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

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Thames Ambulance Service is operated by Thames Ambulance Service Limited. The service provides patient transport services from 16 sites nationwide.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 September 2017 along with an unannounced visit to the service on 4 October 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The service had experienced fast-paced expansion in its PTS work over the past 12 months. However, we were concerned it did not have the systems and processes in place to carry this out safely and reliably, due to our findings for example around lack of monitoring service activity, lack of audit, poor support and management for operational staff and patient complaints.

Services we do not rate

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

We found the following areas where the service needs to improve:

- There was a poor culture around incident reporting, investigating and learning. The service's incident management process was not embedded across all sites. Not all staff were aware of the service's incident management policy.
- We were told about a patient death that had occurred, which was not notified to the Care Quality Commission as a statutory notification.A service lead could not locate the incident report or explain where they were in terms of the investigation of this.
- The service did not have a clinical quality dashboard or similar to provide an overall picture of safety and quality at any given time by collating information, for example around incidents, infections, safeguarding referrals, and complaints among other indicators.
- The process and responsibility for deep cleaning vehicles at the Grimsby and Scunthorpe sites was unclear and inconsistent with the service policy on deep cleaning and infection prevention and control (IPC)
- There were no audits for deep cleaning or IPC being carried out at the Grimsby and Scunthorpe sites.
- It was not clear who had oversight of vehicle and equipment safety at the Grimsby and Scunthorpe sites as there was no documentation around this.
- The service did not have clear records to show that all vehicles had received an MOT.
- The documentation of safeguarding referrals and investigations was unclear and inconsistent.
- Service leads were not able to demonstrate effective oversight of training compliance to ensure staff were up to date with mandatory training.
- It was not clear what the service policy and procedure was relating to transporting children and the risks this could present.

Summary of findings

- There was a lack of consistency in how to access policies and procedures across sites. There was no evidence that updates to policy and guidance, was being shared between sites to ensure staff were working to the same standards. Many of the policies at the Grimsby site were out of date.
- There was no audit activity taking place at Grimsby and Scunthorpe for the service to monitor its own performance in terms of quality and safety aspects.
- There was no formal induction procedure for staff at the Grimsby and Scunthorpe sites. Team leaders, who were responsible for the day to day operations at site level, had received no additional training or induction to ensure they were competent in this role.
- Staff at Grimsby and Scunthorpe raised concerns they had not been trained to use equipment such as wheelchairs, ramps and stretchers. The service did not provide evidence of staff competencies in this.
- There was no system to ensure appraisals were carried out annually. Staff at Grimsby and Scunthorpe confirmed they had not had appraisals. This was not compliant with the service's guidance on staff appraisals.
- Staff said they did not always receive the information they needed from a discharging hospital, such as whether a patient had MRSA, was living with mental health difficulties, or any particular mobility needs. This meant they often arrived and realised they would not be able to carry out the transfer.
- Managers at each site could not explain how the service was monitoring any key performance indicators to ensure services were planned and delivered to meet patients' needs, or show us any systems for this.
- There was no clear process for managing and learning from complaints across all sites.
- There was no vision or strategy for the service.
- Governance, risk management and quality measurement processes were not embedded at all sites. Service leads could not explain their local risks and were not aware of any systems for monitoring and mitigating risk.
- No meetings for staff or service leads were taking place in the northern region.
- There was evidence of a poor culture and morale at the Grimsby and Scunthorpe sites, in relation to staff feeling unsupported.
- There were no systems for public or staff engagement at the service.

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

- Vehicles at the Canvey Island base had 'deep cleaning passports' to document deep cleans, and were deep cleaned every six weeks at this site in accordance with service policy.
- Equipment on vehicles at the Canvey Island base was checked and in accordance with the equipment and vehicle checklist. This was also audited by an external company, with actions highlighted for improvement.
- At the Canvey Island site, there had been initiatives to improve safeguarding awareness, reporting and learning since our previous inspection. For example, the service had employed a safeguarding lead since our last inspection, trained to level four in safeguarding, and staff at this site confirmed they could access them for advice and support.
- The service had a deteriorating patient policy, which was an improvement from the previous inspection.
- Operational staff displayed a patient-focused approach and ensured patients' privacy and dignity were maintained. This was reflected in positive feedback from patients about the care from frontline staff.

Summary of findings

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

Heidi Smoult

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We 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: • There was no effective system across the service for incident reporting, investigation and learning from incidents. • There was no clinical quality dashboard to display and monitor safety and quality information. • Procedures and good practice around cleanliness and IPC were not embedded across the service. • There was no evidence that vehicles at Grimsby and Scunthorpe were receiving regular deep cleans and it was not clear who was responsible for deep cleaning. • At the Grimsby base, there was a potential health and hygiene risk due to bird faeces on the floor within the station where the ambulances parked and were cleaned. • There was a lack of clear processes including auditto ensure consistent maintenance of the environment and equipment across all sites and to ensure vehicles and equipment were safe for use. • Safeguarding procedures and awareness were not embedded across all sites.At Grimsby and Scunthorpe, it was not clear what the escalation arrangements were, or how the service ensured appropriate learning and feedback. • There was a lack of clear consistent processes across all sites to ensure all staff were up to date with mandatory training. • It was not clear what the service policy and procedure was relating to transporting children and the risks this could present.

Summary of findings

- We were unable to assess staffing levels against patient needs as the service was not monitoring the rate of unfilled shifts.
- There was a lack of consistency in policies and procedures between sites.
- There was no audit activity taking place at Grimsby and Scunthorpe.
- There was no clear system to monitor response times for patients; therefore it was not clear whether the service was meeting targets set by each clinical commissioning group.
- There was a lack of clear processes to ensure all staff had the necessary skills, knowledge and competencies and a lack of support for operational staff.
- There was no evidence to show that staff were appropriately trained and supported to use the equipment required in their day to day roles
- There was no system for monitoring appraisals to ensure staff were competent and supported. Staff, particularly in Grimsby and Scunthorpe, said they had not had appraisals.
- There was no consistent procedure across sites for maintaining staff files and it was unclear who had overall responsibility for this.
- Staff did not always receive the information they needed about a patient's condition and needs, meaning they sometimes arrived for a journey and realised they were not able or equipped to carry it out.
- Staff did not receive training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.
- Operational staff displayed a patient-focused approach to their work, and patients we spoke with felt that operational staff were caring, friendly and helpful.
- There was no evidence of the service monitoring any key performance indicators to ensure services were planned and delivered to meet patients' needs.

Summary of findings

- There was no specific training for staff in meeting the needs of patients living with learning disabilities or dementia.
- The service did not have its own access to translation services for patients whose first language was not English.
- We had concerns about patient access and flow due to the high level of delayed journeys..
- There was an up-to-date complaints policy and procedure at Canvey Island; however, there was no evidence this was in place at Grimsby and Scunthorpe. Staff at these sites could not give examples of feedback or learning from complaints.
- There was no record of complaints for any sites in the northern region, so we were not assured complaints were being reported and monitored.
- The complaints records for the southern region were not collated, audited or tracked to monitor themes and trends and act appropriately to resolve and reduce complaints.
- Management and governance structures were not clear at site level.
- Staff consistently reported that the senior management team was not visible and at the Grimsby and Scunthorpe sites they were not clear about escalation processes for concerns.
- There was no documentation of any meetings taking place in the northern region.
- There was a poor culture and morale at the Grimsby and Scunthorpe sites.
- There was no vision or strategy.
- We were concerned that governance and risk management processes had not been fully established prior to taking on new contracts nationwide to ensure the service was able to manage these effectively and safely.
- There was a lack of oversight from regional service leads about the risks in their areas and about their performance.

Summary of findings

- There were no systems in the northern region for monitoring and mitigating risk, such as a local risk register.
- There were no means of staff or public engagement with the service.

Thames Ambulance Service

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Thames Ambulance Service

Thames Ambulance Service is operated by Thames Ambulance Service Limited. It was founded in 1996 and is part of the Thames Group, a nationwide provider of transport to support 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 Gateshead, Hull, Grimsby, Scunthorpe, Lincoln, Louth, Boston, Grantham, Heckington, Spalding, Sussex, Ipswich, Kettering, Milton Keynes, and Northampton.

The current registered manager has been in post since June 2017.

Prior to this inspection, we had received a number of enquiries from staff and patients which had identified certain concerning trends, notably around management and culture, training, appraisals, equipment, deep cleaning of vehicles, and significant delays to patient transport. Following this, we issued an information and evidence request under section 64 of the Health and Social Care Act 2008 (Power to require documents and information etc.) This informed our inspection planning. We had also carried out two formal meetings with the senior management team in May and September 2017 to discuss the changes within the service with regard to their action plan from the previous inspection and their growth in PTS work.

We had previously carried out a comprehensive inspection in November and December 2016, which found that the service was not meeting all standards of quality and safety it was inspected against. On the basis of that inspection, the service immediately voluntarily ceased the urgent and emergency work they were providing to the local NHS ambulance service. The CQC imposed conditions on the service's registration based on the findings of that inspection, as follows:

- To ensure there was a suitable clinical professional employed, with sufficient qualifications, skills and experience to be responsible for safeguarding;
- To operate an effective audit and monitoring system that provides assurance that vehicles are clean, equipment is clean and fit for purpose, vehicles are appropriately stocked, and records are completed accurately;
- To ensure that all incidents and near miss events are reported, recorded and investigated by the service, and to implement systems to minimise the risk of further incidents occurring;
- To ensure that there is an effective process to review and monitor the outcomes and performance for contracts and ad hoc work;
- To ensure that policies, procedures and protocols are in place, up to date, reflect current practice and ensure that staff are aware of them to provide safe patient care and treatment;
- To ensure that that there is an effective governance process for the management of monitoring of risk within the service;

Detailed findings

- To work openly and transparently with service commissioners, stakeholders and regulators to develop and agree quality monitoring systems and key performance indicators (KPIs) for the service in order to demonstrate that the service is providing care that protects people's health, safety and wellbeing;
- To send CQC improvement plan and weekly updates of actions.

The CQC also issued four requirement notices based on the findings of the inspection in relation to the following regulations:

- Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment
- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance
- Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment and abuse
- Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Requirements in relation to registered managers.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two CQC inspection managers, and six other CQC inspectors. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the service's registered location at Canvey Island and two non-registered 'satellite' sites at Grimsby and Scunthorpe. We revisited the Scunthorpe and Grimsby sites subsequently to carry out the unannounced follow-up inspection. We also visited the renal unit of one subcontracting NHS acute trust and the outpatients department of another to speak to patients who use the patient transport service.

Across all three sites, we spoke with 12 ambulance care assistants, two administrative staff, senior managers (including the chief operating officer, chief executive officer, regional director, area managers, and interim mobilisation director), the HR director, four team leaders and five patients who used the service. We inspected 11 vehicles across the three sites.

We were not able to directly observe any patient journeys or review records as the service did not keep them.

Facts and data about Thames Ambulance Service

The service is registered to provide the following regulated activities:

- Transport, triage and medical advice provided remotely

The service has 16 bases altogether nationwide, as of the time of inspection. Of these, two are registered locations as of the time of inspection

The service's Canvey Island base has 49 PTS vehicles and 81 members of staff and operates from 5.30am to 1am, seven days a week. The Grimsby base has 26 vehicles and 54 members of staff, and operates 24 hours a day for patient discharges, and from 5.30am to 1am for outpatients and renal dialysis. The Scunthorpe base has 23 vehicles and 44 members of staff, and operates 24 hours a day for patient discharges, and from 5.30am to 1am for outpatients and renal dialysis.

Detailed findings

Operational (road) staff are employed as ambulance care assistants within the service.

Activity (October 2017 to September 2017)

- We are unable to provide information on the service's annual activity such as number of patient journeys, same-day and advance booking figures because the service did not provide this information upon request.

Track record on safety:

- We are unable to provide data on the number of incidents because the service did not provide this information upon request.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Patient transport services (PTS) were the only service carried out. Please see full information about the service above.

Summary of findings

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. As there was only one core service, please see summary of findings above.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- There was no effective system across the service for incident reporting, investigation and learning from incidents, both internally and externally. We were not assured that incident reporting and learning was embedded into the service and that investigations into incidents were being carried out and documented appropriately and consistently across sites.
- There was an incident reporting and serious incident (SI) policy and procedure used at the Canvey Island base, which was up-to-date. However, we were concerned that this had not been shared among all sites. We saw a paper copy of the incident reporting and SI policy and procedure at Grimsby, which was beyond its review date (August 2017). A service lead was aware it was out of date but not aware there was a different policy in use at other sites. Staff including service leads at both sites could not explain what the policy and procedure was for reporting, investigating and learning from incidents.
- At the Canvey Island site there was an electronic incident log in use for the service's sites in the southern region; however, incidents were not collated and monitored at the Grimsby and Scunthorpe sites. Incidents were reported via a paper incident report form at these sites; however, there was no document showing, for instance, how many incidents had occurred in the region, or of what type. This meant the service did not have oversight of the incidents that were occurring in this area. When an incident report form was submitted, we were told it would go into the relevant staff member's HR file. We saw an example of this in one staff file at Scunthorpe.
- The regional operations manager told us there would be an 'action plan' if actions were needed following the incident reported, and that they would work on this with the relevant members of staff involved in the incident, but confirmed there was no documentation of this process. A service lead at Scunthorpe said that damage to vehicles was the most common incident but, due to lack of documentation, there was no evidence to verify this or track corresponding actions. This meant there was a risk of preventable incidents reoccurring.
- During our inspection of the Canvey Island base, we reviewed the electronic log used to record details of all incidents, serious incidents, safeguarding referrals and complaints relating to sites in the southern region only. Incidents were logged and recorded on the spreadsheet; however there were issues around clarity and documentation. For example, there was a serious incident recorded as 'closed' but in the 'open' tab. Another incident was reported on 19 May 2017 and remained open at the time of our inspection in September 2017. The lead investigator was recorded as a member of staff who had left the organisation. There was some evidence of actions taken; however, this included "awaiting next TASL and provider meeting" but no dates of when this action had been documented on the spreadsheet or when the next meeting was. This incident therefore remained open without any clarity to the progress and ownership.
- We requested to review the root cause analysis (RCA) from a serious incident regarding a deterioration of a renal dialysis patient. However the senior member of staff could not locate this on the internal system, and could only locate a desk top review. The senior member of staff had to contact the investigator and provided the report following the inspection.
- When we reviewed this RCA, we had concerns about the content and effectiveness of the RCA. The incident occurred on 14 November 2016 and the report was completed on 27 July 2017. This length of time was not in accordance with the policy, which specified a timeframe of 60 days for serious incident investigations to be completed. The RCA did not provide reasons for the length of time. The action plan was sparse and did not include evidence of sharing learning with staff, in particular, those at other sites to ensure similar incidents did not reoccur.
- The desk top review of this serious incident, completed on 14 September 2017, stated that Thames Ambulance Service Limited were unable to complete their obligations under the duty of candour requirements as the contact details of the family were not up to date. 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.

- We requested any other RCAs that had been completed in the last 12 months but only received one that had been completed in August 2016, for an incident in December 2015. As we had not received an incident log under our data request, we were unable to ascertain whether there should have been any other RCAs carried out by the service.
- On the unannounced inspection, we were told about a patient death that had occurred. The regional operations manager thought it had been around May. The team leader said they thought it was around January/February. This death was not notified to the Care Quality Commission as a statutory notification and the service leads were not aware of this requirement. The regional operations manager could not explain where they were in terms of the investigation of this and did not know who was involved in the investigation. We asked to see the incident report format Grimsby and were told that as all incident report forms were paper based it would take 'a few days' to access it as it was filed at Scunthorpe. When we visited the Scunthorpe site later that day we asked to see it again and both the team leader and the regional ops manager were unable to locate it. We requested it after the inspection and did not receive this information.
- A service lead told us about an injury to a patient in January, which was not reported as an incident at the time so only came to light when the patient's family raised it after some time. We were told the relevant member of staff said they had no recollection of this incident and the service lead did not know what more they could do to look into it. We were therefore not assured that all staff were aware of their responsibility to report incidents both internally and externally.
- There were no systems for sharing learning from incidents among staff at the service. We spoke with ten members of staff across the three sites about feedback and learning from incidents or safeguarding concerns raised. All ten were unable to give examples of feedback or learning. The incident reporting and serious incident (SI) policy and procedure from Canvey Island stated that 'area managers and equivalents were responsible for the dissemination of general learning points from SIs as routine'. However, at our unannounced inspection of Grimsby and Scunthorpe, the regional operations manager for the Lincolnshire area confirmed there were no systems to share learning and feedback from incidents, and could not give any examples of actions that had been taken or lessons learned following an incident.This meant there was an increased risk that potentially avoidable incidents could reoccur.
- At previous meetings with the service and at our inspection of Canvey Island, service leads told us they had introduced systems to improve incident reporting and learning. For example, there was a 'rapid review panel' (RRP) responsible for 'urgent assessment of all adverse incidents, safeguarding events and complaints in order that the issue can be correctly categorised; with all issues discussed and identified for further action as appropriate', as specified in the panel's terms of reference. The up-to-date policy from Canvey Island referred to the RRP but staff at the Grimsby and Scunthorpe sites, including service leads, were not aware of this panel.
- We reviewed minutes of the RRP meetings from March, April and May 2017. The panel was comprised of the chief executive officer, medical director, chief operating officer, associate director of quality and clinical governance, and regional director. The minutes showed discussion of incidents across all sites and actions, such as reiterating to staff to enforce the right to appropriately challenge any discharge that they feel would pose a risk to themselves or patients. However, it was not documented anywhere where actions were followed up, or how learning from these meetings was to be shared with staff.
- The team leader at Canvey Island was able to explain duty of candour and mandatory training data showed that 100% of staff were up to date with training in duty of candour. However, because of the concerns around incident reporting and awareness particularly at the Grimsby and Scunthorpe sites, we were not assured that duty of candour was always carried out when required or embedded across all sites.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service did not have a clinical quality dashboard or similar to provide an overall picture of safety and quality at any given time by collating information, for example around incidents, infections, safeguarding referrals, and complaints among other indicators.
- Operational staff, and team leaders we spoke with, did not show awareness of how such data was being monitored and recorded, and it was not clear who was responsible for this. This meant we were concerned about the lack of oversight of safety and quality in the service.

Cleanliness, infection control and hygiene

- Following our previous inspection of Canvey Island in November 2016, we told the service they needed to improve their infection prevention and control (IPC) processes, particularly in relation to the cleanliness of vehicles. We saw there had been improvements at Canvey Island to address this, but these were not in place at Grimsby and Scunthorpe. Therefore, we had concerns that policies, procedures and good practice around cleanliness and IPC were not embedded across the service.
- There was an up-to-date policy for IPC in use at the Canvey island site, which staff knew how to access via the electronic portal. However, at Grimsby, the policy we saw for management of patients with an infection was over a year beyond its review date (September 2016). Therefore we were concerned about the lack of consideration, oversight, and information to guide staff at this site in relation to IPC. Within the deep clean folder we reviewed at the Grimsby sitethere was no policy on deep cleaning.
- Operational staff were responsible for the routine cleaning of the vehicle at the end of their shift. This was done at the station and we were told this was the policy and procedure for all sites. However, the Grimsby site did not have hot water to do this properly and there was no plan documented to address this. The Scunthorpe site was in the process of moving on the day of our inspection to address a concern that the previous site did not have the appropriate facilities for routine vehicle cleaning, including hot water. At the new site, there was a designated wash area for vehicles outside the building and hot water was available.
- There was cleaning equipment available at each site, including screen wash, antibacterial spray, wash buckets and fluid for cleaning floors and vehicle exteriors.
- Vehicles at the Canvey Island base had 'deep cleaning passports' to document deep cleans. We saw these for all four vehicles we inspected at this base and they were clear and comprehensive. The service policy was for every vehicle to be deep cleaned at least every six weeks, and immediately after a patient journey if the vehicle had become contaminated during the transfer. The passports documented the last deep clean and when the next one was due and all vehicles we checked were compliant with the policy. However, this passport system was not used at the Grimsby and Scunthorpe sites.
- At Canvey Island, deep cleaning of vehicles was outsourced to a specialist cleaning company. We saw records of this for the Canvey Island site, which was an improvement from our previous inspection; however, this was not in use at all sites. Service leads at the Scunthorpe site said deep cleans there were being done by the in-house infection prevention and control (IPC) team every six weeks and as required after contamination of a vehicle or transporting a patient with a risk of infection. This was confirmed by a member of the IPC team. The IPC team had been in post since August 2017. Prior to that, deep cleaning had been outsourced. There were two members of this IPC team dedicated to vehicles at Scunthorpe, Grimsby and Hull.
- However, three members of staff at Grimsby and a service lead there said deep cleaning was the responsibility of operational staff. We asked if they had training in deep cleaning to carry this out and they confirmed they had not. Minutes from the senior management team meeting in July 2017 documented that deep cleans were being carried out by road staff at the Grimsby, Scunthorpe and Hull sites but that 'discussions were underway' with an external specialist company. It was therefore unclear who had responsibility for deep cleaning and whether this information was shared with staff.
- Our concerns were heightened because this was in line with concerns raised to us from staff both before and

after the inspection. From January to October 2017, we received 17 individual concerns from staff through our electronic information system relating to IPC and cleanliness of vehicles.

- There were deep cleaning audits taking place at Canvey Island. This was done by the outsourced vehicle cleaning company every six weeks and included random swab checks as part of the general cleanliness and IPC audit. The results for each vehicle deep clean were available through the service's online account with the company. We viewed this account (which was live and updated as the latest audit was carried out) and saw it comprised a record for each vehicle, including the date of the last deep clean and the date it was next due a deep clean. All vehicles at Canvey Island were compliant with deep cleaning and IPC according to the online account at the time of our inspection.
- However, a similar system had not been rolled out to other sites. Service leads confirmed there were no audits for deep cleaning or IPC being carried out at the Grimsby and Scunthorpe sites. A service lead at Scunthorpe said they were formulating a deep clean spreadsheet to monitor this but there was no evidence of this or timeframe for implementation. We requested evidence that vehicle deep cleans have been completed at Scunthorpe, Hull and Grimsby from June to September, and any vehicle deep cleaning or IPC audits from the same period for these sites, and did not receive any evidence.
- We reviewed a folder for the deep cleaning of vehicles at Grimsby, which showed poor compliance with the deep cleaning schedule. In February 2017, all vehicles received a deep clean according to the records and were all next due a deep clean in March or April 2017. However, the records showed that only four vehicles were deep cleaned in March and two in April. The records for May 2017 showed that four vehicles were deep cleaned and were next due a deep clean in July. There were no records for July 2017 in the folder. In August, four vehicles out of 21 on the list received a deep clean. There was no clear system for prioritising deep cleans of vehicles from the layout of this folder and these records and it was not clear whether the same six-week policy that we saw at Canvey was in use.
- One of the three vehicles we checked at the Grimsby base at the first part of our inspection had crumbs on the seats and floor in the cab area. This vehicle was about to go out for a patient transfer. Two of the vehicles did not have any clinical waste disposal bags on board.
- We checked one vehicle at the Scunthorpe site on 19 September and a further two on our unannounced inspection on 4 October. They were all visibly clean. They all had gloves to protect against contamination risk but no aprons. There was no hand cleansing gel in the vehicle but we were told staff carried these on their person. However, on asking two care assistants if they had their own hand cleansing gel, one showed us they had and the other did not.
- All vehicles we inspected at the Canvey Island base were visibly clean and tidy. There was anti-bacterial spray and an IPC kit within each vehicle which included personal protective equipment (PPE) in a range of sizes, spill mop up kits, and vomit bowls.
- Compliance with the 'bare below the elbows' (BBE) principle was variable. For example, one ACA at the Scunthorpe site was wearing a bracelet, which was not good practice for infection control purposes. We raised this at the time and the member of staff removed it. The service was not carrying out audits or spot checks of uniform and BBE to ensure good practice.
- At the Grimsby base there was a potential health and hygiene risk due to bird faeces on the floor within the station where the ambulances parked. Service leads were aware of this but confirmed there were no specific actions or work ongoing to mitigate this risk. It was not on the locality risk register for the site.
- There were cleaning bays at the Canvey Island base, which were stocked with spare disposable clean linen, emergency eye wash solution, and information such as chemical first aid guidance and clinical waste instructions.
- There were clinical waste bins at all three sites which were locked securely. An external company picked up this waste every two weeks for disposal. There was a risk included on the operational locality risk register for the Scunthorpe site relating to staff incorrectly placing sharps bins in the main clinical waste bags. This risk had an action specified for the locality manager to display a

clinical notice that sharps bins must not be placed in clinical waste bins. However, we did not see this notice displayed at the new Scunthorpe site when we returned for the unannounced inspection.

Environment and equipment

- There was a lack of clear processes to ensure consistent maintenance of the environment and equipment across all sites. At Canvey Island there were equipment procedures and policies in place and staff knew their responsibilities regarding checking equipment and the escalation system for reporting equipment that required replacement, which was an improvement from our previous inspection of this site. However, we had concerns that this was not embedded across the service, as these processes were not evident at Grimsby and Scunthorpe, and staff including leads were not clear on who had responsibility for environment and equipment maintenance, or an escalation process to raise equipment concerns.
- We checked four vehicles at the Canvey Island base. They contained all equipment in line with the equipment checklists, which staff signed off at each shift. Our review of checklists for the four vehicles we inspected at this base showed that staff were completing these checks at the start and end of their shifts to document equipment that had been used during the shift and needed replacement. They would report any equipment that was faulty or needed replacement to the operations manager at this site.
- Equipment at Canvey Island was also checked as part of the audits carried out by the outsourced cleaning company. Equipment issues within vehicles were highlighted in the online account used by the service to monitor this; for example, a vehicle was found to have a fire extinguisher past its servicing date (the audit did not include by how long). The service would then action these issues. However, this process was not in place at Grimsby or Scunthorpe.
- We checked three vehicles at the Grimsby base. Two did not have fire extinguishers on board. This was not in line with the Department of Transport Guidance Note 27: Guidance for the carriage of gas cylinders on vehicles. This guidance states that; 'All vehicles shall carry fire extinguishers. They shall be kept in a serviceable condition, in-date for test, protected against the effects of the weather and be easily accessible to the vehicle crew.' Equipment was otherwise in line with the checklist provided and in date.
- One wheelchair access vehicle (WAV) we checked at Grimsby was 5,000 miles past its servicing requirements. We raised this to the service lead on site who was not able to provide us with vehicle servicing records but said the vehicle would be taken out of action until resolved. We requested the vehicle servicing records for all three sites following the inspection but did not receive this.
- A service lead at Grimsby said they were currently scheduling in vehicle servicing for the next month and showed us a checklist for this. There was also a board in the office displaying dates for vehicle servicing and MOTs, but it was not clear from this whether the dates reflected when the service was due or when it had actually taken place.
- There was no clear process to escalate vehicle servicing concerns at Grimsby. Each vehicle had a flowchart in the glove box to guide staff in the event of a vehicle fault or servicing issue. It included relevant contact details including the external vehicle recovery and repair company, and the team leader at the site, however it was not clear what the escalation policy was past this point. There was no fleet co-ordinator responsible for ensuring that vehicles were maintained and serviced. Our conversations with staff confirmed that there was no clear process and there was no clear accountable person for vehicles and equipment were safe for use.
- We checked three vehicles at the Scunthorpe site on the first part of inspection and a further two on the unannounced inspection. One vehicle had been in an accident the previous week causing the ramp to be out of service. We were told control were aware of this so would not allocate this vehicle to any wheelchair users. However, on the dashboard there was a notice saying 'not road worthy – do not drive'. When we asked about this, the service lead said this was due to floor straps that had been removed and were awaiting replacement. Prior to us inspecting it, they had confirmed that this vehicle was ready to go out on the road. We therefore had concerns about oversight of vehicle safety at site level.

- One WAV had two tension straps in the back to secure a wheelchair; the right hand strap behind the driver's seat was frayed and would not recoil. Staff told us the vehicle was in use and staff used a work around to ensure patient safety. Staff informed us this was an ongoing issue and had been reported on a daily basis via their daily check sheets for a long time but nothing had been done. The floor of the vehicle had not been lowered resulting in patients in high wheelchairs/sitting on cushions or who were very tall travelling with their head on one side for the entire journey. If patients were not willing to do that, they had to wait for a more suitable vehicle to arrive.
- Another vehicle had been involved in an incident causing damage to the bottom of the bumper. A member of staff told us this happened 'three or four months ago' and was reported but the damage had not been repaired and the vehicle was still being used.
- At the time of inspecting the new Scunthorpe site, someone from the external maintenance company arrived with seven sets of wheelchair straps and informed us he would be replacing all the damaged wheelchair straps on vehicles the day of our inspection. We did not see issues with the wheelchair straps in the two vehicles we checked when we returned on the unannounced.
- Staff told us vehicles were not always fit for purpose and they were expected to take them out with equipment faults. These concerns from the Grimsby and Scunthorpe sites were in line with concerns raised to us from staff both before and after the inspection, in relation to equipment and vehicles, particularly around wheelchair securing straps and wheelchair access vehicles. A service lead we spoke with on the unannounced inspection at Grimsby was aware there were equipment and vehicle issues, particularly in relation to wheelchairs and had escalated these concerns. For example, they said recently a handle had snapped off the wheelchair during use. They raised concerns that there was no clear escalation policy or clear named persons responsible for vehicle and equipment maintenance.
- We were unable to see any completed daily vehicle checklists for the last six months at Grimsby and Scunthorpe. However, at Scunthorpe, there was a large cardboard box of older vehicle checklists dating back to January 2017 and earlier, but it was not clear whether these were being checked and who had responsibility. Following the inspection, we requested an example of daily vehicle checklists used at Grimsby and Scunthorpe and any applicable audits of these documents for last 3 months. However, we did not receive this, which heightened our concerns about the lack of oversight and monitoring of the vehicle checklists. A director we spoke with at Scunthorpe said that, as of the end of September 2017, the electronic vehicle check sheets would be documented within the service's electronic portal and app. However, when we returned for the unannounced inspection on 4 October 2017 this had not yet taken place.
- At the Scunthorpe site on the announced inspection we were shown a set of movable steps that had been bought for WAV vehicles to aid patient access. However, they were stowed in the passenger well unsecured so could present a risk of injury if the vehicle was involved in an incident. No risk assessment had been undertaken for these steps, which we raised as a concern to the on-site lead. When we returned for the unannounced we saw the steps again, and a service lead confirmed there had been no risk assessment carried out.
- Staff we spoke with at Scunthorpe raised concerns that vehicles were due to have MOTs and told us three had failed on the same day as our inspection. Following our inspection we requested documentation of vehicle MOTs for the three sites we inspected but the service did not provide this.
- A service lead at Grimsby told us on the unannounced inspection that two of the phones used by staff to receive their patient bookings were broken and there were not enough phones and chargers on site to go round, meaning staff sometimes had to use their own phones. There was no clear process or point of contact to for the repair and replacement of phones.
- We were sent an incident report log for vehicle and equipment issues, which was provider wide and stated for each entry which site it related to. However, it was not clear from this log whether issues had been addressed and when. Out of a total 30 entries recorded between February and September 2017, six were documented as 'completed' but only one had a corresponding date of when it had been completed. Five entries did not document the date of the incident.

Two entries had an estimated date of 6 April 2017 but in the 'notes' section they still showed 'awaiting authorisation' from the registered manager. It was unclear from this log which issues had been addressed, progress as to actions, who had oversight of vehicle and equipment issues and who was responsible for keeping this log up to date.

- We saw evidence of 'daily vehicle situation reports' for July and August 2017 for the three sites, following our inspection. These were sent to service managers and highlighted the vehicles that were currently off road, reasons and any actions ongoing to repair them.
- We saw certificates of motor insurance were in date for all the vehicles we inspected.
- We inspected the station areas and facilities and each of the three sites. There was secure key coded access used at each site. Much of the Canvey Island site was no longer in use as the work from that base had decreased significantly since our previous inspection.
- The Grimsby site had indoor parking for vehicles and had recently been refurbished, with a new kitchen, crew room, and toilets. There was also sufficient space for staff to park their own vehicles.
- On the day of our inspection, the Scunthorpe site was in the process of moving so we were unable to fully assess this site. We returned to the new site on the unannounced inspection. At the new site there was indoor parking, offices, toilet and kitchen facilities, a staff room and equipment store.
- We checked the equipment store room at the new site on the unannounced inspection. It was disorganised and unclear in its layout. For example, there was a baby car seat on the floor of the store room. We asked whether this was suitable for use and were told it was not, but there was nothing to warn staff of this. Although the site was still in an early stage following the move, we were concerned there was a risk of staff picking up equipment from this store for the vehicles which was not meant to be used.
- We checked the equipment stock room at Canvey Island on the announced inspection and saw there was an adequate supply of replacement equipment including uniforms. All stock we checked was in date. Stock was checked every two weeks and an order was made once a month. The stock list showed that staff recorded when items had been taken from the store and the quantity remaining.
- We inspected the consumables store within the operations centre at Canvey Island. There was a stock issue list displayed to monitor what had been taken and needed replacement, and expiry dates were on the outside of boxes. All consumables we checked in this store were within date.
- The equipment stock room at Grimsby was clean and well laid out. We checked 22 pieces of equipment in this room; including oxygen masks, oxygen meters and nasal cannulas, and saw they were all stored safely and within expiry date.
- Following the inspection, we requested the service's equipment log or evidence to show how equipment was checked, including equipment stock audit for the last six months. We received spreadsheets of 'service reports' for the Canvey Island, Sussex and Ipswich sites, with an external company named. These consisted of a list of equipment and the manufacturer, when it had been tested by this external company, pass/fail and any recommendations. However, this spreadsheet did not provide assurance that all equipment was being checked across all sites and how regularly. The Sussex and Ipswich spreadsheets were from September 2016. The Canvey Island spreadsheet documented equipment testing from August 2016 to December 2016. There was no spreadsheet or other evidence in relation to equipment at the Grimsby and Scunthorpe sites. We were therefore not assured that equipment was being regularly checked across all sites to ensure it was safe for use and it was unclear who was responsible for this.
- Oxygen cylinders were stored securely and appropriately at all three sites we inspected. They were locked in a storage unit, with empty and full cylinders clearly separated and a sign to distinguish empty and full, although stored within the same unit.

Medicines

- The vehicles only carried oxygen and no other medicines.

- The service still held a Home Office controlled drugs licence because they had in the past carried out urgent and emergency work, but were not actively using this and were not going to renew this upon expiry.
- There was a management of medicines policy, last reviewed in February 2017, which was accessible via the intranet to staff at the Canvey Island site. However, this did not contain any information on transporting patients' own medicines, which service leads confirmed sometimes happened.
- We had concerns the policy had not been shared with staff at all sites, which we have reported on under the 'Effective' domain.

Records

- Staff accessed patient booking information via the electronic system, including collection times, address and other relevant information such as medical conditions, mobility, oxygen needs and escort if applicable. If any issues or changes in the patient's condition arose during the journey, staff would document this electronically through the service app. This would then act as the service's own record of patient journeys. However, this was not being audited.
- Individual patient records supplied by any contracting NHS trust were transported with the patient during journeys. We were unable to review any records because they went straight to the receiving provider and the service did not keep any on site.

Safeguarding

- Following concerns in relation to safeguarding identified at our previous inspection in November 2016, the service developed an action plan to improve safeguarding processes. While we saw some improvements at the Canvey Island site, we were not assured that these were embedded across all sites.
- There were up-to-date policies for safeguarding both children and vulnerable adults. We had seen these prior to inspection as they had been part of the service's action plan following our previous inspection in November 2016. Staff at the Canvey Island site were aware of the policies and how to access them. However, these policies had not been shared or embedded at all sites. Staff at the Grimsby site were unable to locate this policy and were not aware of what it included.
- At the Canvey Island site, the service had implemented a rapid review panel to oversee safeguarding referrals. The service had also employed a safeguarding lead since our last inspection, who was trained to level four in safeguarding. They were responsible for overseeing all safeguarding referrals and investigations for the service. We were told staff could access them for advice and support in relation to raising and reporting safeguarding concerns. We were unable to speak with the lead at the time of inspection as they were on leave.
- We reviewed ten sets of minutes of rapid review panel meetings from April to July 2017, which involved discussion of safeguarding concerns raised by staff at various sites and actions following discussion. However, they were not consistently clear and comprehensive. For example, the actions from May and July had no date stated for completion and there was no documentation to show the actions had been carried out. For example, there was an action to 'review the Patient Handover Policy and Procedure and ensure all crew adhere to the Procedures' but no evidence of this being carried out following the meeting. One set of minutes from June 2017 did include a post-meeting note to provide an update as to the actions but the other minutes did not include this.
- Operational staff were trained to level two in safeguarding children. The registered manager told us that all staff were undergoing face-to-face safeguarding training delivered by the NHS ambulance trust and this had been well received by staff. However, the training data we requested after the inspection showed two compliance rates - 7% for ECAs who had been transferred under the Transfer of Undertakings (Protection of Employment) regulations (TUPE), and 100%for ACAs. We could not fully assess this as the data did not provide actual numbers of each staff group, or whether there were mitigating actions or reasons for the lack of this training for the TUPE'd staff.
- We had concerns around the documentation of safeguarding referrals. We reviewed the safeguarding referrals that were recorded from January – September 2017 and found it was not clear which safeguarding concerns had been to the rapid referral panel; whether they had been subsequently closed; or if there were any further requirements of actions from the provider. For

example, one concern recorded in January 2017 did not show whether it had been reviewed at the rapid review panel and whether there were any outstanding actions for the provider.

- We spoke with a safeguarding 'champion' at the Canvey Island site who was trained to level three in safeguarding children and adults. Their role was to provide support for staff who were unsure about potential safeguarding concerns. They reviewed any safeguarding concerns submitted at the site and then escalated them to the registered manager. Within the operations centre at the Canvey Island base there was a sealed box for staff to submit safeguarding referrals out of hours.
- The registered manager told us there were plans to have a designated safeguarding champion at every base. However, this was not in place at the time of our inspection, so we were not assured that staff at all sites had access to a named member of staff with appropriate training, skills and knowledge to provide safeguarding advice. This was also not in line with the service's own action plan dated April 2017, which stated that level three training was scheduled for all staff. This was following a requirement notice issued following our previous inspection, which stated that the service 'must make sure there is a suitable clinical professional employed, with sufficient qualifications, skills and experience to be responsible for the services responsibilities in relation to safeguarding both vulnerable adults and children to demonstrate lines of accountability, reporting and investigation'.
- We had concerns around the safeguarding arrangements at the Grimsby and Scunthorpe sites. At Grimsby, we were told the process was for staff to escalate safeguarding concerns directly to the team leader (verbally or on a paper report). However, it was not clear what the escalation arrangements past this point were, or how the service ensured appropriate learning and feedback. Staff at these sites were not able to give examples of where they had received any feedback or shared learning regarding safeguarding concerns.Within an appraisal form completed in July 2017 for a Scunthorpe staff member, they recounted a safeguarding issue relating to a vulnerable patient whose food was out of date. When we asked the service lead about this (who had completed this appraisal) they told us the incident had taken place months before and was not raised as a safeguarding concern at the time.
- We spoke with the interim mobilisation director at the Scunthorpe site, who told us the process was for a crew member to report the safeguarding concern to either their team leader or the control room at Lincoln, who would then forward it to the safeguarding email address.
- The service lead at Scunthorpe told us that if a staff member informed them of a safeguarding concern, they would be asked to complete an incident report form and the lead would then escalate it to the regional manager, and/or the local authority. This process was specified in the incident reporting policy that was in use at Canvey Island. This service lead told us they would contact the regional manager for any safeguarding concerns out of hours as well. When asked, they said they would telephone the local authority safeguarding team during the day if a member of staff reported a concern, which was specified in the service policies on safeguarding children and vulnerable adults.
- Three ambulance care assistants at Scunthorpe could explain what constituted safeguarding concerns. They said they would complete an incident report or tell the team leader and felt the issue would be dealt with appropriately. If a team leader was not available they said they would call the control centre in Lincoln to report their concerns. However, they were not aware if the service had its own safeguarding team and were not aware of the safeguarding email address to raise concerns.
- We were therefore concerned that there were discrepancies between sites in the process for escalating safeguarding concerns and a lack of clear process shared consistently with staff to ensure safeguarding concerns were reported and investigated appropriately.
- Three members of staff at the Grimsby site said they had not received safeguarding training for two years. This reflected concerns received from staff prior to inspection, namely that they were not up-to-date with

safeguarding training and did not feel supported to report safeguarding concerns (for example by having a clear process to follow that was shared consistently with all staff).

Mandatory training

- There was a lack of clear consistent processes across all sites to ensure all staff were up to date with mandatory training. At the Grimsby and Scunthorpe sites in particular, it was not clear who was responsible for ensuring this.
- We spoke with the training coordinator at the Canvey Island site. They only had access to training records for the staff at that site and said this was the case for each site. However, team leaders we asked at the Grimsby and Scunthorpe sites were not able to access training records for their staff. We were therefore not assured there was effective oversight of training compliance to ensure staff were up to date with mandatory training and booked onto refresher training where required.
- We requested training compliance data for the sites we visited after the inspection and received a document showing training compliance for each module, including manual handling, However, the information was not broken down by site or by staff member, for example to show where a staff member was overdue in specific modules, or to show the dates of training completed. It was therefore unclear how training compliance was being monitored to ensure staff remained up to date.
- The data showed variable compliance rates. For example, 81% had completed IPC training; 88% had completed basic life support training. However, only 4% had completed bariatric manual handling training, although it was not clear whether this was mandatory for all staff or whether it was an additional training course.
- Staff at the Grimsby and Scunthorpe sites in particular told us they were not up to date with mandatory training; therefore, we were not assured as to the accuracy of the data or the sites to which it applied. The data also did not specify a target compliance rate.
- Driving training had been carried out by a driving assessor for the staff at Canvey Island before commencing employment. However there was no evidence of formal driver training for the staff at Grimsby and Scunthorpe. While the staff who had transferred to the service under TUPE had received driver training under their previous employer, they had not received any training from the service since transferring.

Assessing and responding to patient risk

- The service had a deteriorating patient policy in place. This was an improvement from the previous inspection where there had not been one. This stated that in the event of deterioration during transfer, staff must dial 999.
- In the case of cardiac arrest or respiratory arrest, the policy stated the vehicle must be pulled over and appropriate treatment started, following basic resuscitation guidelines, call and follow the advice of the emergency service. Upon arrival of the emergency crew, there would be a handover to them.
- Staff could explain what they would do in the event of serious deterioration of a patient's condition, namely dial 999, although operational staff at all three sites did not show awareness of the policy itself. Staff would document a deterioration in a patient's condition on the service electronic portal which showed the patient's booking information and would also inform the control room.
- Conflict resolution was not included in mandatory training for staff, although staff, including the area manager, confirmed they frequently encountered situations of violent or aggressive patients. Therefore staff may not have been equipped with the appropriate resources and knowledge to best deal with aggressive patients or difficult situations. The policy on lone working also stated that staff who may be involved in lone working must have this training, so there was a risk the service was not compliant with its own policy.
- Staff said they would refuse to take a patient if they felt the patient posed a particular risk which had not been communicated to staff in advance by the hospital or which became evident such as patients with severe mental health difficulties or particularly challenging behaviour, as staff were not trained to transfer such patients.
- The service did not transfer patients detained under the Mental Health Act. However, in meeting minutes from March 2017 included discussion about the transfer of a

patient with severe mental health difficulties who had been assessed under the Mental Health Act. This had occurred because the full patient information had not been communicated to the crew. The minutes stated that they were in contact with the CCG and the discharging trust to investigate this.

- It was not clear what the service policy and procedure was relating to transporting children and the risks this could present. We were told they transported children on very rare occasions but when we requested data showing the number of children transported by the service (across all sites) in the last 12 months, the service did not provide this evidence. Meeting minutes from March 2017 discussed a case of a 12 year old child booked for transfer, which stated the child should not have been booked for the service due to aggression and behavioural problems. We were not assured staff were equipped and supported to recognise and respond to risks transporting children.

Staffing

- Operational staff were all ambulance care assistants (ACAs). Some staff who had transferred across under the Transfer of Undertakings (Protection of Employment) regulations TUPE were qualified as emergency care assistants (ECAs) but were working in an ACA capacity only due to the solely PTS scope of the service. At Canvey Island, staff worked on a three-week rota and confirmed they received sufficient time off between shifts.
- The service did not rely on bank or agency staff, but did employ some volunteer drivers.
- There were 42 staff at Grimsby and 45 at Scunthorpe which comprised staff who had previously worked for the NHS patient transport service and been moved under TUPE; new recruits; and bank staff.
- Team leaders were responsible for putting together rotas. We were told these were sent to control on a weekly basis, and control staff would then allocate staff to jobs for the following week.
- We could not identify how many times a shift could not be filled because this information was not monitored. Two members of staff we spoke with in the Canvey Island control centre said that 'occasionally' they had to refuse patient journeys due to staffing.

Response to major incidents

- The service had a comprehensive Business Continuity Plan, which was under review at the time of inspection. It had last been reviewed in March 2017. This included guidance on specific incidents for example, fire, gas or electrical incidents, staff shortages and flood damage.
- However, because of our concerns around policies in general, which we have reported on under the 'Effective' domain, we were not assured this policy had been shared with staff at all sites outside Canvey Island.
- Training in responding to major incidents was not included in the mandatory training provided by the service.

Are patient transport services effective?

Evidence-based care and treatment

- There was a lack of consistency in awareness of how to access policies and procedures. In the Canvey island base, there was a notice to staff explaining where policies could be found. Service leads confirmed they would access them electronically via the intranet, but an ACA at Canvey Island said they would access them within physical files in the control room. Staff at the Scunthorpe and Grimsby site told us they would access hard copies of policies within the station. This was a concern, particularly because policies from the Canvey Island site stated they were to be shared with all staff across all sites via the intranet; however, this did not match what staff told us in Grimsby and Scunthorpe.
- We reviewed a policy folder at Grimsby and found many of the policies to be out of date, including the Control of Substances Hazardous to Health (COSHH) policy (due for review January 2017); whistleblowing procedure (due for review June 2017); management of patients with infection policy (due for review September 2016) and major incident policy and procedure (due for review February 2017). We raised this with the regional operations manager, who told us the most up to date policies were stored electronically so the paper copies did not apply. However, they could not access this information online for us to review when requested; and two team leaders and operational staff confirmed that the sites only had paper copies.

- A service lead in this region recognised that many policies were out of date and was planning to update them. However, they had no clear point of contact to achieve this. They were not made aware of the up-to-date policies that we received at the inspection of Canvey Island. This was a concern as the service was not showing compliance at a provider-wide level with their own action plan following the previous inspection, which specified that the service must 'ensure that policies, procedures and protocols are in place, up to date, reflect current practice and ensure that staff are aware of them to provide safe patient care and treatment.'
- It was evident that information and updates to policy, best practice and guidance, was not being shared between sites to ensure staff were working to the same policy and standards.
- Service leads at the Grimsby and Scunthorpe sites confirmed no audit activity was taking place there. When we requested audit data for these sites following our inspection, we did not receive any. Therefore, we were not assured the service was monitoring its own performance, quality, safety and activity. This also meant the service was not compliant with its own action plan that had been established in December 2016 following our previous inspection.
- There was an audit plan for 2017 which we received following the inspection. This document included 23 individual audit items such as deep cleaning, information governance and patient satisfaction. Each item showed whether a team leader, area manager, or regional director was responsible. However, there was no evidence this was being carried out at Grimsby and Scunthorpe. Service leads who were specified (by role rather than name) as being responsible for some of these audits, showed no awareness of this plan and told us audits were not being carried out, and there was no evidence of audit results.

Assessment and planning of care

- The service had recently introduced an electronic system for managing bookings and planning patient transport. The electronic booking system was supported by a software application that delivered details of patient journeys to crew mobile phones. Staff in the operations centres at Canvey Island and Lincoln (for the Grimsby and Scunthorpe staff) allocated staff to patient journeys as bookings came through. Staff had individual password protected accounts to access this system.
- However, staff reported there were issues with the system. Three members of staff at Canvey Island said that while the app was useful in planning patient journeys, in practice it did not function reliably. In this event they would call the control room to find out where they needed to go. A member of staff at Grimsby told us that, because they were working on overtime, the app did not allow them to be allocated to bookings so they had to go directly to the local acute trust to find out which patients required transport.
- Service leads recognised that the system was still in its early stages of implementation and that further development was needed for it to ensure staff had reliable access to see the journeys to which they had been allocated.

Response times and patient outcomes

- Managers could not show us clear systems to monitor response times for patients, or explain how this was done; therefore it was not clear whether the service was meeting targets set by each clinical commissioning group. Managers at all three sites could not show us a system or document for this information when we asked on inspection. We also sent a data request for this information after the inspection and did not receive anything. We asked how the service would, for example, be able to show the number of delayed transports as a proportion of their overall transport and they were unable to provide an answer.
- The electronic system used for bookings required crew members to log the time they picked up patients and the time of drop off; however, there was no evidence this information was being collated and monitored so managers could have oversight of response times.
- Following our inspection, we requested evidence to show the number of delayed transfers in the past 12 months, as a proportion of all transfers carried out. We also asked for information on how is this monitored, and who is responsible for monitoring across all sites at the service. The service did not provide this.

- We also requested any additional documentation to monitor the service's activity, such as the number of patient journeys, response times, time on vehicles, and same day booking figures within the last year, but the service did not provide this. Therefore we could not fully assess performance.

Competent staff

- We had concerns about the lack of clear processes to ensure that all staff had the necessary skills, knowledge and competencies and a lack of support for operational staff to carry out their roles effectively, both on commencement and on an ongoing basis.
- There was no formal induction procedure for staff at the Grimsby and Scunthorpe sites. A team leader told us all TUPE'd staff had undertaken vehicle familiarisation and introduction to the electronic system upon commencement of the contract in October 2016. TUPE stands for the) Regulations. This is relevant to any redundancy decisions where a business or part of it is transferred from one owner to another. A manager at Scunthorpe said all these staff would have undertaken vehicle familiarisation, equipment familiarisation, wheelchair restraint system and infection, prevention and control (IPC) awareness, but stated staff 'probably wouldn't have recognised it as training'. However, this was not documented and we were therefore not assured as to the induction processes.
- The team leaders at all three sites had not received additional training or development to help them carry out this more senior role competently. One team leader said they had not received any formal induction, and had been expected to carry out their role straight away without a clear explanation of their responsibilities. This was a concern as these staff were responsible for the day-to-day operations at site level.
- We received 11 enquiries through the CQC electronic reporting system between January and October 2017 regarding lack of appropriate training to ensure staff were competent to carry out their roles.
- We requested evidence of staff competencies on equipment used in ambulances such as wheelchairs, ramps, stretchers - for staff at Grimsby and Scunthorpe and did not receive this. We were therefore concerned that the service was not ensuring staff were appropriately trained and supported to use the equipment required in their day to day roles.
- Service leads told us that staff at the Grimsby and Scunthorpe sites who had been transferred from their previous employer under the Transfer of Undertakings (Protection of Employment) regulations had their training records transferred to ensure they had the necessary skills and competencies when the contracts commenced in October 2016. We requested evidence of this and received a list of staff names and the dates of transferring the training records; however, only basic life support and manual handling were included in this.
- We were told by administrative staff at Canvey Island and managers in Grimsby and Scunthorpe that disclosure and barring service (DBS) records were held by human resources department in Doncaster. Administrative staff at the Canvey Island site said they could not access these. A team leader told us they did not know when staff DBS checks last took place, but they had last had one in January 2016 as part of their previous role. We requested evidence of staff DBS checks and how this is monitored at Grimsby and Scunthorpe following the inspection. The service did not provide this information.
- We requested evidence of driving licence checks for all staff at the three sites we inspected. We received a list of staff names with a corresponding month when this had been done. However, this was not sufficient assurance that driving licences were being checked upon commencing work and monitored thereafter, as all the staff from Grimsby and Scunthorpe were listed as having their driving licences checked in October 2017. This was despite the data being requested in September 2017. All staff at Canvey Island were listed as having their licences checked in August 2017. It was therefore not clear from this list whether all driving licences were checked on commencing work.
- There were no arrangements for ongoing checks of driving competence, such as spot checks.
- We requested appraisal rates for staff prior to inspection as part of an information request under section 64 of the Health and Social Care Act 2008 but the service did not

provide this information. We received a template appraisal form and guidance for managers or team leaders on conducting appraisals and there was no formal policy related to appraisals.

- Following our inspection, we requested the percentage of staff who had undergone appraisals, for each of the three sites we inspected. The service did not provide this. Therefore we were concerned there was no system for monitoring appraisals to ensure staff were competent and supported. This was not compliant with the service's guidance on staff appraisals, which stated they should be carried out annually.
- This was supported by staff we spoke with. One ambulance care assistant at Canvey Island said they last had an appraisal in "early 2016". Three ACAs at Grimsby said they had not had an appraisal. In one staff file in Scunthorpe, there was an appraisal form that showed this member of staff had received no mandatory training upon transfer to the service and none since. This appraisal was deemed a 'tick box' exercise rather than a meaningful process to support staff and meet their needs.
- At a meeting we attended with the service in September 2017, prior to our inspection, senior managers acknowledged appraisals had not yet been carried out for all staff at the Grimsby and Scunthorpe sites and that as the contracts came into operation in October 2016, the staff had been in place for nearly one year so were due appraisals. However, by the time of our inspection, there was no evidence of any progress with this.
- Since the recent introduction of the team leader role over the previous six months, team leaders also had responsibility for carrying out appraisals. This was intended to share the responsibility and time taken to do appraisals. However, the team leaders at all three sites acknowledged it was an issue that they had not yet been able to carry out appraisals. This was due to a number of factors, including not having been allocated their team yet, and being new in post themselves. The team leader at Scunthorpe was responsible for 45 staff and told us they had done 'eight or nine' appraisals. However, as we did not receive the data, we were unable to verify this.
- We requested staff files at all three sites to review evidence of staff competencies and induction. At Canvey Island, administrative staff and team leaders were unable to access these on site and we were told these were held centrally by the HR team, which was based in Doncaster. We were therefore concerned about the potential lack of oversight at site level around maintaining and ensuring staff competencies, although one team leader told us there were plans to move towards site-specific electronic staff files. There was no timeframe in place for this.
- However, at Scunthorpe, managers had access to staff files and we were told there was a copy held at site and one at HR in Doncaster for each staff member. These were stored in a lockable filing cabinet. There was therefore no consistent procedure across sites for holding and maintaining staff files and it was unclear who had overall responsibility for this.
- We reviewed five staff files at Scunthorpe and found no consistency in their contents. One contained an incident report form completed by this member of staff and a statement of the main terms of employment, signed in November 2016. There was no other content. Another contained evidence of the last appraisal alongside personal details, but no other content. Another file contained personal details, evidence of a staff induction, HR policy signed to acknowledge understanding, guidance from the NHS Litigation Authority on duty of candour, copy of driving licence signed to give the service permission to access DVLA records, the service computer systems code of practice, declaration of other employment, working time regulations, copy of documents list received, staff training agreement, confirmation of receipt of ID badge, and copies of passport and driving licence.

Coordination with other providers and multi-disciplinary working

- The service had recently employed a patient transit coordinator located at the contracting acute trust to manage patient transfers under the contract operated from the Canvey Island site. The area manager also attended monthly meetings with the trust and had twice-weekly calls with the trust and local clinical commissioning group (CCG). However, one ACA who had worked for the service for two years was unaware of the patient transit coordinator.

Patient transport services (PTS)

- At Grimsby we were told there were two ambulance liaison officers (ALOs) based at the local acute trust to be the point of contact between the two services.

Access to information

- We requested the service's policy on transporting patients with a do not attempt cardiopulmonary resuscitation (DNACPR) order in place, however, they did not provide this. We were told by an ACA and staff in the control centre at Canvey Island that if crew were informed there was a DNACPR in place, they would request to see the original document as evidence. The ACA was able to give an example of when this had happened.
- Staff said they did not always receive the information they needed from a discharging hospital, such as whether a patient had MRSA or any particular mobility needs. This meant they often arrived and realised they would not be able to carry out the transfer, for example if the patient had obvious mental health difficulties, as staff were not trained in this. We were told this was partly due to issues with the service's bookings system and partly due to a lack of information provided by contracting NHS trusts at the time of booking. The team leader we spoke with at Canvey Island gave an example of a husband and wife living with dementia, who were both discharged at the same time and said in such cases the staff would need to check there was a care package in place as the hospital did not always provide this information.
- However, they confirmed they were not recording this or reporting it as an incident so it was not possible to assess how many journeys were aborted due to the appropriate patient information not being communicated.
- There was a pack allocated to each vehicle at the Canvey Island base with 22 items such as safeguarding referral forms, an allocated phone, and various guidance for staff. This pack was picked up and returned by staff at the beginning and end of each shift.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not receive training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Staff who had transferred to the service under TUPE had received training from their previous employer and showed awareness of the principles, but this had been over a year before our inspection and they had not been supported by managers in the service to maintain knowledge and training regarding capacity.
- There was a policy on MCA accessed electronically, which had last been reviewed in August 2017. However, the information in this policy was generic and had not been adapted to explain what staff in the service specifically should do if they had concerns about a patient's mental capacity.
- Also, because of our concerns around the consistency of policies and procedures, we were not assured this had been shared with staff at the Scunthorpe and Grimsby sites.

Are patient transport services caring?

Compassionate care

- We spoke with five patients in the renal unit of a local acute trust who were regular users of the transport service. They all told us that operational staff were caring, friendly and helpful. For example, one patient told us staff "treated them with kindness" and another said they "have a laugh with them".
- We were unable to directly observe any patient transfers at the time of our inspection. However, operational staff we spoke with displayed a patient-focused approach to carrying out transfers and could give examples of providing compassionate care.
- Staff explained they would maintain patients' dignity by using blankets to cover them if required. The team leader we spoke with at Canvey Island said that privacy and dignity could be an issue as the hospital sometimes discharged patients wearing only a hospital gown. In this instance, we were told staff would insist on the patient being fully dressed prior to transfer.
- Following the inspection, we requested patient feedback for October 2016 – September 2017 to assess patient experience; however, the service did not provide this.

Understanding and involvement of patients and those close to them

Patient transport services (PTS)

- Patients and relatives were not consistently kept informed of delays to planned journeys. This was confirmed by all patients we spoke with during inspection as well as staff at a receiving local renal unit.
- Operational staff we spoke with displayed a patient-centred approach to care and consistently told us they enjoyed chatting to patients and their families.

Emotional support

- As we were unable to observe any patient journeys and did not receive patient feedback from the service, we were not able to fully assess how staff supported patients in their emotional needs at times of distress.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- In the previous 12 months (October 2016 to September 2017), the service had grown significantly to provide patient transport services (PTS) from 16 sites nationwide.
- The service was commissioned by local clinical commissioning groups (CCGs) to transport patients, who were unable to use public or other transport due to their medical condition, to local NHS acute hospitals. This included those attending hospital outpatient clinics, hospital discharges, and transfers to regular treatment such as chemotherapy or renal dialysis.
- The contract at the service's Canvey Island base was solely for transporting dialysis patients to one local acute NHS trust. At Grimsby and Scunthorpe there were similar renal dialysis contracts with the local acute trusts and staff also carried out ad hoc PTS work for outpatients appointments and discharges from hospital. Patient journeys were therefore a mixture of pre-booked transport and on-the-day bookings. However, the service did not provide us with information on booking numbers.
- Managers at each site could not explain how the service was monitoring any key performance indicators to ensure services were planned and delivered to meet patients' needs, or show us any systems for this. We have reported on this fully in the 'Effective' domain.

Meeting people's individual needs

- There was no specific training for staff in meeting the needs of patients living with learning disabilities or dementia, although staff confirmed they did regularly transport such patients. However, the team leader at Canvey Island and operational staff at all three bases showed an understanding of adapting their communication to meet the needs of such patients despite the lack of formal training in this area.
- The service did not have its own access to translation services for patients whose first language was not English. The team leader at Canvey Island told us they would go through the hospital's translation service if staff felt this was necessary. This was a concern as the service covered a broad geographical area and population demographic and would regularly transport patients whose first language was not English.
- There was a bariatric vehicle at both Scunthorpe and Canvey Island sites equipped to meet the needs of bariatric patients. Bariatric patients and their places of residence were risk assessed using a dedicated bariatric pro-forma. We reviewed this pro-forma following inspection and saw it contained a questionnaire and appropriate risk framework to guide staff when transferring bariatric patients.

Access and flow

- The service ran contracts awarded from clinical commissioning groups (CCGs). Patients were booked for transport against a set of eligibility criteria, which was determined by the contracting CCG.
- For the contract carried out from the Canvey Island base, the contracting acute NHS trust booked the transport for patients according to the patient admission criteria. The admission criteria were set by the local clinical commissioning group (CCG). Jobs were booked and allocated in the control room at the Canvey Island base. Jobs were booked through the control room at Lincoln for both the Grimsby and Scunthorpe sites.

Patient transport services (PTS)

- We had concerns about patient access and flow due to the high level of delayed journeys. Prior to this inspection, we had received 25 concerns from both patients and staff, between March and October 2017, regarding delayed transport. All five patients we spoke with on inspection also raised concerns about frequent delays or vehicles not arriving at all. For example, one patient said a family member now often drove them to the hospital as staff were regularly arriving two hours late. One ACA at Grimsby told us that two or three weeks prior to inspection, there had been a day when 13 patients were left waiting at Grimsby Hospital for several hours. Many of these patients ended up paying for taxis to take them home because they had waited so long for vehicles to arrive and there had been no communication from the service as to when their transport would arrive.
- Managers also recognised delays were a concern. This was reflected in the complaints data we requested from the service. For example, one complaint raised by a member of staff at a receiving provider stated there was a delay of six hours between the agreed pick up time from the hospital and the time the ambulance actually arrived for pick up.
- Two members of staff we spoke with in the operations centre at Canvey Island told us that it would not be formally reported as an incident when there was a delay with transport or if the transport did not turn up at all. This was also confirmed by staff at the Grimsby and Scunthorpe sites.

Learning from complaints and concerns

- There was an up-to-date complaints policy and procedure at Canvey Island. This specified the relevant members of staff involved in investigating complaints, and the timescale for responding to complaints; namely three working days to acknowledge the complaint and 25 working days to respond to the complaint, although it did not state whether this was in writing.
- However, we were concerned that the policy and awareness of the complaints procedure was not shared among all sites. Staff including service leads at the Grimsby and Scunthorpe sites were not aware of how to access the policy or who was responsible for investigating complaints and concerns; and could not give examples of feedback or learning from complaints. One ACA at Scunthorpe said that if a patient wished to complain, they would give them the service's control centre telephone number and also direct them to the Care Quality Commission.
- We requested the complaints log for the past 12 months for all sites. The service only provided complaints records for the southern region. There was no record of complaints for any sites in the northern region, although we had been told by staff including managers that complaints had been reported by patients and families in the region, including one example of an alleged injury to a patient during transfer (which had also not been reported as an incident). We were therefore concerned complaints were not being reported and monitored.
- Furthermore, the complaints records we received in relation to the southern region were kept as individual documents and there was no formal log collating them together. This added to our concerns, as there was no evidence the service was tracking complaints in a formalised way to monitor themes and trends. It was also not clear whether the service was compliant with its own policy in terms of time taken to respond to complaints, and there was no audit to assess this. However, we saw an email from the service sent in September 2017 to a receiving provider apologising for a delayed response to 38 complaints and stating they could not provide a response at this time.
- The information that we did receive showed there were 54 complaints in the southern region that were currently open and 56 that were closed. Some of the closed complaints were outside of the 12 month time period that we requested, for example from May 2016. Within the closed complaints, it was not always clear why they had been closed and there was limited record of actions taken or any responses to complaints. For example, there was a letter of complaint from June 2017 relating to poor driving by staff at the service. This had been closed but there was no accompanying evidence to show what the service had done in response, or any lessons learned and actions taken.
- The registered manager acknowledged that there had been a recent increase in the number of complaints due to a backlog, which had come through via the acute hospital's Patient Advice and Liaison Service (PALS). They told us the main complaints related to delays to patients awaiting transport. This matched the concerns

we had received directly from patients and relatives or carers in the six months prior to the inspection. This was also confirmed by staff we spoke with both at the service and on the renal unit at the contracting acute trust for the Scunthorpe site.

- However, there was no evidence of actions to learn and improve from this complaints trend. For example, managers could not show us that they were monitoring numbers of delayed transfers in order to assess how to reduce delays. The team leader at Canvey Island said the service worked with the patient experience team at the contracting acute trust to discuss and work through complaints.
- We were also concerned about the lack of responsibility taken by the service in some of the responses to complaints that we reviewed from the evidence received. For example, in response to a complaint raised by a staff member about a six-hour delay to patient transport, the email response from the service stated that the delay 'could have been avoided if the patient had been booked and made ready earlier in the day rather than peak time'.
- We spoke with a patient who had concerns about the service at the Grimsby and Scunthorpe sites and had raised complaints several times regarding delays, lack of appropriate wheelchair access, poor communication and the difficulty of the telephone booking system. They told us the process was not clear and they had spoken to a number of staff from the service who had repeatedly assured the patient they would get a call back. The patient, upon request, had a face-to-face meeting with the chief operating officer (COO) and area manager to discuss their concerns and had been given the COO's direct contact details to escalate any further issues.

Are patient transport services well-led?

- The service had experienced significant change in leadership and management as they had taken on new contracts over the last 12 months with many new management posts at regional and site level. This meant that management of Grimsby and Scunthorpe in particular had been unstable. This was confirmed by the operations manager we spoke with at Grimsby (who was responsible for the northern sites).
- We were concerned that management and governance structures were not clear at site level. For example, a team leader told us they had only just been told they had responsibility for the two ambulance liaison officers based at the local trust. It was not clear who was making and communicating decisions such as this. One service lead said they felt each site operated in isolation and there was not much sharing or communication between sites.
- The service had recently appointed 'team leaders' at each base. The purpose of this was to oversee the day-to-day operations at site level. It was unclear and inconsistent what the roles and responsibilities of the team leaders were in practice. For example, at Canvey Island we were told one team leader was responsible for pay discussions with staff while another was responsible for audits and compliance. A team leader at Grimsby told us they were responsible for ensuring appropriate allocation of staff to jobs. The two team leaders we spoke with at Grimsby were unable to produce documentation we requested to see such as vehicle equipment checklists or staff information such as training records, although they were both recent appointments as one had started the role the day before and the other had been in post for three months.
- Staff reported to team leaders at site level, who reported to their area manager. The registered manager told us that the area managers were part of the senior management team who met on a monthly basis. Area managers reported to the regional operations manager. There was one each for the north and south regions. They then reported to the regional director, who fed into the senior leadership team. This was documented in a management structure sent to us in July 2017 following a data request under section 64 of the Health and Social Care Act 2008. However it was new and 18 out of 31 roles specified in the management structure were listed as vacant at the time of receipt.
- However, there was no evidence to show that this reporting and escalation system took place in practice and on a regular basis. For example, team leaders and area managers did not participate in any meetings that were minuted.
- Staff across the Canvey Island, Grimsby and Scunthorpe sites reported that the senior management team was not visible, although one member of staff said the senior

team were "responsive" and spent time in the operations centre once a month to speak to staff. The registered manager informed us that the executive team visited sites monthly.

- We received concerns prior to inspection from staff at non-registered locations (such as Grimsby and Scunthorpe) who felt they had no point of escalation past their team leaders for any concerns they might have. For example, staff told us they raised concerns about equipment but these were not addressed; and they had been told they were not allowed to contact payroll directly for any pay queries but had to go through their manager instead.
- There was evidence of a poor culture and morale at the Grimsby and Scunthorpe sites, in relation to staff feeling unsupported. Nine members of staff across these sites told us they felt unsupported or undervalued, or not listened to. For example, in Scunthorpe, one ACA described the service as 'inept and disorganised' and felt that they could not raise concerns. Another said 'managers stick up for each other and don't give you a clear answer' to questions or concerns. When we approached a group of five staff waiting for vehicles to return, they told us they had been told they must not talk to us but did not tell us by whom.
- A service lead at Grimsby said the service was 'reactive rather than proactive' to concerns. Three ACAs at Grimsby told us they did not feel listened to. The two team leaders we spoke with at Grimsby acknowledged there was an ongoing issue with staff morale and this needed improvement. This reflected the evidence we had received from operational staff before, during and after the inspection around poor morale and staff culture.
- Culture was more positive at Canvey Island. The two ACAs we spoke with said they felt supported and there was always a manager to contact.

Vision and strategy for this this core service

- There was no vision or strategy. This was confirmed by the chief executive officer (CEO). They told us that they were focusing on developing a vision and strategy now that new contracts were up and running. They also said they would not be taking on any new contracts over the next year to allow time for the current ones to settle, due to rapid growth over the previous 12 months.
- Team leaders and regional managers also did not show awareness of any vision, values or strategy for the service. One manager said they thought the vision was to be 'the biggest and best' private ambulance service and that the values of the organisation were based on the patient, but there was nothing shared with staff or documented.
- There was no evidence of staff involvement, or taking account of feedback from operational staff, in developing the strategy and future of the service.

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

- Governance, risk management and quality measurement processes were unclear, particularly at the Grimsby and Scunthorpe sites. The service had experienced fast paced expansion in its PTS work over the past 12 months. However, we were concerned that governance and risk management processes had not been fully established prior to taking on new contracts to ensure the service was able to manage these effectively and safely.
- The service had a clinical governance strategy, last reviewed in February 2017. We were sent this information following a data request under section 64 of the Health and Social Care Act 2008. This set out a three year plan from 2015 to 2017. The 2017 objectives included 'to embed learning from adverse incidents and audits matched to training and supervision' and 'to further develop patient involvement and mechanisms for capturing feedback in a comprehensive and timely manner'. Based on our findings outlined in the sections above, we were not assured the service was working towards these.
- The clinical governance strategy specified that the terms of reference of the clinical governance group (CGG) were to 'determine, agree, monitor and audit the clinical strategy and oversee all aspects of clinical governance across TASL'; and 'to act as the focus and drive for all aspects of clinical governance across TASL, by receiving input from relevant managers and external advisers as appropriate'.
- However, this did not match the clinical governance group terms of reference that we received following our inspection in September 2017 which were more

detailed. It was not clear which document was being used. Also, the service was not compliant with these terms. For example, these terms of reference stated one of the CGG objectives was 'to identify areas for improvement from the review of Serious Incidents, patient surveys/PALS and complaints/incidents including the identification of any themes or trends and ensure appropriate action is taken'. Based on our concerns about the lack of monitoring and learning from incidents and complaints, the service was not meeting this.

- Service leads at the Grimsby and Scunthorpe sites did not show awareness of the CGG or participate in any clinical governance meetings. This heightened our concerns around governance, particularly because we had existing concerns in relation to systems and processes around incident reporting, documentation of infection prevention and control, and audits and we were not assured there was proper oversight of these issues. The two team leaders we spoke with at Grimsby acknowledged there was still a lot of work to do around governance processes.
- There was a lack of oversight from regional service leads about the risks in their areas and about their performance in terms of waiting times and monitoring delays for patients. When we spoke with the operations manager during our inspection of the Grimsby site, they were unable to demonstrate oversight of the governance and risk management processes and it was unclear who was accountable for each role and responsibility. This manager stated they were not aware of a risk register or any systems for monitoring and mitigating risk. However, they were named as the responsible owner for the Gateshead locality risk register when we reviewed this following inspection.
- We reviewed the service's operational and corporate risk registers which were held electronically. There was clear identification of the risk; a red/amber/green (RAG) rating; control; and actions. The individual owner for the risk was identified at the top of the register. However, review dates of each individual risk were not clear. For example, risk S012 had been on the register since February 2015 in relation to failure to keep up to date with legislation and guidance, but there was no documentation of any actions in place, review dates, or explanation as to why the risk was still open. Another risk was rated as 'high' risk, to be reviewed monthly. However, there was no documentation of when the risk was last reviewed, or any actions taken to mitigate the risk. Therefore, it was not clear how risks were being regularly monitored and mitigated using this register.
- A member of senior management at Canvey Island told us that one of their main current operational risks was the implementation of the electronic booking system and their main corporate risk was around staff turnover and the difficulties of transferring staff to the new contracts under TUPE. These were included on the service's risk register, although the implementation of the electronic booking system risk was only included in the Essex locality spreadsheet even though it applied provider-wide.
- Three team leaders we spoke with at Grimsby and Scunthorpe were not aware of any systems for monitoring and mitigating risk, such as a risk register. It was therefore unclear how risks from these sites were being escalated to ensure that these locality risk registers accurately reflected risks at individual sites.
- There was no record of any meetings occurring in the northern region. The regional operations manager told us they had weekly meetings with the six area managers in the region but these were not minuted and there were no documented action plans from these meetings. We asked how they would follow up any concerns and they told us they would 'remember it'. We asked them if they took part in any other meetings that were documented and they said nothing was documented as far as they were aware. However, minutes from the senior management team meeting on 22 May 2017 name this person as being in attendance.
- There was a 'TASL Triangulation Assurance Group'. This had been established in January 2017 as part of the service's action plan following our previous inspection. The terms of reference stated its purpose was to 'undertake the strategic review of all complaints; incidents; serious incidents; safeguarding events; PALS contacts; claims; and other incidents'.
- We requested TTAG minutes for July – September 2017 in a data request following our inspection; however the most recent ones we received were from July 2017, although the terms of reference specified it was to meet monthly. The other meeting minutes sent under this

request related to a different group meeting, namely the 'Thames Ambulance Assurance Meeting'. It was unclear how these two meetings were distinct from each other as they both covered agenda items such as incidents, safeguarding and patient experience.

- These minutes included discussion of 12 separate complaints and it was noted that there was lack of information around lessons learned from these and there was a corresponding action to ensure appropriate detail was shared and ensuing action taken. It was also noted that 'the Lincolnshire register had not been updated, how do we know that concerns are being handled in a timely manner and then entered onto the register?' However, it was not clear to what this query related. There was a corresponding action, to 'provide assurance that all registers are complete and monitored' but it was not documented how they were going to achieve this.

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

- There were no means of public engagement at the service.
- There were no means of staff engagement at the service, although service leads said they were planning to carry out a staff survey later this year. Staff we spoke with reported that although they were aware of significant changes ongoing in the service, they were not involved in discussions about this.
- The last staff survey was published in January 2017 (carried out in November 2016). The response rate was 27%. The results of the survey identified concerns around the lack of team meetings, lack of appropriate training, poor communication from managers and a lack of recognition. There were no actions highlighted within the survey results to improve these issues. Due to our findings regarding similar issues, we were concerned the service was not committed to improving the service based on staff feedback.

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

- The service had experienced fast paced expansion in its PTS work over the past 12 months. However, we were concerned it did not have the systems and processes in place to carry this out safely and reliably, due to our findings for example around lack of monitoring service activity, lack of audit, poor support and management for operational staff and patient complaints.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must improve its incident reporting, investigation and learning processes.
- The service must improve systems and processes for deep cleaning and infection prevention across all sites.
- The service must ensure there are clear systems for reporting, monitoring and addressing equipment and vehicle issues to ensure all equipment and vehicles are safe for use.
- The service must ensure staff receive appropriate induction and training and yearly appraisals to ensure they are competent and supported to carry out their roles.
- 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 ensure risk is effectively monitored and mitigated at all sites include staff understanding and clear roles and accountabilities for the management of risk within the organisation.
- The service must improve documentation of meetings to ensure actions are recorded and followed up.
- The service must improve auditing and performance monitoring systems.
- The service must ensure that there is an effective system to record and monitor complaints (both verbal and written) to identify trends and areas for improvement.

Action the hospital SHOULD take to improve

- The service should implement a clinical quality dashboard or similar to provide an overall picture of safety and quality by collating information, for example around incidents, infections, safeguarding referrals, and complaints among other indicators.
- The service should consider providing training to its staff in order for them to meet the individual needs of patients.
- The service should ensure policies are consistent and shared among staff at all sites, and establish clear systems for staff to access policies.
- The service should implement systems for staff and public engagement to monitor and improve the delivery and effectiveness of the service which it provides.
- The service should improve access to information so that staff always have accurate information about the people they are caring for.
- The service should ensure that all staff have access to translation services to meet the needs of patients and relatives whose first language is not English.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment You have failed to meet the parts of the regulation stated because: There was a lack of oversight and documentation of vehicle and equipment issues at the Grimsby and Scunthorpe sites. Staff consistently told us that they raised concerns about vehicles and they were not addressed. Steps were stowed unsecured in the passenger well so could present a risk of injury, and no risk assessment had been undertaken for this equipment. There was no holder for phones in the vehicles we inspected at Scunthorpe and staff did not have hands-free facilities to safely answer phones when driving. This was a concern because staff told us there was an expectation from managers for staff to answer phones while on the road. At the Grimsby base, there was a potential health and hygiene risk due to bird faeces on the floor within the station where the ambulances parked and were cleaned. Service leads were aware of this but confirmed there were no specific actions or work ongoing to mitigate this risk. It was not on the locality risk register for the site.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints You have failed to meet the parts of the regulation stated because:

This section is primarily information for the provider

Requirement notices

There was no clear process for managing and learning from complaints across all sites. Staff including service leads at the Grimsby and Scunthorpe sites were not aware of how to access the policy or who was responsible for investigating complaints and concerns; and could not give examples of feedback or learning from complaints.

There was no record of complaints for any sites in the northern region, so we were not assured complaints were being reported and monitored.

The complaints records for the southern region were not collated, audited or tracked to monitor themes and trends and act appropriately to address these.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing You have failed to meet the parts of the regulation stated because: There was no formal induction procedure for staff at the Grimsby and Scunthorpe sites. Team leaders, who were responsible for the day to day operations at site level, had received no additional training or induction to ensure they were competent in this role. Staff at Grimsby and Scunthorpe had not been trained to use equipment such as wheelchairs, ramps and stretchers. There was no system to ensure appraisals were carried out annually. Staff at Grimsby and Scunthorpe confirmed they had not had appraisals to ensure they were competent and supported.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance You failed to provide systems and processes for reporting, investigating, and learning from, incidents and safeguarding concerns. There were no systems for sharing learning from incidents within the service. Staff at Grimsby and Scunthorpe confirmed incidents were not collated for monitoring purposes. This meant there was an increased risk that potentially avoidable incidents could reoccur because there was no system for service leads to have oversight of the incidents occurring and being able to take appropriate action. Investigations into incidents were not documented appropriately. It was not clear who had responsibility for investigations at Grimsby and Scunthorpe. The electronic document of reported incidents and safeguarding referrals did not show progress or ownership and it was unclear as to whether investigations were still open. There was a lack of systems and processes for assessing, monitoring and mitigating risk, particularly at Grimsby and Scunthorpe. The risk register for the Canvey Island site lacked clear documentation as to review dates, mitigating actions and the reasons for risks remaining open. You failed to demonstrate a clear structure for reporting and escalating concerns at the Grimsby and Scunthorpe sites and establish systems for communication with and support for staff at these sites. There was no record of any meetings occurring in the northern region.

This section is primarily information for the provider

Enforcement actions

There were no audits taking place at the Grimsby and Scunthorpe sites in order for the service to assess, monitor and improve aspects of quality and safety of services.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...