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 a patient transport service from 16 sites nationwide.

This inspection was an unannounced focused follow up inspection to assess the service's compliance with the warning notice we had issued in October 2017, details of which are included in the background section, below.

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 of improvement in relation to the warning notice we had issued in October 2017:

- Locality risk registers had been introduced and named individuals knew of their responsibilities to maintain these. These fed into a centralised system, overseen by the associate director of corporate services.
- Audits had been implemented to monitor quality and safety aspects of the service and results of these were being collated into monthly reports by a dedicated compliance member of staff.
- There was a quality and governance dedicated team whose responsibilities included assessing safeguarding concerns and escalating incidents for review, and carrying out ad hoc quality visits at sites.
- There were clear separate logs to record incidents and safeguarding concerns and these were overseen and updated by the quality and governance team.
- Investigations into incidents were more robust, clear and comprehensive than at our previous inspection.
- There was improved clarity of job roles, particularly at team leader/area manager levels, towards improving accountability for specific tasks.
- Safeguarding procedures had been strengthened and leads identified to support staff with safeguarding concerns.
- There had been improvements in accessibility of policies via the staff portal app which flagged up clearly when there was a new or updated policy.
- There had been some improvement in measures to ensure regular communication and engagement with operational staff including newsletter updates and information via the mobile app.

However, we also found the following issues in relation to the warning notice where the service provider still needs to improve:

- Processes such as risk management, quality and governance meetings and feedback from incidents were not yet embedded within the organisation.
- Whilst we saw that standardised agendas had been developed for the 'three tier' meetings mentioned in the CQC action plan, there was no evidence that these meetings had taken place. We spoke with two members of staff at Scunthorpe base who advised us that they had held one meeting and were awaiting the minutes from that meeting.
- Staff who were not new recruits were still out of date with refresher training, including in safeguarding. Although governance leads and senior managers were able to explain there was a plan in place to address this, evidence from staff indicated there had been a lack of communication and updates to staff as to when this would be fully effective.
- Not all policies were up to date and relevant for the scope of the service, and shared effectively with staff.
- The service needed to ensure they were identifying specific themes and trends in incidents. Although quality and governance leads verbally recognised this as the next part of the plan, it was not formally documented and there was no set timescale for this.
- There was a lack of clear systems or measures to ensure specific learning, feedback and actions from incidents were shared with all staff across the organisation to reduce the risk of similar incidents reoccurring and to improve staff knowledge and awareness.

Summary of findings

- The service needed to ensure they were identifying specific themes and trends from audit results. Quality and governance leads verbally recognised this needed to be implemented and embedded, but there was no clear plan or timescale for this at the time of inspection
- It was not clear whether actions were being taken in response to concerns highlighted from specific audits, where these actions were documented, and how audit results were shared with the wider staff group.
- There was discrepancy between individual sites in relation to communication and information sharing with operational staff. For example while some sites were having weekly meetings or using a 'speak out' system for escalating concerns, other sites had not yet implemented regular meetings.
- There was also evidence that suggests Grimsby remains a particular point of concern. We discussed this with the quality and governance team at the time of inspection. This included concerns that staff continued to feel disengaged; low morale; lack of effective and consistent communication with staff.

Following this inspection, we told the provider that it must continue to implement and embed measures to comply with the regulations. We also issued the provider with one requirement notice that affected patient transport services. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals, 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. This was a focused inspection to follow up the warning notice we had issued in October 2017 under Regulation 17: Good governance. Therefore this report does not provide a comprehensive overview of all aspects of the service.

Thames Ambulance Service

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Detailed findings

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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 January 2018. At the time of the inspection, a new chief executive officer had recently been appointed in February 2018.

This was a focused inspection to follow up the warning notice we had issued in October 2017 under Regulation 17: Good governance. Therefore, this report does not provide a comprehensive overview of all aspects of the service. Please see full details about the service and the context of this inspection in the information section, below.

Our inspection team

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

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

The service is registered to provide the following regulated activities:

- Transport, triage and medical advice provided remotely

We carried out our previous comprehensive inspection of the service on 19 September and 4 October 2017, where we found serious concerns in relation to governance. As a result, we issued a warning notice under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance) on 26 October 2017 with compliance required by 1 December. The warning notice is summarised as follows:

- The service failed to provide systems and processes for reporting, investigating, and learning from, incidents and safeguarding concerns.
- The service failed to provide systems and processes for assessing, monitoring and mitigating risk at the Grimsby and Scunthorpe sites and there was no oversight or awareness of risks from leads at these sites.
- The service 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.
- The service failed to provide systems and processes to assess, monitor and improve aspects of quality and safety of the services, for example through audits.

The service submitted an action plan on 20 December to demonstrate how they were intending to achieve compliance with Regulation 17.

We carried out a focussed reinspection of the service on 27 and 28 February at the Grimsby and Scunthorpe sites, and additional staff focus groups in advance of this on 14 February 2018 for staff employed at these sites. This was because the concerns we identified in relation to Regulation 17: Good governance at our comprehensive inspection had been particularly serious at the Grimsby and Scunthorpe sites. As part of this same focussed inspection we carried out a visit to the service's Lincoln head office on 9 March 2018. We found:

- Implemented processes and systems for reporting, investigating and sharing learning from incidents and safeguarding concerns were not yet embedded. Staff at focus groups felt there had been no improvement in this area.
- Processes and systems to allow effective oversight of risks were not embedded. Whilst we saw that a centralised risk register was being developed at our visit to Lincoln office on 9 March 2018, this was yet to be rolled out at local level to operational managers.
- A process was being developed to ensure that all staff had received up to date policies in relation to key areas such as safeguarding and incident management, however, this was yet to be implemented and subsequently embedded. Staff at the focus groups felt they had been asked to sign to say they had read updated policies as a 'tick box' exercise but that managers were not ensuring they understood these fully and were supported. Although it was staff's own responsibility to ensure they had read and understood the policies, it was a concern that staff felt managers had not provided any consultation or opportunity to ask questions to help their understanding and engagement.
- Our conversations with staff during our visit on 27 February 2018 and previous focus group on 14 February

2018 demonstrated that there was still a lack of clear structure for reporting and escalating concerns. Staff told us that there had been no improvements in terms of communication and support for staff.

- Whilst a 'communications plan' was in development to share updates and information with staff and standardised agendas had been developed for staff meetings, these meetings were not yet regularly taking place, and staff still reported a lack of engagement and communication and information sharing.
- There had been significant changes to the management structure including the chief executive officer role. A number of the senior management team had left the organisation and they were recruiting to recruit to key roles such as chief operating officer, HR business partners and quality and compliance officer.
- The new senior leadership team was in the process of drafting an overall business plan which they subsequently shared with us.

We provided feedback to the service outlining the above findings and stating that they were not yet compliant with Regulation 17, as highlighted in the warning notice. We then extended the deadline for demonstrating compliance with the warning notice due to exceptional circumstances; notably significant changes within the organisation to the senior leadership team and organisational structures including governance structures.

Following this extension for compliance, the service provided us with a report of actions they were taking to become compliant with Regulation 17: Good governance. Therefore, to fully assess compliance we carried out another focussed reinspection of the service on 15 May 2018.

This inspection was a focused follow up inspection to assess the service's compliance with the warning notice and therefore, we did not assess many of the aspects of the service. The latest inspection findings for aspects that fall outside the specific focus of the warning notice are published in the comprehensive inspection report dated 20 February 2018.

During the inspection of 15 May 2018, we visited the service's Lincoln head office to speak with the senior management team about their action plan and changes in systems and processes since our previous inspection, and to review documents such as the service risk register, audit schedules and results, incident logs and examples of investigations into investigations. We also visited the Grimsby site to follow up specific concerns we had in relation to infection prevention and control identified at the previous inspection. We also reviewed data and documentation provided by the service and took into account feedback from staff at the inspections in February and April 2018 and from a staff focus group we held in February 2018.

Patient transport services (PTS)

Summary of findings

These findings are highly focused as they are only in relation to the warning notice we issued for breach of Regulation 17: Good governance, and the additional specific infection prevention and control issues we found at the Grimsby site. This is explained fully in the information section, above. Therefore, these findings are not comprehensive of the activity of the service.

In comparison to our previous inspection of September and October 2017, we found the following improvements:

- Locality risk registers had been introduced and named individuals knew of their responsibilities to maintain these. These fed into a centralised system, overseen by the quality and clinical governance team.
- Audits had been implemented to monitor quality and safety aspects of the service and results of these were being collated into monthly reports by a dedicated compliance member of staff.
- There was a dedicated quality and clinical governance team whose responsibilities included assessing safeguarding concerns and escalating to the rapid review panel
- There were clear separate logs to record incidents and safeguarding concerns and these were overseen and updated by the quality and clinical governance team.
- Investigations into incidents were more robust, clear and comprehensive than at our previous inspection.
- There was improved clarity of job roles, particularly at team leader/area manager levels, towards improving accountability for specific tasks.
- Safeguarding procedures had been strengthened and leads identified to support staff with safeguarding concerns.
- There had been improvements in accessibility of policies via the internal mobile app on drivers' handheld devices, which flagged up clearly when there was a new or updated policy.
- There had been some improvement in measures to ensure regular communication with operational staff including newsletter updates and information via the mobile app.

However, we also found the following areas of concern:

- Although measures such as regular audits, incident reporting logs, risk registers and stronger governance systems had been introduced, we found these processes were yet to be fully embedded within the organisation. We discussed this with the senior management team at the time and they acknowledged this and were taking steps towards this.
- Whilst we saw that standardised agendas had been developed for the 'three tier' meetings mentioned in the CQC action plan, there was no evidence that these meetings had taken place. We spoke with two members of staff at Scunthorpe base who advised us that they had held one meeting and were awaiting the minutes from that meeting.
- Staff who were not new recruits were still out of date with refresher training including in safeguarding. Although governance leads and senior managers were able to explain there was a plan in place to address this, evidence from staff indicated there had been a lack of communication and updates to staff as to when this would be fully effective.
- Not all policies were up to date and relevant for the scope of the service, and shared effectively with staff.
- There was a lack of identifying specific themes and trends from incidents and audits. Although quality and clinical governance leads verbally recognised this as the next part of the plan, it was not formally documented and there was no set timescale for this.
- There was a lack of clear systems or measures to ensure specific learning, feedback and actions from incidents were shared with all staff across the organisation to reduce the risk of similar incidents reoccurring and to improve staff knowledge and awareness.

Patient transport services (PTS)

- There was discrepancy between individual sites in relation to communication and information sharing with operational staff. For example, while some sites were having weekly meetings or using a 'speak out' system for escalating concerns, other sites had not implemented regular meetings
- There was also evidence that suggests Grimsby remained a particular point of concern. We discussed this with the quality and clinical governance team at the time of inspection. This included concerns that staff continued to feel disengaged; low morale; lack of effective and consistent communication with staff.
- We still had concerns about the specific issue of bird faeces within the Grimsby station. This was not part of the warning notice but we followed it up due to the health and hygiene risk to staff and patients, under Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. Measures such as visual deterrents had not had any noticeable effect, because there was evidence of some fresh bird faeces on the floor within walk ways, and two birds were in the rafters near the door, at the time of inspection in May 2018. Although there was a schedule in place for vermin control and disinfection with an external specialist company, this indicated that this was not sufficient to fully remove the risk.

Are patient transport services safe?

Incidents

- At our previous inspection in September and October 2017, we had serious concerns about the lack of systems and processes for reporting, investigating, and learning from incidents. These concerns included (but were not limited to) a lack of forums or systems to communicate feedback and learning from incidents, a lack of clarity about processes for staff to escalate concerns, a lack of clarity around who was responsible for investigating incidents, and incomplete and unclear documentation of investigations.
- As part of their action plan, the service stated that, as of 13 November 2017, they were establishing a 'learning review group' led by the regional clinical and quality advisors. The aim of this was to ensure "ownership of learning opportunities and actions with the consistent cascade of learning throughout the Company".
- At the initial reinspection on 9 March at Lincoln, we asked managers about this learning review group but it was not clear who was part of this group or the individuals responsible for monitoring and logging incidents.
- Operational staff we spoke with (ambulance care assistants) at both Grimsby and Scunthorpe during our inspection in February 2018, and the focus group in the same month, felt there had been no improvement in terms of receiving feedback and sharing learning from incidents.
- When we returned for our follow up inspection in May 2018, we found evidence of improvement in this area as there was now a clear process for incident reporting and staff including leads knew of their responsibilities. Staff reported an incident using paper reporting forms located at each site and handing them into their team leader on site, who in turn would send this onto the quality and clinical governance team via email. They could also report directly to a dedicated incidents email address. There was no electronic incident reporting form at the time of the inspection; however, we were told this was in development, to continue to improve the process for staff.

Patient transport services (PTS)

- There was a comprehensive, clear and up-to-date incident log which had been in place since April 2018. This could be filtered to show individual sites, types of incidents, and severity. It was clear whether incidents were closed or still open due to ongoing investigations, which was an improvement from the last inspection where there was no clarity around which incidents were still open, and who was responsible for investigations.
- The log showed there had been 17 incidents reported over April and May 2018. There had been no serious incidents reported in this period. At the time of inspection, the process was still relatively new and the quality and clinical governance team were in the process of logging incidents into the spreadsheet so it was acknowledged that this may not have been a complete representation as some sites had yet to input into the main incident log.
- We were told that approximately 95 percent of incidents were reported directly at base level, while the remaining five per cent came via the patient experience team following a complaint or concern.
- However, the incident log did not show all the relevant information. For example, there was a column to show who the lead or investigating officer was, but this had not always been completed. The 'actions' column had only been completed for seven of the 17 incidents recorded in the log, and the reasons for this were not clear. Although we saw actions noted for the relevant incidents in their corresponding rapid review panel (RRP) minutes meaning actions had been considered, all the information around incidents had not been collated into one place to ensure clear tracking and progress of incidents.
- This log was monitored and reviewed by the quality and clinical governance team with individuals assigned to review and investigate specific incidents. Members of this team were responsible for reviewing incident reports and referring them, if necessary, to the 'rapid review panel' (RRP). The RRP convened within 24 hours of an incident being reported to review it and decide on actions.
- The quality and clinical governance team were able to provide examples of changes in practice as a result of incidents reported, namely the implementation of 'Safe System of Work', which was a series of aide memoires to assist staff with manual handling. This had been circulated to staff via the phone app and on notice boards at each station.
- We reviewed the minutes from RRP meetings from February to May 2018. This panel had been in place at our previous inspection in 2017 but we had concerns about how effective it was at that time because there had been no documentation of how actions were followed up, or how learning from these meetings was to be shared with staff. We saw improvement in this area because RRP minutes involved comprehensive consideration of the specific incident and appropriate actions and named owners responsible for these actions.
- There was a dedicated RRP action log so that actions could be monitored and it was clear to see the progress that had been made in relation to a specific incident and the actions that remained outstanding.
- Leads at area and site-specific levels were familiar with this process and could explain the escalation process for incidents and the rapid review panel. This was an improvement from our previous inspection where local leaders at Grimsby and Scunthorpe were not aware this panel existed for reviewing incidents and did not know who was responsible for incident investigations.
- However, the measures for incident reporting, investigation and learning had not been fully embedded into the service, and there remained some concerns in this area. The service was not yet collating themes and trends in a formalised way to identify and thus act upon any patterns in incidents that may be occurring, and share these with staff to improve their understanding and help reduce incidents. We discussed this with the quality and clinical governance team at the time and they acknowledged this was an area they needed to develop further to improve their incident reporting and learning systems. It was recognised that the incident log had only recently been implemented and they intended to develop this further.
- There was evidence of lessons learned for one incident on the log in a specific 'lessons learned' column but it was not clear whether the other 16 incidents had any learning identified as it had not been filled in for these

incidents. Therefore, while the reporting systems were now in place, the service needed to ensure lessons were learned and fed back to staff to promote a learning culture from incidents.

Safeguarding

- At our previous inspection in September and October 2017, we had serious concerns about safeguarding processes, procedures and awareness. Although there had been a combined log of all incidents and safeguarding concerns.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. At Grimsby and Scunthorpe, it was not clear what the escalation arrangements were, or how the service ensured appropriate learning and feedback and staff we had spoken to confirmed they did not know the process, did not know who was responsible for safeguarding processes, were not up to date with safeguarding training and did not receive feedback from concerns raised.
- Staff still reported safeguarding concerns to their team leader, which had been the case at our previous inspection, using a form which was available on vehicles and at stations. At the focus group in February 2018, operational staff knew their own responsibilities about reporting safeguarding concerns and could give examples where they had done so, but said they did not know where the concerns were escalated or discussed after this. Therefore, we had not been not assured there was sufficient improvement in safeguarding processes and awareness.
- However, we saw improvements in this area when we re-inspected in May 2018. There were clear pathways and guidance for staff in each locality to follow, which highlighted the responsibilities of operational staff and process for reporting. Each locality document stated clearly the contact details for the local Safeguarding Adult Board (SAB) or Safeguarding Children's Board (LSCB). These documents also specified the responsibility for team leaders to email the form within 24 hours to the safeguarding mailbox, although it did not specify what the alternative arrangements were if the team leader was on annual leave, for example.
- There was now a dedicated quality and clinical governance team who were responsible for referring safeguarding concerns to the local authority and investigating concerns where required. This included four safeguarding leads trained to level three in safeguarding. They were booked in for level four training within the next few months. This was an improvement from the previous inspection, where there had only been someone trained to this level at Canvey Island and staff in the northern region had not been able to access someone with level three training to raise safeguarding concerns.
- There was a dedicated safeguarding referrals mailbox for the whole service and improved access to this by staff through the staff portal. This mailbox was monitored by the quality and clinical governance team which consisted of five staff, meaning safeguarding concerns were responded to. We saw these staff accessing this to deal with current safeguarding concerns during our inspection of the Lincoln base. Staff could access the NHS safeguarding app directly through the portal on their work phones. This app had been rolled out to all staff from March 2018. This was an improvement because at our previous inspection, operational staff at Grimsby and Scunthorpe staff did not know where they were expected to access this information from to support them in raising safeguarding concerns.
- There were still issues outstanding in relation to safeguarding. Staff who were not new recruits were yet to receive refresher training in safeguarding. Therefore, they were still relying on the training they had received under their employment with a different provider before being transferred to the organisation in 2016. This was raised as a concern by staff at the Grimsby site in particular.
- We discussed this with the quality and clinical governance team who acknowledged this was an issue. Once they had finished their safeguarding training programme for new recruits, the focus was to implement refresher training for all staff who had been there longer than one year. They told us they wanted to implement face-to-face training to ensure staff were

engaged with it because this had been found to be more effective. However, this was due to be completed by mid-2019, which was a long time for staff to not have refresher training in safeguarding.

- Furthermore, while there had been circulation of updated policies about raising safeguarding concerns and the flowchart to help staff was available at sites and via the app, there had not been any face-to-face communication, briefings or meetings to support staff with this and help their understanding, particularly for the staff who had been transferred from other organisations and were overdue refresher safeguarding training.
- While the service had implemented measures to improve the reporting and acting upon safeguarding concerns, systems for feedback to staff was still lacking. This meant there was a risk of missed opportunities for further learning to ensure staff were fully engaged with and aware of the safeguarding process.

Cleanliness, infection control and hygiene

- We did not inspect this area comprehensively as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.
- However, we did review the specific issue of bird faeces within the Grimsby station. This was due to the concerns we identified at the previous inspection in September and October 2017 relating to a health and hygiene risk due to bird faeces on the floor within the station where the ambulances parked. At that time, service leads were aware this was an issue 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. We had issued a requirement notice in relation to this, under Regulation 12 of the Health and Social Care Act
- The service had, as of April 2018, taken actions in response to the requirement notice including model birds of prey placed at strategic points to deter the birds, reflective mobiles across the door as a visual deterrent, and white painted demarcation lines as an indication mark to keep the roller shutter over the entrance point lower preventing easy access to the birds. We saw these in place at the station when we re-inspected.
- However, we were concerned that these measures were not having a significant deterrent impact on the problem of pigeons coming into the station. There was evidence of some fresh bird faeces on the floor within walk ways, and two birds were in the rafters near the door, at the time of inspection in May 2018. Although there was a schedule in place for vermin control and disinfection with an external specialist company, this indicated that this was not sufficient to fully remove the risk.
- Staff including local managers confirmed that the doors to the station were regularly left open. This was because the entrance doors were large and staff were frequently going in and out of the station on vehicles, meaning it was considered a major inconvenience to be constantly opening and closing doors.
- We discussed with the quality and clinical governance team at the time of inspection who were aware that there was still a hygiene risk due to pigeons coming into the station and needed to put in place measures to ensure the doors remained closed when not in use to mitigate the risk. There was also an appointment scheduled to assess the possibility of installing an electronic sonic bird deterrent.
- This risk was also included on the Grimsby locality risk register since February 2018, which was an improvement from the previous inspection.
- In relation to wider IPC observations within the station, a dedicated team based at Lincoln came to deep clean (including steam cleaning) vehicles during the night, when vehicles were not being used. The dates of when each vehicle had last been deep cleaned and were next due were written on a board in the office on site and this showed all vehicles were up-to-date with deep cleans.
- We inspected two vehicles on site and saw they were visibly clean. During our inspection we witnessed two staff members carrying out a routine clean of a vehicle, and there were clear records signed by staff to confirm vehicle cleanliness prior to the next shift, which was an improvement from the previous inspection in September and October 2017.

Environment and equipment

Patient transport services (PTS)

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.

Medicines

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.

Records

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.

Assessing and responding to patient risk

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.

Staffing

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.

Anticipated resource and capacity risks

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.

Response to major incidents

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act (Good governance), which we were following up.

Are patient transport services effective?

Evidence-based care and treatment

- We followed up this area of the service in relation to the concerns we identified in September and October 2017, namely that 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.
- As part of their action plan to address this, the service implemented an audit schedule in place since February 2018. We reviewed the audit compliance spreadsheet which showed the results of all audits at site level on a quarterly basis, including, but not limited to, uniform, COSHH, vehicle, deep cleaning and hand hygiene audits. It was separated into regions so it was clear if one site or region was having a particular issue with non-compliance, although it was too early to fully assess results or identify any patterns from the audits as they had only been in place for three months
- This was overseen by the specialist data governance lead, who submitted an internal report monthly to the senior leadership team, as well as a quarterly report to the clinical commissioning groups (CCGs). We spoke with this member of staff who explained to us how they were able to present the data and identify areas of concern from audits.
- However, there were still areas for improvement in relation to audit. While the spreadsheet was comprehensive and a useful tool for monitoring aspects of quality, there was no section for documenting actions in response to poor audit results. For example, one weekly vehicle cleanliness audit carried out at the Lincoln base found compliance of cleanliness of the cab area to be 63% and for the exterior, 69%, but there was nothing to say how these results were being shared with staff at the base or measures to improve these results. Also, there were no target compliance rates specified for any of the audits included on the spreadsheet.
- Staff could access policies and procedures via the app on work phones and also in hard copy at the station. Updates to policies and procedures were flagged up clearly to staff with a 'NEW' sign in red next to the policy name on the app. This was an improvement from the previous inspection, although access was not consistent as the risk registers highlighted that not all phones were working properly. Also while there had been notifications about policy changes

Patient transport services (PTS)

- There had not been any face-to-face updates or briefings which staff and Grimsby and Scunthorpe had previously reported an issue in relation to their understanding and use of relevant policies.
- The quality and clinical governance team carried out site visits where they would do spot checks of staff knowledge on important updates to policy, such as what they would do in the event of a deteriorating patient.
- Not all policies were up to date and reflective of the service. The quality and clinical governance team acknowledged this with us at the time of inspection and told us they were working through policies with the help of the clinical adviser to do this, with support from but this was a lengthy process.

Assessment and planning of care

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Response times and patient outcomes

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Competent staff

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Coordination with other providers

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Multi-disciplinary working

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Access to information

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Are patient transport services caring?

Compassionate care

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Understanding and involvement of patients and those close to them

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Emotional support

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Supporting people to manage their own health

Patient transport services (PTS)

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Meeting people's individual needs

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Access and flow

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Learning from complaints and concerns

- We did not inspect this area of the service as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.

Are patient transport services well-led?

Leadership of service

- At our previous inspection in September and October 2017, there was a lack of systems for communication with and support for staff at these sites from leads at site, area and provider levels.
- At this follow up inspection, we found evidence that leadership at local, regional and provider levels had been strengthened. There was a new chief executive officer (CEO) in post since February 2018. Other new leadership roles included an interim head of patient experience, associate director of HR and locality business managers for each of the four main regions (South Yorkshire, Lincolnshire, Central and South)
- There was now a clear senior leadership structure with a director of operations, director of workforce, finance director, director of quality and clinical governance, and director of corporate services, and a medical adviser, reporting to the CEO. These leads had improved oversight of the main concerns and risks and what was needed to address them.
- Leads we spoke with at the follow up inspection in May 2018 at both site and regional levels had improved awareness of their responsibilities including locality risk registers and supporting operational staff to report incidents.

Vision and strategy for this this core service

- At our previous inspection in September and October 2017, there had been no clear vision and strategy.
- At the time of our focussed follow-up re-inspection in May 2018 the service had introduced a business plan including a three-year strategy, to achieve the vision of "Achieving excellence in everything we do".
- The plan identified the main priorities for the service, namely, improving the patient experience; improving performance; consolidating their position and exploring new growth opportunities; committing to improve governance arrangements; and improving communication internally and externally.
- There were actions identified to work toward each of these priorities on an annual basis, and a recognition of the challenges that may be barriers to achieving these priorities.
- However, at the time of our inspection in May 2018 there had not yet been any consultation and communication to engage staff in the vision and strategy.

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

Patient transport services (PTS)

- At our previous inspection in September and October 2017, we had serious concerns about governance and risk management and quality measurement in the service. This was due to factors including lack of clear structure for reporting and escalating concerns at the Grimsby and Scunthorpe sites; and the lack of systems and processes for monitoring and mitigating risk in the service.
- When we followed this up in May 2018, there were measures implemented to improve governance and risk management. Although these were very recent and would therefore take longer to become embedded in the service, particularly due to the fact the service had many sites nationwide and a large and widely dispersed staff base, it was a significant improvement from our previous inspection. The service were aware they would need to keep working on these to achieve sustained long-term improvement of governance in the service.
- There was now a dedicated quality and clinical governance team in place, which we were told had received positive feedback from the local clinical commissioning groups (CCGs) who contracted the services. This was led by the director of quality & clinical governance and also included regional governance leads for the north and south, and a dedicated data compliance lead.
- Monthly quality and governance meetings were taking place. We were told that from June 2018, four members of operational staff (different staff each time) were going to be invited to each of these meetings. This was specified in the team's plan and showed improved practice as it meant the service was involving all staff in governance.
- There was a locality risk register for each site which was the responsibility of each base manager. This was an improvement from 2017, where there had been no accountability or ownership of risk registers. This now fed into an overall risk register for the service which was assessed by the associate director of corporate services. Overall there were 164 risks documented for the service.
- We reviewed the risk register and saw that risks had been rated appropriately according to how serious they were. Each site team leader was the owner for the risks at their site. Each risk indicated how frequently they were to be reviewed at site level and any changes were relayed to the quality and clinical governance team.
- There were mitigating actions documented for each risk and target dates for compliance. For example, at the Spalding base there was an IPC risk, rated high, due to the lack of vehicle washing facilities. Actions included arranging a contract to move their base to allow for more appropriate washing facilities, which had taken place in April 2018, and contact with an external IPC company to install specialist washing facilities.
- Quality and governance leads were able to explain the main risks on the register when we asked; for example, the risk that fire assessments for stations were out of date, and the need for updated training for fire marshals at each station. They could explain the reasons for these and the mitigating actions they were taking. This was an improvement from our inspection in September and October 2017, where leads at site and area level could not give examples of risks or how they were being monitored.
- There was a structured improvement plan in place for the Lincoln control centre, which had been identified as a concern by the service. The plan was separated into themes including 'communication', 'training', 'establishment' and 'management', among others, with actions such as 'Produce objectives for management' and 'Customer Service training program, e.g. pre-amble conflict management', with target dates specified for each action. Previously there had been no evidence of any actions to improve this despite concerns, and no accountable persons to oversee it. Therefore, this was an improvement in terms of the quality improvement of an identified concern.

Culture within the service

- At our previous inspection in September and October 2017, we found a poor culture and morale at the Grimsby and Scunthorpe sites, in particular, in relation to staff feeling unsupported.
- At this follow up inspection, we found gradual positive improvements in culture and attitude. The senior team reported they felt culture and morale was beginning to improve; however, it was acknowledged this would be a long-term and gradual process.

- There was a new HR team in place. Their current priority was getting staff files into order but after that the plan was to focus on identifying the root causes of poor morale and working on measures to boost culture and morale.
- However, we still had concerns about the local culture at Grimsby as there remained evidence of low morale among staff, and a 'divide' between staff who were new recruits to the organisation, and those who had been transferred across from other organisations. Poor culture and morale was included as a risk on the locality risk registers for Scunthorpe, Grimsby and Spalding in particular.
- The service had not yet achieved and embedded a shared learning culture. The quality and clinical governance team said they did not always share actions and learning from incidents across the whole staff group because they did not want to come across as 'blaming' individuals or identifying members of staff involved in specific incidents. However, this ran the risk of potentially avoidable incidents reoccurring as it limited learning opportunities from incidents. For example, we were told there had been an update to the service's deteriorating patient policy on the back of an incident that had been reported, but they had not shared this incident context with operational staff, only the update to the policy. We fed this back to the service at the time of inspection, which they acknowledged.

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

- At our previous inspection in September and October 2017, there was a lack of systems for communication with and support for staff.
- The service's action plan in response to these concerns specified that the service was establishing a 'three-tier staff engagement briefing' to take place on different days and times to ensure maximum opportunity of attendance. The three tiers were operational staff with team leaders; team leaders with area managers; and area managers with regional directors.
- The action plan stated the service was rolling out the 'TASL Staff Room' across all sites to ensure a centralized accessible area for staff during their working day. This was to be programmed into all staff handsets, ensuring that front line staff can view the area as required in real time whilst on shift, as well as on desktop computers such as those in the control centre. It also stated the service was issuing every staff member with a unique TASL email account to which important updates, newsletters and other information would be sent.
- At this follow up focussed inspection in May 2018, we found initial improvements in this area, although these were yet to be fully embedded and there was discrepancy between sites in the level and means of staff engagement. The three tier staff meetings as outlined in the initial action plan had not been embedded across all sites at the tier one level between team leaders and operational staff.
- We saw the staff room website and app in use, which included links to NHS safeguarding app and hospital maps, internal policies and procedures, safe systems of work and any other relevant staff communications including the newly introduced newsletter, 'Battenberg'.
- The weekly newsletter 'Battenberg' had been implemented by the new chief executive in March 2018. Senior leads felt this had been well received by operational staff. We reviewed recent newsletters and saw they included updates about staff pensions, recent changes in management structures and also a recognition of two members of staff at Canvey Island involved in raising a safeguarding concern.
- We saw examples of updates to staff through monthly briefings. For example, the April staff briefing included a reminder to driver staff to escalate any issues they had experienced in communicating with the control room, and reminders about taking meal breaks and finishing shifts on time, and an introduction to the new CEO. There was evidence of staff signing these to show they had read and were aware of the information in the briefing.
- There was evidence of improvement in systems for staff engagement and communication. For example, the head of quality and clinical governance had implemented a 'Speak out' system at the control centre in Lincoln. This was in response to concerns about disengagement and low morale among staff in the control centre. There was also a 'high five' board to recognise achievements each week or staff who had gone 'above and beyond'.

Patient transport services (PTS)

- There was a 'communications plan' in place since February 2018. This was led by the director of operations, and there was a dedicated communications officer in post since February 2018 to help with the implementation of this across the service. The plan included specific activities to drive improvement in this area, such as implementation of the 'internal staff newsletter, updates, news, compliments from the patient experience team, placed on staff areas' and 'Volunteer Car Service Drivers meeting and communication of queries and questions to be sent out to all e-mail addresses'. There were timescales specified for each activity and a notes section which documented any progress or information in relation to each activity. This was an improvement from the last inspection where there had been no oversight of the communication and engagement issues or any systems to ensure effective communication with all staff.
- There were notice boards displaying information and updates for staff including updates to policies, reminders about hand hygiene and useful contacts. There was a plan to standardise these notice boards across sites so that staff across the service had access to the same information and guidance and updates.
- However, there was discrepancy in staff meetings being carried out which was recognised as an issue by the quality and clinical governance team. For example, Sussex had regular meetings that were well attended but so far face-to-face regular meetings had not been implemented at Grimsby and Spalding. The team were carrying out site visits to engage with staff to find out reasons for this and try to address them.
- At Grimsby we still had concerns that staff felt disengaged and that their work was not recognised. The quality and clinical governance team acknowledged this was a site of particular concern in terms of culture and engagement and they had so far struggled to implement regular staff meetings at this site. However, there was a new area manager covering this site. They had set up staff meetings and team building events at other bases and planned to do that at Grimsby but had only been in post a few weeks at the time of our inspection.
- Ensuring quality communications between base management and staff' was also included as a risk on the locality risk register for Grimsby and there were actions documented to work towards reducing this, such as 'regional updates, training and communication through base meetings', which although were not taking place regularly at the time, had been scheduled for the year ahead.
  We did not inspect this area of the service specifically as it was not part of the warning notice and action plan under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance), which we were following up.
- However, measures that we had seen introduced to improve governance, such as the risk register, additional quality and governance roles, newsletters and an audit schedule indicated gradual improvement towards a more sustainable service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must continue their work to implement, develop and embed systems and processes for monitoring and mitigating risk; monitoring and learning from incidents; supporting and communicating with operational staff, notably at the Grimsby site; and using audit results to identify themes and trends to improve quality and safety in the service, in order to be compliant with Regulation 17: good governance. Please note this is only in relation to the warning notice that we had previously issued in October 2017 due to the focused nature of this inspection.

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 17 HSCA (RA) Regulations 2014 Good governance The service must continue to develop and embed systems and processes to assess, monitor and mitigate risk in the service, for example by way of the risk register they had recently introduced since our previous inspection. The service must continue to develop and embed systems and processes to monitor incidents, identify learning and actions and share these effectively and consistently with staff. The service must continue to develop and embed systems and processes to assess, monitor and improve the service. While there was an audit schedule now in place, this was not yet embedded or developed to ensure any themes or trends from audit results were identified and acted upon in order to improve quality and safety aspects of the service. The service must continue to develop and embed systems and processes to engage with, communicate with and support operational staff, particularly at the Grimsby site which was recognised as a particular concern.