Thames Ambulance Service reviewed this with the commissioning trust and stated that these signatures were from the commissioning providers staff.
- We reviewed the service's 'Management of Controlled Drugs (CD) Standard Operating Procedure', which stated that drugs including morphine and diazepam "are to be carried in Thames' CD bags secured in the vehicle CD cabinet during an active shift". We had been expressly told by staff and managers that they did not use controlled drugs and we saw there were no CDs or CD bags on the vehicles we checked. The standard operating procedure (SOP) should therefore have been amended as it contained incorrect information. It had last been reviewed in February 2016 but had not been amended in line with service practice.
- The SOP also referred to the "Station's CD store". When we asked managers about this, we were told the controlled drugs store was now at the service's Milton Keynes base.
- We inspected the Milton Keynes location to assess medicines management but there were no medicines stored on site. There were only medical gases (Entonox and oxygen) which we saw were stored securely. We saw there was a CD cupboard but no CDs stored within and we were told there were plans to store medicines in the future depending on the acquisition of new contracts. We checked three vehicles at this location and found no medicines stored within.

Emergency and urgent care services

Records

- The service did not store patient report forms (PRFs) for emergency patients on vehicles. One copy of the PRF stayed with the patient and a carbon copy was brought back to the Canvey Island base for auditing before being sent to the commissioning ambulance provider.
- Staff told us that depending on the situation they would put information into patient records at the location or a receiving provider, or the staff from the commissioning ambulance provider would do this.
- We had concerns around records management. The registered manager who was responsible for storing and auditing did not have sufficient oversight of the process. For example, records we reviewed had documentation of medicines being used and these records were being signed off by Thames Ambulance Service staff. Records had evidence of more than one person writing on them and it was not always possible to ascertain whether the documentation and sign off had been done by a member of Thames Ambulance staff or staff from the NHS commissioning provider.
- When we asked the registered manager about this, he acknowledged that record keeping was an issue. However, there was no evidence of any actions being taken or of any communication with all staff for learning and improvement. This was not on the service's risk register.
- We raised this with the senior management who told us they had not been made aware of this issue. We were therefore concerned that the appropriate information was not being escalated to management.
- The records audit, which was completed by the registered manager, was not fit for purpose as it had not captured the issues we had found in relation to records management and we saw no evidence of any actions documented to improve records management.
- We were told that the copies of PRFs for auditing were held at the Canvey Island base for no longer than 14 days, however on our review of records on the unannounced inspection they dated back to 10 November (a backlog of four weeks). The registered manager told us this was because they had been away and busy with incident investigations.
- Staff we spoke with told us that they would be made aware of any pre-existing conditions or safety risks by the commissioning provider via the patient referral form and told us this was communicated effectively.
- Staff we spoke with told us they would only accept original forms for do not attempt cardiopulmonary resuscitation (DNACPR) and would refuse copies.

Assessing and responding to patient risk

- Staff confirmed they did not restrain patients themselves. In the event of a patient requiring restraint a qualified member of the NHS staff or an a police escort would do this.
- An operations manager was unable to explain clearly the process in relation to assessing and managing risks presented by a patient experiencing a mental health crisis. We were told it would depend on the particular contract under which staff were working. Staff confirmed they would usually rely on the staff from the commissioning provider or the police if necessary, to manage a patient experiencing a mental health crisis; however, we were concerned that front line staff were not given adequate support or training to help them respond to risk in this situation.
- We were concerned that there was nothing in place to ensure staff were able to assess and respond to specific risks presented by children due to the lack of specialist equipment and training for treating children in an emergency. An operations manager said this was not a concern because the NHS emergency provider was "good at not calling us for paediatrics". However they accepted there was "a risk" that Thames Ambulance Service staff could be the first person on scene, for example in a last resort situation where no other back up was available, and may not be able to safely respond to risk. The service could not provide data on how many paediatric cases they responded to.
- Staff told us they would receive specialist clinical advice if required on scene or in transit via the single point of contact at the commissioning provider.
- If additional resources were required staff would contact the commissioning provider in conjunction with staff from that service.
- In the event of a deteriorating patient staff would rely on the ambulance staff employed by the commissioning provider; however, we were concerned that staff were not adequately supported to respond to patient deterioration if they were the first person on scene. Staff told us they would manage the patient as best as they could, until staff from the NHS provider arrived.

- Staff confirmed they had not been trained in mental health conditions specifically and how to recognise patients with these conditions and respond appropriately to any potential risks they presented.

Staffing

- There were 135 staff at the Canvey Island base which was in line with planned staffing levels.
- No paramedics or emergency medical technicians were employed by the service as their remit under their emergency contract was to provide back up to the regional NHS ambulance service.
- Staff worked 12 hour shifts and shift patterns were four days on and four days off.
- We asked staff about receiving adequate time off between shifts, particularly if they had a long journey at the end of their shift, meaning it could run two or three hours over, and they then had to clean the vehicle as staff were required to do as standard at the end of a shift. All staff confirmed that they would let operations managers at both Thames Ambulance Service and the commissioning provider know that they had finished late and compensate for this by starting later than planned the following day. They told us they always received the required 11 hours rest time between shifts. If they finished late, they were able to leave a note saying they had not been able to clean the vehicle at the end of the shift and the crew using it on the following shift would clean the vehicle and check stock before starting.
- Staff felt that staffing levels were usually sufficient to meet demand, although there were occasions when demand was unexpectedly and suddenly high, which they said, could be challenging.
- On our unannounced inspections at local A&E departments, and from our evidence speaking to staff, the skill mix on urgent care transport vehicles was sufficient. Depending on the severity of the emergency call, there would either be two emergency care assistants (ECAs) with enhanced qualifications, or one enhanced ECA and one intermediate ECA (who would be the driver).
- The staff sickness rates submitted by the service were not sufficient to accurately assess staff sickness. For example, the data showed a total of over 1,000 days of staff sickness in Basildon with 161 maternity leave days and eight paternity days, but there was no indication of a timeframe for this so it was not possible to assess staff sickness as a proportion.

Anticipated resource and capacity risks

- Demand was variable as it depended on the need of the commissioning emergency care provider.
- We asked what would happen in the event of unexpected demand such as winter pressures, or low resources and staffing within the service. We were told that as the service did not have any bank or agency staff, they would just provide as much as they could. An operations manager said they would call staff to see if they could come in on overtime, although there was no policy or procedure formalising this.

Response to major incidents

- There was a major incident plan which was up-to-date and set out the responsibilities of the service and staff in the event of a major incident.
- We asked urgent and emergency operational staff about their awareness of what to do in a major incident. They told us that all vehicles would need to be made ready to go out and all fuel tanks would need to be at least half full.
- However, there had been no recent “trial runs” of major incidents. Staff we spoke with said there had been recent training but it did not include a trial major incident scenario.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Evidence-based care and treatment

- Local policies and procedures were not consistently kept up-to-date. For example the controlled drugs standard operating procedure (SOP) had not been amended to include the most relevant information for the service, as it included information about controlled drugs storage which was no longer applicable.
- The service completed several audits internally, including handwashing audits, vehicle audits and

station audits. However, we were not assured that the results of these audits were reflective of the service or that actions were taken following audits. This has been explained in the safe section of the report.
- Performance monitoring under their emergency contracts was the responsibility of the commissioning provider.

Assessment and planning of care

- Thames emergency crews worked 12-hour shifts and were deployed at the start of their shift to the Bedfordshire and Hertfordshire area under the control of the regional NHS ambulance service to await back-up calls.
- Decisions not to convey the patient to hospital ('see and treat') and decisions to ensure patients are admitted to the most appropriate hospital (such as specialist units) for treatment would be managed by the commissioning NHS ambulance provider.
- Staff confirmed they would on occasion transport a patient without a paramedic or technician from the commissioning ambulance provider accompanying them, as long as the paramedic had first assessed the patient to be sufficiently stable. However owing to the issues in relation to records there was no clear evidence documenting when patients had been transported without a paramedic.
- Enhanced clinical advice and support was made available to crews via the single point of contact at the regional NHS ambulance service.
- Patients who had suffered a stroke or heart attack would be assessed and managed by staff from the NHS emergency service. However, staff told us that in the event that they were the first person on scene before paramedics arrived, they would manage the patient as best as they could (without medicines) in the meantime, although they said this was unlikely.

Response times and patient outcomes

- The operations manager could not tell us how they were currently performing against targets. There was a duty manager who had responsibility for monitoring response times against targets; they told us there had only been two monthly reports under this contract so far. We saw a document to assess compliance against the key performance indicators under the contract with the local NHS ambulance service for November 2016 but it did not indicate response times and only monitored cancellations. This data showed that, of 300 shifts booked under the emergency contract in November 2016, 132 were cancelled due to 'sickness' (seven shifts) 'unable to resource' (65 shifts) and 'other' (60 shifts).
- We spoke with the clinical governance and compliance officer who was responsible for monitoring the service's clinical key performance indicators (KPIs) under their contract with the NHS ambulance service. These KPIs included vehicle cleanliness, equipment cleanliness and number of incidents reported to the NHS service via DATIX (the reporting system). They told us they submitted this data monthly to the NHS ambulance provider. However they did not monitor or measure response times for emergency calls under the contract.
- The commissioning NHS emergency provider was responsible for monitoring crew response times as they called on the service when backup was required.
- Ensuring timely access to the appropriate acute facilities for cardiac patients would be led by the commissioning NHS provider with the service providing back up only.

Competent staff

- Four out of the five frontline staff we spoke with at the Canvey Island base confirmed they had had a recent appraisal. The fifth said they were overdue one but that this was because they had recently been off work for several weeks and they were aware their manager was arranging this. There was no target appraisal rate set against which the service could monitor compliance.
- An operations manager told us the service had recently introduced a new appraisals system so there had been delays in completing appraisals. Data submitted by the service prior to inspection showed that 57% of emergency support workers and 80% of emergency care assistants were up-to-date with appraisals, although this had improved by the time of our inspection.
- Two frontline staff told us there was limited opportunity for continual training to develop their competences.
- Bariatric-equipped ambulances were staffed only by bariatric trained staff, of which there were 10 at the Canvey Island base.
- We were concerned that staff who had a First Person on Scene (Enhanced) qualification (FPOS enhanced) were not able to maintain their skills and competencies. FPOS enhanced staff are qualified to provide emergency medication including adrenaline and Entonox (nitrous oxide and oxygen for pain relief). However, under the service level agreement (SLA)with commissioning NHS

providers, these staff were only contracted to work in a capacity of emergency care support worker (ECSW) which meant they would not be able to administer these medicines. There were 52 FPOS enhanced staff employed across the service.

- We also raised this with the clinical governance officer who confirmed that staff could not maintain their FPOS competencies in practice. They told us this qualification was refreshed on a three-yearly basis.
- We were concerned that maintenance and 'make-ready' staff were often required to restock vehicles with gas cylinders but had not received training in handling medical gases.
- The operations manager told us driving assessments were carried out yearly; however this did not match what we had been told by staff. Three frontline staff said blue light driver training was refreshed every two years. One other staff member we spoke with reported it was refreshed every three to five years. We were therefore concerned about the lack of consistency in and awareness of ensuring blue light competency was maintained.
- All other mandatory training for staff was refreshed yearly, as confirmed by the training lead.
- There were no arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. Staff told us that if they had a concern about the standard of a crew member's driving they would inform managers.
- Disclosure and barring service (DBS) checks for staff were refreshed every three years in accordance with national requirements and staff confirmed this.
- The service used a dedicated training company, Thames Training and Development, to provide their staff training. This was accredited by awarding bodies such as the Institute of Health Care and Development (IHCD), Edexcel, and FutureQual. Blue light training was a three-week course run by the IHCD.
- Driver licence checks were carried out every six months according to the Safer Recruitment Policy. The staff we spoke to confirmed this and knew it was their responsibility to inform the service managers of any changes to their licence status. We were told by an operations manager that the service would cease employment of a staff member if they had more than six points on their licence; however data on staff driving license showed that one member of staff had nine points on their license and was still employed by the service (although they were not carrying out driving responsibilities).
- We asked four frontline staff about driving licence checks and three told us that they were carried out yearly. They also said the service would suspend driving responsibilities for that staff member in the first instance which did not match what we had been told by a manager. Although the checks were run automatically, we were concerned that frontline staff were not kept informed of the checking process or that local practice did not match what was stated in the policy.
- The service did not require drivers to pass an eyesight test to commence employment, although it was required for those drivers undertaking advanced driver training.
- The Safer Recruitment Policy stated that staff were responsible for maintaining their own registration; there was no evidence of any support for staff from the service in this.

Coordination with other providers

- Emergency staff reported they had good links with commissioning providers for whom they were providing back up. For example, if they required additional bariatric equipment the provider would ensure this was delivered immediately.
- Staff escalated any issues to the single point of contact at the NHS ambulance provider and reported that this worked well.
- The service reported that one of its challenges was coordination with NHS commissioners due to "long procedures". They said this was included as an agenda item within contract review meetings to improve coordination through "open dialogue". However, we did not see evidence of any further action from the service to work towards better coordination.
- Coordination with other services and agencies such as fire and rescue or the police would be led by the commissioning emergency provider. However, staff we spoke with gave an example of where they had stopped during a non-emergency transfer to help at an accident. Staff had supported the patient at the scene alongside the fire and rescue service.

- As part of our unannounced inspection we observed three handovers involving Thames staff at a local A&E department. We saw these were carried out appropriately with the patient handover card completed including the times of pick up and transfer.

Multi-disciplinary working

- Externally, urgent and emergency staff consistently reported good working relationships with ambulance crews including paramedics from commissioning providers and hospital staff at receiving A&E departments.

Access to information

- Six frontline staff we spoke with told us they were able to access all the information they needed to care for a patient. They said any pre-existing conditions or potential risks were always flagged by the commissioning provider.
- However, we were told of an incident where a patient who later died at a receiving hospital had not been flagged as a patient living with dementia. This was a concern as it meant staff may not have always been receiving all relevant information to treat a patient effectively. The manager said this was then raised as an issue at meetings with local clinical commissioning groups (CCGs) to try and improve information sharing but we could not ascertain that there was any further action taken. This was not included on the service's risk register
- Operational staff told us that poor communication from senior managers meant they did not always have access to all the information they needed to carry out their role effectively. One staff member gave a recent example of where they had been treating a patient a long distance away and kept having to chase up managers by phone to receive the information they needed on the patient. Staff said they often had to phone the operations base several times to chase them up for support and information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked six frontline staff members about obtaining a patient's consent to care and treatment. They were clear on this procedure. One member of staff told us they did not use restraint but all patients were asked whether they were happy to be transported before the transfer took place.
- We did not see any written signatures on the forms we saw during our unannounced inspection at a receiving A&E department. When we asked staff about this, they said they did not complete Mental Capacity Act (MCA) forms as this was the responsibility of the NHS ambulance provider.
- Staff confirmed that if they were in doubt as to a patient's capacity to make decisions about their care and treatment they would request a mental capacity assessor from the commissioning provider as they did not have competence to do this themselves.
- The service conducted monthly audits on documenting patients' capacity from patient report forms (PRFs) on emergency backup calls with the regional NHS ambulance provider. The audit from May 2016 showed that, out of 150 PRFs, there was documentation of a capacity assessment in 147. However, it was not clear whether these capacity assessments would have been completed by staff from the commissioning NHS provider or by Thames Ambulance Service staff.

Are emergency and urgent care services caring?

Compassionate care

- The service conducted a patient satisfaction survey in February 2016, which consisted of 90 responses, although it was not clear whether responses related to the emergency side of the service or the patient transport service (PTS) side. Feedback about staff was positive, with comments such as "The ambulance staff were so friendly and lovely with my very elderly mum". However, there was a negative theme about lack of communication to patients when staff were delayed.
- All responses to the question 'Is your dignity and privacy respected' scored either four or five on a scale of one to five on the patient survey in February 2016.
- When we carried out an unannounced inspection of the service at a local A&E department we saw staff using blankets to ensure patients were covered and comfortable when being moved from the vehicle.

- When speaking with operational staff, we found they had a patient-focused approach and were committed to providing the best care possible for their patients.
- We asked staff how they would deal with a deteriorating patient in the presence of a family member or carer. They told us they had not experienced this situation but would continue to speak with both the patient and the family or carer to help keep them calm.

Understanding and involvement of patients and those close to them

- We did not have the opportunity to observe staff treating or transporting patients in an emergency capacity so were unable to fully assess how they involved patients and families in their own care. However, frontline staff clearly displayed a patient-focused approach in carrying out their roles and were able to give examples of times when they had involved patients and their families or carers in discussions about their care and treatment.

Emotional support

- We asked three emergency frontline staff what they would do to support family or carers in the event of a patient death during transport or treatment. None of them had experienced this; however they explained they would keep talking to the family or carers and support them as best they could and showed an empathetic and supportive approach.
- One member of staff gave an example of where an elderly patient had passed away on arrival at their home. They told us they stayed with the relatives until a GP arrived to certify the patient's death and kept them as calm as possible by talking to them.

Supporting people to manage their own health

- Under the emergency contract, Thames Ambulance Service's remit was to provide back up so the NHS commissioning provider would take the lead in any identifying of frequent patients and supporting them to access other services if required. We did not see any evidence that the service had any input into this.

Are emergency and urgent care services responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The urgent and emergency service was delivered under the contract with the regional NHS ambulance provider. At the start of each shift crews from the Canvey Island base were dispatched to the Bedfordshire/Hertfordshire area to await and respond to back up calls from the provider. Crews would return to their base at the end of the shift.
- The service worked with the local clinical commissioning group (CCG), who confirmed that the service had listened to and acted on guidance from the CCG to improve service delivery.

Meeting people's individual needs

- Staff gave examples of where they had responded quickly and appropriately to meet people's individual needs. For example, they told us about a bariatric patient who had fallen on an escalator causing injury. Thames Ambulance Service staff had contacted the commissioning provider for additional bariatric equipment in order to safely and quickly move the patient into the ambulance.
- There was no arrangement for staff to access translation services. Staff told us this had not caused a problem for them as they had always been able to rely on a family member or carer to translate if necessary. However we were concerned that this was not a sufficient arrangement to ensure staff were able to meet the needs of a patient whose first language was not English. We were also concerned that operational leads had not considered translation services may be required.
- There was nothing in place to ensure the specific needs of patients living with dementia or learning disabilities were met, such as pictorial communication cards.
- If a patient posed a risk of violence or aggression staff would ask for a police escort and escalate to the single point of contact at the NHS ambulance provider as they could not restrain patients themselves.

Access and flow

Emergency and urgent care services

- Patients accessed the service via the NHS commissioning ambulance service who would call on Thames Ambulance Service crews as required for emergency back-up.
- The results of a patient survey, dated February 2016 showed concerns over responsiveness. 22 out of the 90 responses submitted raised issues about waiting times, delays, and a lack of communication from the service to let patients know when they were running late. However, it was not possible to identify which of these related specifically to urgent and emergency calls as the feedback was not separate from the patient transport services provided by the service.
- However, the service had not submitted response performance data for weeks 36 to 40 because of a lack of information so we were unable to fully assess recent information in relation to access and flow. We were told this data was therefore not representative of their actual performance. The operations manager told us this was because of a recent technical issue and acknowledged there were problems with monitoring the data in this way.

Learning from complaints and concerns

- There were no formal systems or procedures in place for sharing learning from complaints and concerns among all staff at the service. We were therefore concerned that actions would not be taken to improve staff competence and the quality of the service for patients. The service had not set a target response time for addressing complaints.
- Between January 2016 and October 2016 there had been 68 formal complaints recorded. Of these, 52 were recorded as non-clinical and 16 recorded as clinical. In April 2016 there had been five complaints categorised as patient safety complaints; however there were no further details about these complaints in the document we were shown.
- Complaints and incidents were logged in the same document so we were not assured they were being dealt with appropriately. In the document, we saw there was no evidence of actions taken or lessons learned as a result of complaints.
- The service did not benchmark its complaints against other local or national providers so we were not assured that they were continuously self-monitoring their performance and assessing how they could improve from any complaints or concerns raised.
- Any complaints in relation to subcontracted services from the NHS ambulance service would be led and dealt with by the commissioning provider. Staff told us they may be asked by that provider for statements to assist with complaints in the case of joint responsibility.

Are emergency and urgent care services well-led?

Leadership / culture of service related to this core service

- We have reported our main findings on leadership and culture for the service under the patient transport section of this report.
- We received a mixed view from staff about the approachability and support received from managers. All six frontline staff we spoke with told us managers were visible. They said they felt comfortable raising any concerns to managers, although three of these staff also told us there were “certain managers” who were less approachable.
- All staff we spoke with at the Canvey Island base told us there was a positive team-based culture and that they enjoyed their work and in particular, working with the other crew members. One frontline staff member said ‘this is a good team’ and described the culture as ‘open’; another said the team was ‘like family’.
- However, the evidence gathered during our inspection demonstrated that there was a closed culture within the service. The culture was not centred on the needs and experiences of people using the service and there was a lack of openness and transparency from leadership level.
- Staff were not routinely informed of outcomes of incidents or investigations and there was a lack of emphasis on learning and organisational improvement. This was demonstrated in the services inability to evidence change through complaints, incidents or adverse events. Concerns were also raised to us by stakeholders that they believed there was not a positive culture regarding incidents and learning.
- We were concerned that staff were not fully involved in the decisions taken by managers and the activity of the service. For example, three frontline staff we spoke with told us they did not receive a formal debrief or explanation about why the contract with a regional NHS ambulance service had been temporarily suspended

and managers had just told them they would not be providing backup work for the provider for the foreseeable future. Staff added that this resulted in rumours being circulated within the service and caused uncertainty among staff. The provider stated that a newsletter had been provided to staff.

Vision and strategy for this this core service

- There was no clear vision and strategy for the service. There were plans to open more bases to grow the service but there was no evidence that managers had considered the potential risks associated with this.

Governance, risk management and quality measurement

- We have reported on Governance, risk management and quality measurements under the Patient Transport section of this report. Please see this section for our findings.
- We discussed our immediate concerns with the provider. The provider voluntarily agreed to suspend the regulated activities of treatment of disease, disorder or injury; and diagnostic and screening procedures and suspension of undertaking emergency work until further notice. The commissioning NHS ambulance service who contracts the service also issued a suspension of contract notice to ensure that improvements were made before the service could resume.
- The risk register was not kept up-to-date and did not include many of the risks we identified during the inspection. For example, it included an entry of 'Staff on Basildon contract not signed off competent to give Atropine'. The register stated that training had been arranged. As staff were not authorised to give atropine it was not clear why this would be a risk for the service or why there would be training in it.

Public and staff engagement

- All frontline staff we spoke to felt engaged with the work they carried out. For example, one said "I really enjoy the work; I can't get enough of it".
- However, we were concerned service managers were not committed to engaging staff in the activity and direction of the service. There were staff meetings and a monthly newsletter, but no further means of engaging and motivating staff. Staff told us there "used to be" an employee of the month scheme to recognise achievement and work but this was no longer in place.
- In a monthly newsletter from July 2016 staff had been recognised for 'outstanding achievement'; however in more recent newsletters there was no similar recognition.
- We were unable to fully assess staff engagement and participation in meetings as these were not minuted. There was no evidence of regular meetings to engage all staff, update them on any developments and share any learning.
- The service did not have any formal methods in place for engaging with the public to consider ways they might be able to develop and improve the service.
- The local clinical commissioning group (CCG) raised concerns with us that the patient experience survey undertaken by the service was not frequent or detailed enough, with a lack of focus on themes and trends and there was not sufficient evidence of feedback being used to develop the service further. They did not give any further information about whether there were any actions to improve this.

Innovation, improvement and sustainability

- We asked an operations manager about any areas of development or improvement they were proud of but they could not tell us any specific examples.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

PTS was provided from the service's bases in Milton Keynes, Lincolnshire, Gateshead, Grimsby, Scunthorpe, Sussex and Canvey Island. All of these bases were managed from the Canvey Island Head Office and this was where we undertook the bulk of our inspection. We did not inspect the other registered location for the service.

Summary of findings

Overall we have not rated patient transport services (PTS) at Thames Ambulance Service because we were not committed to rating independent providers of ambulance services at the time of this inspection.

- There was a poor culture around reporting, investigating and learning from incidents and a lack of accountability for incidents. Staff were not given the appropriate support and guidance to be able to report incidents consistently. There was a lack of systems and processes to ensure lessons were learned and shared.
- There was a lack of oversight of and accountability for safeguarding concerns. Safeguarding referrals were not made appropriately to the local authority; safeguarding training was not in line with national guidance; and the safeguarding lead was not investigating safeguarding concerns effectively.
- There were issues with cleanliness and hygiene in PTS vehicles. These concerns had not been recognised by service managers and were not reflected in local infection prevention and control audits.
- Oxygen cylinders were not secured in ambulances. They were left loose in overhead cupboards posing a risk of falling on to people below.
- There was a lack of systems or support to ensure staff were able to assess and respond to patient deterioration and risk.

Patient transport services (PTS)

- Audits were not fit for purpose (in particular, the records audit, infection prevention audit and vehicle equipment compliance audit) as they were not highlighting areas of concern and actions for improvement.
- There was no arrangement for staff to access translation services to communicate with patients whose first language was not English.
- There was nothing in place to ensure the specific needs of patients living with dementia or learning disabilities were met, such as pictorial communication cards.
- There were no formal systems for sharing learning from complaints and concerns among all staff at the service to drive service improvement, and the service did not benchmark its complaints against other providers.
- The service's risk register was not reflective of all the potential risks faced by the service and was not kept up-to-date. There was no evidence of action to minimise risks within the service.
- Meetings were not consistently minuted and the minutes of team and governance meetings that were provided were not sufficiently detailed.
- There was a lack of accountability and responsibility from management.

Are patient transport services safe?

Incidents

- We spoke with nine members of staff, four of whom told us that they were aware of the processes in which to report incidents which was via an incident report form. The other five members of staff were inconsistent in their responses stating they either would not know what to do or would report directly to a manager. Staff we spoke with were also unclear on which situations would lead to an incident report being completed. For example, a patient fall or accident with equipment.
- This meant we were not confident that all staff understood their responsibilities in reporting an incident. This was confirmed on our review of incidents from the service. On three occasions we found that serious incidents had not been reported internally and these incidents had been notified to the service via a third party sometime after their occurrence.
- It was also confirmed by the services Registered Manager that incidents were identified when patients complained about the service. We reviewed a sample of these complaints and it was evident the compliant amounted to an incident; however no such incident had been reported at the time of its occurrence.
- We reviewed the services incident log and found that there was no differentiation being made between serious incidents, incidents, near misses, complaints or safeguarding concerns. This meant the service was unable to assess or analyse its incidents to identify themes and trends or areas of improvement. CQC fed these concerns back to management at the time of inspection. We noted at our unannounced inspection, two weeks later, work had begun to separate the report.
- We were also concerned about the services ability to properly investigate incidents. This was because on two occasions we found that despite being made aware of incidents, investigations had not been completed. On a third occasion we found that whilst an investigation had been started, key information gathering had not been completed at the time of our inspection for an incident which occurred in August 2016.
- We spoke to four members of staff who could not tell us what duty of candour meant. The duty of candour is a regulatory duty that relates to openness and

transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Staff told us that they received information on learning from incidents via memos which were delivered to their work pigeon holes. We asked to be provided with such memos and were provided with two from August 2016. These memos however did not relate to learning from incidents, therefore we cannot be confident learning or improvement occurred.
- In addition, five out of six members of staff we spoke with could not provide detail on any learning or change in practice which had been implemented following an incident.

Cleanliness, infection control and hygiene

- We were not confident in the services infection control processes because out of four ambulances (that were due to go out on shift) we saw that two of these (50%) were unclean. On one ambulance we saw discarded sweet wrappers and food on the floors and on another there was a significant amount of dirt and dust.
- We also found that on three out of the four ambulances we inspected personal protective equipment, for example gloves and aprons, were either not available or were seen to be stored inappropriately which meant they had become dirty.
- We reviewed infection control audits and noted that vehicle cleanliness in August 2016 for the Canvey Island base scored 96%, September 2016 scored 85% and in October 100%. Data for other bases was not made available to us.
- However, we were not confident in the services data due to our findings of dirty ambulances on the day of our inspection.
- Four out of five members of staff reported to us that they would not always be made aware of specific infection risks either on their job sheets or by hospital staff when they collected patients. These issues were not being report to management in a formal way and the hospitals had not been contacted to engage in improvements in information sharing.
- The services cleaning requirements were that ambulances were cleaned at the end of each shift. Staff were given 15 minutes in which to achieve this and we observed this cleaning taking place throughout our inspection. We were not however confident that this was a sufficient amount of time for appropriate cleaning to take place as 50% of ambulances we checked were unclean.
- There was a deep clean schedule and records confirmed all ambulances were deep cleaned on a monthly basis or as needed when contamination had occurred.
- We spoke with seven members of staff who all told us that it was their own responsibility to maintain their uniforms. However, if a uniform was to become seriously contaminated then these would be discarded through infectious waste and replaced.

Environment and equipment

- Staff completed a vehicle check at the beginning of each shift, using a daily vehicle inspection check list. This included electrical (e.g. lights / radio), non-electrical (including patient safety equipment / chair restraints), and medical (oxygen / first aid box). We reviewed the check list for two vehicles and noted they were completed to state that all equipment was in place.
- However, our own checks of the equipment on four vehicles demonstrated that, whilst the equipment was present, some of it was found to be out of date. This included consumable items such as sterile packed bandages, gloves, aprons and cleaning products. This was brought to the attention of management at the time of our inspection.
- Vehicles were fitted with a winch for use when assisting patients in wheelchairs onto a vehicle.
- There was a variety of equipment on the PTS vehicles that ensured the safety of patients. This included carry chairs, slide sheets, PAT slides, standard safety belts, strapping to attach wheelchairs to the vehicle floor and padded uprights to ensure wheelchairs were secure during the journey. These were observed to be in good working order; however, on a number of occasions we noted the equipment was dirty.

Medicines

- The four PTS ambulances we inspected only carried oxygen there was no other medication routinely carried.
- Oxygen cylinders we saw were unsecured. For example, on three ambulances we noted that oxygen cylinders were placed unsecured in overhead storage cupboards and on another occasion a cylinder was not secured in its holder appropriately, it was left loose and the holder was ill-fitting. This meant there was a risk that cylinders

could have become detached or fallen from height causing injury to staff or people on the ambulances. We found reference to one incident on the services incident log that an injury had already been caused to a member of staff by a loose oxygen cylinder.

- We looked at 10 oxygen cylinders and the majority of these were in date. However, on one occasion we found that an ambulance was carrying an oxygen cylinder which required replacement in January 2016. All cylinders we inspected were full.
- Outside of ambulance vehicles we saw that oxygen cylinders were stored in a secure shelter. Full and empty cylinders were stored separately and whilst oxygen and Entonox were stored together, these were clearly labelled.
- The service did not store or utilise controlled drugs although it had a license to do so. The services controlled drug licence was for the Milton Keynes base. We therefore undertook an unannounced inspection to this base and found no drugs were stored. However, we were told that the service was looking to expand its provision of services and the use of controlled drugs may be utilised at a later date. The provider should however note that the controlled drug license holder no longer worked for the organisation.

Records

- PTS drivers had printed work sheets at the start of a shift. This included collection times, address and patient specific information such as relevant medical conditions, mobility, oxygen therapy and escort if applicable.
- Records were kept securely on ambulances. Staff reported they kept records in sealed envelopes so as to protect people's confidentiality and ensured these records were locked in the cab when away from the ambulance.

Safeguarding

- We were concerned about the safeguarding arrangements in place at the service. This was because we were given many conflicting examples of the how the internal referral process worked. For example, staff working on the ambulances told us that they would contact one of three people in the organisation to discuss their safeguarding concerns and report a safeguarding. However, this view was not shared by three senior members of staff who all said that concerns should be discussed with the services safeguarding lead before a referral was made. This view matched the guidance provided in the services safeguarding referral standard operating procedure dated 31/10/2016.
- In addition, we found that the services named safeguarding lead, who was responsible for ensuring all safeguarding referrals and investigations met statutory guidance, was not involved in all safeguarding investigations being undertaken by the service. This meant we could not be assured that safeguarding investigations were undertaken appropriately with the correct expertise and advice having been sought.
- There was reference in clinical governance meeting minutes dated 16 November 2016 that safeguarding concerns were being reported and investigated internally without being referred to the local authority. The local authority is required by statutory legislation to investigate such concerns. There were three internal safeguarding concerns that we were made aware of. We contacted the local authorities in the areas to which they related and were informed that none of these concerns had been reported as required.
- We reviewed the job description for the Clinical Trainer and Business Manager post, the post which we were informed was the services named safeguarding lead and found no reference to any safeguarding responsibility being required within this post. We were therefore concerned that the person undertaking this role did not possess the right qualifications or experience.
- When we reviewed training compliance we noted that staff had not been provided with children's level three safeguarding where this was applicable. We also found that the safeguarding lead and named doctor had not received level 4 safeguarding children training as required by the intercollegiate document. This meant we could not be assured staff were supported with appropriate training to enable them to act on safeguarding concerns relating to children and young people.
- However, the safeguarding lead told us that a recent risk assessment had been carried out and was reported to the clinical governance committee. We requested to see this risk assessment and saw that it was completed in November 2016. Whilst there was reference to level 3 training being required by staff, there was no reference to the requirement of level 4 manager training being required. In addition, this risk assessment could not have been reviewed by the clinical governance

committee because a meeting had not taken place in the timeframe since the risk assessment was completed and our inspection. This meant senior leaders of the organisation had not been made aware of their responsibilities in relation to safeguarding children.

- Furthermore, we reviewed the services Safeguarding Children and Young People policy dated 02 November 2007, and signed as up to date on 31 October 2016 by the services Executive Management Team, and found this to be out of date. It had not been updated to include statutory guidance, namely Working together to safeguard children issued by the Department of Education in 2015 or the training and competency requirements of staff as referenced in the Royal College of Paediatrics and Child Health's Intercollegiate Document issued in March 2014.
- Child protection training had however been provided and 94% of staff were up to date with this training.
- We also reviewed the services safeguarding vulnerable adult's policy dated 02 November 2007 and signed by the Executive Management Team as up to date on 31 October 2016. This policy had been updated to reflect the most recent legislative requirements such as those in the Care Act 2014.
- Safeguarding adults training was provided to staff and at the time of our inspection 93% of staff had received this training.

Mandatory training

- There was, in general, good compliance with mandatory training across the service. The services target for mandatory training was 85%.
- Mandatory training included health and safety (89% compliance), manual handling (93% compliance), data protection (93% compliance), equality and diversity (95% compliance and, AED and oxygen (89% compliance).
- Basic life support training was also provided and 90% of staff were up to date with this training and 88% of staff were up to date with intermediate life support training.
- Staff that drove ambulance vehicles were provided with enhanced driver training and at the time of our inspection 92% of staff had received this training.
- The lowest compliance score was in bariatric manual handling training where only 75% of staff had completed this training. We could not be provided with information which demonstrated how the skills of staff were matched to the work they undertook. This meant we could not be assured all staff who transported bariatric patients had received the appropriate training.

Assessing and responding to patient risk

- There was no policy or guidance in place to guide staff about what to do in the event a patient deteriorated during their transport.
- We spoke to nine members of staff about the process to follow should a patient become unwell during their transport. We received a mixed response, five members of staff stated that they would call 999 for emergency back-up and four provided different responses which included calling a clinical advice line or stating they would transport the patient direct to A&E.
- When asked, senior management stated the process in the event of patient deterioration should be that 999 is called. This meant that a significant proportion of the staff we spoke with were unaware of their responsibilities to call for immediate emergency back-up.
- We were made aware of an incident where a patient was found to be deteriorating during their transport journey; however, the PTS crews did not call for emergency support and transported this patient direct to A&E with no emergency alert. This patient later died. An internal investigation in relation to this incident had not been completed at the time of our inspection despite almost three months having passed since the incident occurring.
- The lack of formal procedure, and inconsistency in staff knowledge and understanding of action to take in the event of a patient becoming seriously unwell meant that patients were at risk of not receiving appropriate care and treatment when they needed it.

Staffing

- Staffing levels generally met planned levels. The service had access to bank support. We were told by a senior manager that if a member of staff was to be unexpectedly absent then they would call off duty members of staff for cover.
- However, if this could not be achieved we were told that shifts would not run and management would try and arrange taxis for the patients and the contracting services would be contacted to inform them of the lack of available support.

Patient transport services (PTS)

- We could not identify how many times a shift could not be filled because this information was not monitored.
- Five members of staff we spoke with stated that staffing was not a problem and shifts were on the whole filled appropriately. They also confirmed that existing staff members were happy to cover sickness absence when this occurred.
- Staff had access to on call duty managers out of hours for escalation and management support.
- Staff worked in shift patterns of four days on and four days off. Staff received their shift rotas a day in advance of their shift. Staff we spoke with were happy with this arrangement.
- In general, staff worked within the working time directives and worked an 11 hour shift with adequate breaks and time included to clean their ambulances following the end of their shift.

Response to major incidents

- The PTS had a comprehensive Business Continuity Plan, reviewed July 2016. This included actions and responsibilities for situations that may affect capacity or demand, such as loss of IT infrastructure, loss of premises, floods or severe adverse weather.
- The service's major incident plan dated 18 February 2016 included the role of the ambulance service in a major incident. The plan included potential emergencies locally and nationally and how they would co-ordinate with NHS ambulance providers to provide support in these situations. .
- We were told by senior management that PTS staff were involved in major incident response rehearsals. However, five out of six members of staff we spoke with stated they were not aware of the plans, which would need to be followed in the event a major incident.

Are patient transport services effective?

Evidence-based care and treatment

- The service had policies and guidance in place to support evidence based care and treatment. The majority of documents we looked at were up to date. There were however a few which had not been updated appropriately. This included the services 'Procedure for the handling and transfer of patient identification and save haven' policy which was due for review in March 2016 and the services Safeguarding Children and Young People Policy which did not reflect the most up to date statutory guidance.

Assessment and planning of care

- Assessments of patient needs were carried out by the ambulance liaison office.
- Information was then passed to Thames so that they could plan their workload accordingly. For example, what equipment would be needed and whether or not a one or two man crew was needed.
- On the day of the patient journey, the crews were provided with daily job sheets. These included relevant patient information and alerts to any necessary medical information such as if the patient had diabetes, suffered from a learning disability or had particular requirements in relation their mobility. We reviewed five of these job sheets and saw one occasion where an additional need had been highlighted.
- However, we were told by a member of operational staff that there were numerous occasions where care had not been planned appropriately. For example, we were told that the booking centre were booking two man crews or ambulances with specialist equipment when these were not needed or not identifying mobility needs appropriately. However, this could not be evidenced in data form because the service did not monitor or report these incidents. Two members of staff we spoke with did confirm that incidents of this nature had occurred within the service.
- For example, one member of staff had been sent to job alone and there was a requirement to support the person with mobility. However, due to a significant amount of steps at the property this could not be achieved safely with only one member of staff and the patient consequently could not be transported to their appointment.

Response times and patient outcomes

- The service did not benchmark itself against other providers. This was confirmed by senior managers we spoke with.
- The service only provided performance outcome data for one of its contracts or ad-hoc work undertaken,

despite being asked through data requests and on inspection to provided evidence to us that would demonstrate how it was monitoring service provision and patient outcomes throughout the service.
- We were given conflicting responses from senior managers about the reasons for data not being available. For example, one manager we spoke with told us that the information could not be produced from the computer system in use at the service and that funding was not being made available to replace it. However, a formal response from the service stated that an external contractor had been providing incorrect data which was the reason for performance data not being available. This meant that the service had been unable to measure its performance and determine outcomes for patients.
- In addition, the service did not undertake audits which would allow it to assess it was meeting the needs of the patient groups it served. We asked to be provided with an audit strategy and audit plan and this was not provided. The only audits provided to us were in relation to record keeping, infection control and vehicle maintenance which have been reported on separately within this report.

Competent staff

- Only 75% of PTS staff had received an appraisal at the time of our inspection. However, this was a yearly rolling figure and we were told that all staff would have their appraisal completed by the end of the financial year.
- There were no arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. Staff told us that if they had a concern about the standard of a crew member's driving they would inform managers.
- Driver licence checks were carried out every six months according to the Safer Recruitment Policy. The staff we spoke to confirmed this and knew it was their responsibility to inform the service managers of any changes to their licence status. We were told by an operations manager that the service would cease employment of a staff member if they had more than six points on their licence; however data on one staff driving license showed that one member of staff had nine points on their license and was still employed by the service. This person no longer drove for the service.
- We asked four members of staff about driving licence checks and three told us that they were carried out yearly. Although the checks were run automatically and we saw evidence of this, we were concerned that staff were not kept informed of the checking process or that local practice did not match what was stated in the policy.

Coordination with other providers and multi-disciplinary working

- PTS bookings were coordinated through booking centres where the most appropriate and available transport was selected for each booking. This could be single or double person crew or a volunteer driver. However, we were informed that on a number of occasions double person crews were booked when this was not appropriate. We could not be provided with data on the amount of times this had happened because the service did not monitor this information. However, it was confirmed to us that no coordination or engagement had taken place with the booking teams involved. This meant we could not be confident Thames was coordinating with other providers appropriately.
- However, there were established relationships with local health care providers. We observed positive communication between drivers and staff at their planned destination.
- We received feedback from a number of the health providers that utilised Thames for patient transport. The majority provided positive feedback about the service provided which included comments about Thames being receptive when coordinating services locally.
- The service attended regular contract monitoring meetings with commissioners. We noted that where appropriate other healthcare providers such as NHS Hospitals were engaged with as part of these meetings to discuss service provision.
- We observed handovers taking place at a hospital and noted appropriate information being exchanged by ambulance and nursing staff.
- We were told that do not attempt cardiac pulmonary resuscitation (DNACPR) orders were communicated in advance of journeys to PTS crew and that this would be on their job sheet. We did not see any records at the time of inspection which included this information.

Access to information

- PTS crews had routine access to patient details such as name, date of birth, address and drop off locations.

- This information was present on the crew's daily job sheets which also included a section for special notes. In this section crews should have been alerted to any relevant medical information such as if the patient had diabetes, suffered from a learning disability or had particular requirements in relation to support with their mobility.
- We reviewed five job sheets during our inspection and saw that a special note was present on only one record. We cannot confirm if other special notes should have been present but staff had reported to us that the availability of information on these records was inconsistent. For example, one member of staff told us that they were not made aware of illnesses such as dementia. A second member of stated that they had had to cancel a patients transport journey because information about access to the property was not communicated meaning the patient could not be transferred from their home to the ambulance safely.
- PTS staff told us that they relied on hospital staff handing over any relevant information about patients verbally when they were discharged. However, four out of five members of staff spoken with told us that this did not always happen and they were not always made aware of patients leaving hospital with an infection risk.
- This presented a risk because the lack of formalisation of sharing this information meant that important information may not be handed over to ensure that PTS crews could provide the appropriate care whilst transporting patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2010. They understood that a capacity assessment may be needed for a person who was thought to lack capacity and stated that if they came across a situation where they had concerns they would seek advice and support from a manager.
- Mental Capacity Act and Deprivation of Liberty Safeguard training compliance stood at 97% for the organisation.

Are patient transport services caring?

Compassionate care

- We were unable to speak to patients as part of this inspection because we did not travel with crews during this inspection and although asked, the service was unable to provide us with contact details of patients which they had recently transported.
- We were provided with an undated copy of a friends and family test which demonstrated 24 patients had been asked about their likeliness to recommend the service. Twenty three patients stated they were extremely likely or likely to recommend the service with one person stating they were not likely to recommend. However, these figures and responses are not a confident marker of the quality of the service provided because of the extremely low response rate. For example, across one contract, the service transported an average of 3,955 patients each month from October to December 2016.
- We reviewed a patient satisfaction survey carried out in February 2016 and found that 99% of patients that responded felt that the ambulance crews respected their privacy and dignity.
- This satisfaction survey also found that 99% of patients felt that the ambulance crews listened to them and that they were friendly and helpful to them.
- Positive comments received from patients included "personnel are always caring and helpful", "Very friendly help you with any problems" and "We have used numerous ambulances over the past 6 months and without exception all the drivers and attendants have been very kind and attentive ".
- We were not provided with any further patient feedback despite additional requests.

Understanding and involvement of patients and those close to them

- Eligibility for transport services were communicated to patients via the contracting authority.
- There was a mixed response from patients in the February 2016 survey about communication from drivers. One person commented "prompt service, crew had good knowledge of procedure I was having, they settled my nerves" and another said "the ambulance staff were so friendly and lovely with my very elderly mum".
- However, other patients stated there was "poor communication by management", "communication between drivers and office needs to be improved" and "control/office are too slow at telling drivers of changes e.g. being delayed - Control don't tell drivers."

Patient transport services (PTS)

Emotional support

- All of the staff we spoke with demonstrated a caring and supportive attitude. We were told on multiple occasions that should a patient become agitated or anxious staff would spend time reassuring the patient.
- Staff encouraged patients to bring family members or carers on their journeys.
- We heard of one example where a patient who had a heart attack during transportation died. The staff member involved told us how they had stayed to support the families involved, to calm the situation and provide information where relevant.

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

Service planning and delivery to meet the needs of local people

- Patient transport services (PTS) provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment such as chemotherapy or renal dialysis.
- The service provided both NHS care, under NHS contracts, and ad-hoc private work.
- Out of area or out of hours patient transport was subject to CCG approval for funding. This included patients attending specialist medical services.

Meeting people's individual needs

- The service did not provide ambulance transfers for people who had been detained under the Mental Health Act 1983. However, we asked staff to describe to us how they were supported to care for people who may be travelling with them and who had mental health needs. We spoke with three members of staff who told us that they had not been provided with training or support on how to identify or deal with these situations.
- Senior managers told us that should patients become violent or aggressive then ambulances crews were expected to call to the police for assistance. When we asked staff how this would be managed we were told by three out of four members of staff that they had not received any training on how to deal with this situation with one member of staff stating that they would restrain a patient who tried to leave their ambulance. Staff members are not trained to restrain and this could amount to a deprivation of a person's liberty.
- The service did not provide training to support staff to care for people living with dementia or a learning difficulty. There was also no communication training and staff were not provided with communication aids to aid effectiveness communication with these specific patient groups.
- However, staff we asked stated that if they were transporting a person living with a learning difficulty or dementia then they would find out as much as possible about the needs of the patient from the control room and check if they had a carer which could accompany the patient. Staff stated they would always double check the patient drop off address and ensure they were escorted to the exact place of appointment and made comfortable.
- There were no systems in place to support people whose first language was not English. Staff we spoke with told us they would use "common sense" or utilise relatives to translate where they were available. This is not an appropriate method of communication because it cannot be guaranteed that the relatives have appropriately understood information which needs to be relayed.

Staff received training on how to appropriately support bariatric patients when transferring them to and from ambulances. The ambulance fleet included a bariatric ambulance which contained appropriate equipment to provide care to this patient group. We were told by senior managers that a further two bariatric ambulances had been ordered.

Access and flow

- The service ran contracts awarded from commissioning groups and other healthcare providers. Each contract had its own booking system which were run by the contractors. Patients were booked for transport against a set of eligibility criteria which was determined by the contracting authority.
- We found there were significant issues with a new contract working with a local commissioning group. We saw from minutes dated 13 October 2016 that the service could not cope with the demand of this service

as it was not prepared for the level of booking calls it needed to handle. It was reported that 200 calls a day were expected but in reality 1200 calls per day were being received. We followed this up following our inspection and found that a normal level service had resumed and call levels had fallen.

- We were provided with performance data on one of the services PTS contracts and this showed the service was not timely and did not promote patient flow. For example, in the month of October 2016 only 57% of patients requiring admission to hospital arrived on time against a target of 90%. In November 2016 only 60% of patients arrived on time.
- For the months April to November 2016 the service did not meet its target of 90% once for people arriving to their outpatient appointment on time. In November 2016 only 73% of patients arrived on time. This meant we were not assured the service was able to respond when it performed poorly due to the consistent performance failure demonstrated with the data provided.
- The target of 90% of patents attending their renal appointment was also missed on six out of eight occasions from April to November 2016. This was at its worst in August 2016 where only 67% of patients arrive in time but there had been a month on month improvement to the target being met in November 2016 with 98% of patients arriving on time.
- The service performed better with hospital pick-ups and transfers. We found targets were consistently met from April to November 2016 for the percentage of patients collected within 60 minutes of Thames being informed of the ready time and the percentage of patients collected within 30 minutes of their renal treatment.
- The service did not collate performance data across its contracted or private activity so we are unable to report on how responsive the service is in terms of arrival times to collect patients, arrival times of patients to their destinations or excess waiting times overall.
- However, there were a number of negative comments in the patient satisfaction survey about ambulances not being on time, 22% of patients in this survey commented on long wait times. For example, one person commented that a poor aspect of the service was “not knowing what time transport arrives or if they will”. A second person commented “I often wait 3 hours after dialysis before I am taken home” and a third person stated the ambulances were “not always on time, sometimes no show”.

Learning from complaints and concerns

- Complaints and concerns were discussed at the clinical governance group. We reviewed minutes from July 2016 and November 2016 meetings and found that whilst the numbers of complaints were reported together with a brief description of the nature of the complaint, there was no reference to any follow up action or emphasis on learning from complaints.
- We asked five staff members if they could provide examples of how a compliant had led to change or improvement in the service and they could not provide examples.
- We asked three senior managers if they could give us an example of how they had learnt from complaints and we had a mixed response. Two managers provided a response when they had been directly involved in a complaint, another manager could not provide a response.
- The senior managers reported to us, in their presentation of the service, that the service prided itself on being a learning organisation. However, the organisation was unable to demonstrate this to us during inspection.
- There was no formal monitoring of the time it took to respond to complaints.
- The service did not benchmark itself against other providers in relation to the complaints it received which meant it could not assess how effective it was within the sector with providing positive experiences for people using the service.
- We spoke with four members of staff who told us that if a patient wanted to make a complaint then they would provide them with the telephone contact details of Thames. There was no information material present on ambulances, which the crews could provide to patients to guide them through the complaints process.

Are patient transport services well-led?

Leadership / culture of service related to this core service

Patient transport services (PTS)

- The service was led by an Executive Management Team (EMT) which was made up of the chief executive officer (CEO), the chief operating officer (COO), the finance director, HR director and director of Training and Development. Overall accountability of the service lay with the CEO.
- Locally, PTS services were managed by a regional operations director and a number of operations managers with support from a CQC registered manager. However, we were concerned about the local management because neither of the two senior managers we spoke with had a clear understanding of their role or responsibilities. For example, we asked both members of staff to tell us about the contracts in their areas and performance against them. Neither manager could provide a response.
- We found that the Registered Manager of the service had not reported incidents, not raised or reported safeguarding referrals and not undertaken investigations or acted on concerns regarding staff or vehicles in a timely way.
- Throughout our inspection we found a lack of ownership generally in relation to key responsibilities within the organisation. For example, we asked a member of staff who was responsible for risk management and was told that it was the COO; the COO however told us that risk management was managed by the Governance and Compliance Officer. When we asked the Governance and Compliance Manager about their responsibilities in relation to risk management they told us that the COO was responsible.
- We had a mixed view from staff about the approachability and support received from managers. Two members of staff told us that managers were unapproachable and unsupportive whilst another two members of staff felt their manager was open and supportive.
- The evidence gathered during our inspection demonstrated that there was a closed culture within the service. The culture was not centred on the needs and experiences of people using the service and there was a lack of openness and transparency from leadership level.

Staff were not routinely informed of outcomes of incidents or investigations and there was a lack of emphasis on learning and organisational improvement. This was demonstrated in the services inability to evidence change through complaints, incidents or adverse events.

Vision and strategy for this this core service

- There was no clear vision and strategy for the service. Whilst there were ideas to open more bases to grow the service, there was no plan to demonstrate that managers had strategically planned this growth.

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

- There was no framework in place for the service to describe its governance arrangements. We found that reporting arrangements to ensure effective information sharing and decision making were weak.
- Key governance committees did not meet their own terms of reference (ToR). For example, the terms of reference for the clinical governance committee dated 02 February 2016 were not met in clinical governance meetings dated 13 July 2016 or 16 November 2016. The minutes of those meetings confirmed that the standing agenda items as required by the ToR were not discussed.
- We also found that the corporate governance committee had been taking place without terms of reference. The terms of reference for this group were not put in place until 30 November 2016, one week following our inspection.
- A requirement of both these meetings was that they reported into the EMT meeting. However, we asked to be provided with minutes of the EMT meetings and were informed that these meetings were not regularly minuted. This was not in line with the ToR for the EMT meeting which stated that draft minutes of the meetings would be made available within two working days of it having taken place.
- Furthermore, the ToR for the EMT stated that it was accountable to the Board**.** However, Board meetings did not take place. This was confirmed by the leadership team during our inspection.

- This lack of reporting structure and accountability meant the service did not have in place an effective system to allow it to monitor, assess and make decisions to ensure the health, welfare or safety of people using the service and staff was maintained.
- Risk management systems were not robust. As reported above in the leadership part of this report, there was no accountability for the management of risk within the service. We asked to review risk registers for all of the services managed from the Canvey head office which included bases in Milton Keynes, Canvey Island, Sussex, Grimsby, Scunthorpe and Gateshead. We were only provided with registers from Canvey Island, Milton Keynes and Sussex.
- On review of these registers, we found that risks were poorly identified, managed and mitigated. For example, on one register we found that a risk had been identified in relation to the possibility of overflowing bins. This was the only descriptor of risk presented with no detail as to what risk the overflowing bins presented or indeed how that would be mitigated.
- There was a lack of standardisation for risk assessments also. For example, we saw the risk assessment for driving dated 28/11/2016 and the risk assessment for the use of carry chairs dated the same date which were not completed on the template set for use within the services Risk Management Policy dated 06 February 2016.
- In addition, it was noted that the above risk assessments were not undertaken until following our request to see them. This showed these risks were not being managed prior to our inspection. This is also confirmed by the absence of such risk on any risk register seen by us. As it took the Commission highlighting these areas which required assessment, we are not assured in the services ability to identify and mitigate known risk.
- On the services corporate risk register, submitted to us following our inspection, we saw two risks dated 22 November 2016. These risks related specifically to the failings of the service identified during that inspection. The purpose of a risk management system is to identify risks prior to their occurrence in order that mitigating plans have been assessed and affected.
- There was a poor incident reporting culture which has been reported on in detail under the safe domain of this report. This poor culture meant that the service could not assess its quality based on themes and trends which can be gathered from a strong incident management system.
- There was no audit strategy or plan in place for the service. This meant there was limited opportunity for the service to measure its quality against set internal or external standards.
- The service did not report or act on patient experience. We were provided with a patient feedback survey dated February 2016 and found that there was no reference to these results being discussed at any of the services governance committees.
- The policy development and approval process was not robust. We found policies, such as the Safeguarding Children Policy, that although had been reviewed and updated had not taken into account new legislation or guidance which was relevant to the running of the service.
- The services Statement of Purpose (SoP) as required by the Care Quality Commissions (Registration) Requirements 2009 did not meet Regulation 12 of those regulations. In particular, the SoP did not contain required information such as the kinds of services provided and the range of service users' needs which those services intended to meet, information about the provider and registered manager or details of the locations where services were provided.

One clinical commissioning group (CCG) had also raised concerns about the governance systems at the service, particularly in relation to their identification and subsequent management of serious incidents. The CCG stated that it had raised these concerns with Thames and they were working together to improve the processes.

Public and staff engagement (local and service level if this is the main core service)

- Staff reported to us that team meetings were not routinely held and we could not be provided with minutes of meetings we were told did occur. This meant we could not assess staff engagement and participation in meetings. There was no evidence of regular forums to engage all staff, update them on any developments and share any learning.
- We were informed that communication took place via newsletters and memos and saw this to be accurate. We reviewed newsletters from September, October and

November 2016 and saw that staff were kept informed of happenings within the organisation, which included initiation of a staff survey, details of updated policies and updates with regards to the contracts the service was running.

- The service did not routinely engage with the public or its patients to assess the level of service that it provided.
- One local clinical commissioning group raised concerns with us prior to our inspection that the patient experience survey undertaken by the service was not frequent or detailed enough, with a lack of focus on themes and trends. They felt there was insufficient evidence of feedback being used to develop the service further.We found this to be accurate during our inspection. The only patient experience survey we were provided with, despite asking for further information, was from February 2016. We also found that this information was not collated or analysed to ensure improvements to the service could be made.

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

- The service planned to expand in the future (although this was not supported by a strategic plan) and we heard from management that plans were underway to move the location of its head office to more central location. It was envisaged that this move would allow the management team to have more contact with teams which worked in northern areas of the country.
- Plans were also underway to restructure the service with more locations and managers being registered with the Care Quality Commission. It was envisaged that this change in structure would strengthen lines of accountability and allow the company to work in a more streamlined way.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

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- The service must improve its incident reporting, investigation and learning process.
- The service must operate a robust governance framework which allows it to effectively assess and monitor the services it is providing.
- The service must improve its risk management systems to include staff understanding and clear roles and accountabilities for the management of risk within the organisation.
- The leadership team must have a clear understanding of their roles and responsibilities.
- The service must improve auditing and performance monitoring systems.
- The service must improve the way in which it learns and develops.
- The service must improve its processes for safeguarding adults and children to ensure that staff are trained appropriately and there are appropriate reporting arrangements in place and that this is monitored.
- The service must employ a registered manager who is fit and proper to undertake the role.
- The service must ensure there is a deteriorating patient policy in place and that staff are fully aware of their responsibilities when caring for a patient who becomes seriously unwell.

Action the hospital SHOULD take to improve

- The service should improve access to information so that staff always have accurate information about the people they are caring for.
- The service should review its arrangements which provide assurance on the cleanliness of PTS vehicles.
- The service should improve its systems which monitor equipment on PTS vehicles.
- The service should review the way in which oxygen cylinders are secured on ambulances.
- The service should consider providing training to its staff in order for them to meet the individual needs of patients.
- The service should review the way in which it engages with its staff, the public and its patients with regards to the delivery and effectiveness of the service which it provides.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include:- 1. assessing the risks to the health and safety of service users of receiving their care and treatment; 2. doing all that is reasonably practicable to mitigate any such risks You have failed to meet the parts of the regulation stated because there was no deteriorating patient policy and some staff were not aware of their responsibilities should a patient deteriorate in their care. This meant that patients were at risk of not receiving appropriate or timely care and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose 12 (1) The registered person must give the Commission a statement of purpose containing the information listed in Schedule 3. You have failed to meet this part of the regulation because you failed to submit a statement of purpose which met the above requirement.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.— 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; d. maintain securely such other records as are necessary to be kept in relation to— I. persons employed in the carrying on of the regulated activity, and II. the management of the regulated activity; e. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

This section is primarily information for the provider

Enforcement actions

f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

You failed to meet the parts of the regulation stated because you did not operate systems of processes to allow you to effectively assess the quality of the services you were providing. This included, but is not limited to, an absence of a proper incident reporting and investigation system, a weak risk management process, an absence of seeking and acting on feedback from people who used your services and a lack of appropriate audit and improvement systems particularly in relation to vehicle cleanliness and patient outcomes.

You also failed to ensure that an accurate and contemporaneous record in respect of each service user. This is because it was unclear from your records who administered medicines on emergency call outs. Records were also not stored or maintained securely. We found a backlog of unchecked records which should have been sent for secure storing.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13. 1. Service users must be protected from abuse and improper treatment in accordance with this regulation. 2. Systems and processes must be established and operated effectively to prevent abuse of service users. 3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. You failed to meet the parts of the regulation stated because we found that systems and process were not operated effectively to allow you to investigate

This section is primarily information for the provider

Enforcement actions

immediately the allegation of abuse. Evidence gathered during our inspection demonstrated to us that you were not reporting safeguarding concerns to the appropriate authority for proper or timely investigation to occur.

Your systems and processes were not operated effectively to allow you to ensure you had suitably skilled and qualified staff in relation to safeguarding children from abuse. Staff were not trained to level 3 or level 4 in safeguarding children as required by statutory guidance.

Regulated activity

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers

7.

1. A person (M) shall not manage the carrying on of a regulated activity as a registered manager unless M is fit to do so.
2. M is not fit to be a registered manager in respect of a regulated activity unless M is—
   A. of good character,
   B. has the necessary qualifications, competence, skills and experience to manage the carrying on of the regulated activity,

You have failed to meet the parts of the regulation stated because you did not identify concerns in the ability of the registered manager to perform their role particularly in relation to incident management, safeguarding concerns, audits, and governance arrangements. Evidence gathered during our inspection demonstrated that the registered manager was not fit because they did not have the necessary qualifications, skills or competence to manage the carrying on of the regulated activity.