Thames Ambulance Service Ltd

Thames Ambulance Service Grimsby Office

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	Requires improvement
Patient transport services (PTS)	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Thames Ambulance Service Grimsby Office and Hull Office satellite location is operated by Thames Ambulance Service Limited. The service provides a non-emergency patient transport service from several sites throughout England. Thames ambulance Service Ltd had 17 ambulance stations throughout the UK from which patients transport services were delivered. This inspection report details our findings at the Grimsby Office.

We inspected the service using our comprehensive inspection methodology. We carried out the short-announced part of the inspection on 1 May 2019.

We previously carried out an announced comprehensive inspection as part of Thames Ambulance Service Limited on 23 October 2018. During our inspection, there were several safety concerns identified, primarily regarding the safe transport of patients with mental health needs, transport of patients with bariatric needs and transport of children aged under 12 years. Because of this, we issued the provider with a warning notice over their non-compliance of Regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also imposed four further conditions on their registration.

Prior to this, we carried out focussed inspection on the 15 May 2018 to follow up a warning notice we had issued to the provider in October 2017 over a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 (MCA).

Our rating of this service improved. We rated it as **Requires improvement** overall.

- The provider had systems and process in place for staff to report incidents. However, incident investigation records were not always fully detailed, and evidence of wider learning was not fully embedded.
- We were not assured that the service had enough staff with to provide the right care.
- The service did not always ensure that policies reflected national guidance.
- The provider monitored response time, however, commissioner's key performance indicators were not met.
- Staff had not participated in the appraisal processes to discuss their performance and learning needs.
- Frontline staff worked well together to support the needs of patients, however there was sometimes conflict between control room staff and frontline staff.
- The service did not always plan and provide services in a way that met the needs of local people.
- The service did not always take into account patients' individual needs.
- Waiting times were not always in line with good practice.
- The service did not always systematically improve service quality and safeguarded high standards of care.
- The service had made improvements to working practices with further improvements planned. However, performance remained below commissioner targets.

However, we also found:

- There were systems and processes in place to monitor and oversee staff compliance with mandatory training completion.

Summary of findings

- Staff had received training on how to recognise and report abuse.
- The service controlled infection risk well
- The service had suitable premises and equipment for the range of services it provided.
- Staff completed risk assessments for each patient.
- Staff kept records of patients' care and treatment.
- The service followed best practice when storing oxygen.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Leadership and management of the service had been through a number of changes. The senior management team had been restructured and station managers had been introduced, which had increased staff confidence in the leadership of the service.
- The service had a vision of what it wanted to achieve and plans to turn this in to action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had systems in place to identify local risks and plans to eliminate or reduce them.
- The service collected and managed information, using secure electronic systems with security safeguards.
- The service had improved patient and staff engagement process.

We rated the service as **Requires improvement** overall.

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, to help the service improve. We also issued the provider with one requirement notice that affected patient transport services. Details are at the end of the report.

Nigel Acheson
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)	Requires improvement 	We rated the service as **Requires improvement** overall, we rated effective inadequate; safe, responsive and well-led as requires improvement and caring good. This is an improvement from our last inspection when we rated the service Inadequate. The service had made improvements since the last inspection in October 2018. The cleanliness of the Grimsby Office had improved with measures in place to maintain these standards. Incident investigation records were not always fully detailed, and evidence of wider learning was not fully embedded. The service did not always systematically improve service quality and safeguarded high standards of care. The provider monitored response time, however, commissioner's key performance indicators were not met. The service did not always plan and provide services in a way that met the needs of local people and did not always take into account patients' individual needs. Waiting times were not always in line with good practice. There was sometimes conflict between control room staff and frontline staff. We were not assured that the service had enough staff with to provide the right care. The service had conveyed bariatric and child patients while registration conditions were in place for these patient groups. The service did not always ensure that policies reflected national guidance. Staff had not participated in the appraisal processes to discuss their performance and learning needs. Staff had not always completed mandatory training in line with the target set by the provider. However, we also found:

Summary of findings

The service had suitable premises and equipment for the range of services it provided and controlled infection risk well. The service followed best practice when storing oxygen.

Staff kept records of patients' care and treatment and completed risk assessments for each patient.

Staff had received training on how to recognise and report abuse. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff cared for patients with compassion and provided emotional support to patients to minimise their distress. Feedback from patients confirmed that staff treated them well and with kindness. Staff involved patients care.

Leadership and management of the service had been through a number of changes. The senior management team had been restructured and station managers had been introduced, which had increased staff confidence in the leadership of the service. The service had a vision of what it wanted to achieve and plans to turn this in to action.

Managers across the service promoted a positive culture. Frontline staff worked well together to support the needs of patients. The service had improved patient and staff engagement process.

The provider collected and managed information, using secure electronic systems with security safeguards. The service had systems in place to identify local risks and plans to eliminate or reduce them.

Requires improvement

Thames Ambulance Service Grimsby Office

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Background to Thames Ambulance Service Grimsby Office

Thames Ambulance Service Grimsby Office and Hull satellite location is operated by Thames Ambulance Service Limited. The service opened in 2016. It is an independent non-emergency patient transport service (PTS) in Grimsby, Lincolnshire with satellite location in Hull and Louth. The service primarily serves the communities of North Lincolnshire and Humberside.

The service undertook PTS contracts awarded by local clinical commissioning groups

At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in January 2019.

We previously inspected this service as part of Thames Ambulance Service Limited. Following our inspection of that service in October 2018, we issued the provider with a warning notice over their non-compliance of Regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also imposed four further conditions on their registration, which also apply to Grimsby Office and Hull satellite location.

Our inspection team

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

Facts and data about Thames Ambulance Service Grimsby Office

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

At the time of this inspection, the service had the following conditions of registration in place, which were applied in January 2019, following an inspection in October 2018 (across the whole provider, including the Grimsby and Hull locations):

Detailed findings

- The registered provider must cease the transport of children aged under 12 years, or less than 135cm in height, until the Care Quality Commission is assured that the appropriate safety requirements for transportation have been met.
- The registered provider must cease the transport of bariatric patients (patients who are over 25 stone or have a complex bariatric requirement) who need assistance to move or where there is a difficult removal due to environment. This will remain in place until the Care Quality Commission is assured that all staff managing bariatric patients are appropriately trained in risk assessment and moving and handling.
- The registered provider must ensure that, following initial assessment, an appropriately trained crew will attend to meet the needs of individual patients who may require additional support due to mental health needs; this includes appropriate training.
- The registered provider must ensure necessary information concerning patient needs according to their physical and mental health is provided to staff prior to carrying on the regulated activity, including information about complex needs and patients living with dementia or a learning disability at point of accepting a journey.

The provider applied to have these conditions removed prior to the inspection and submitted evidence to support their application. We reviewed all of the information provided and assessed all aspects of the conditions during the inspection. We will be writing to the provider to remove the conditions imposed in January 2019.

During the inspection, we visited Grimsby Office and the Hull satellite location. We spoke with 14 staff including; patient transport drivers and management. We also received 25 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 13 sets of patient records.

There was an NHS England oversight group monitoring the service in the 12 months before this inspection and the CQC were also receiving updates to the service's action plan in response to the breaches identified at the previous inspection.

At the time of our inspection the service employed 85 staff at the Grimsby and Hull offices and operated 41 non-emergency patient transport vehicles.

Grimsby Office Activity (April 2018 to March 2019)

- There were 43,227 patient transport journeys undertaken

Track record on safety (July 2018 to February 2019)

- Zero Never events
- Clinical incidents 16 no harm, 9 low harm, 2 moderate harm, no severe harm, no death
- Zero serious incidents
- 15 complaints

Hull satellite location Activity (April 2018 to February 2019)

- There were 43,837 patient transport journeys undertaken.

Track record on safety (July 2018 to February 2019

- Zero Never events
- Clinical incidents 11 no harm, 9 low harm, 2 moderate harm, no severe harm, no death
- Zero serious incidents
- 12 complaints

Our ratings for this service

Our ratings for this service are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement

Patient transport services (PTS)

Safe	Requires improvement
Effective	Inadequate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Grimsby Office and Hull satellite location supplied a non-emergency patient transport service to commissioners across various areas of the United Kingdom, primarily for the communities of North Lincolnshire, Grimsby and Hull. The service maintained a fleet of non-emergency vehicles, including non-emergency ambulances, wheelchair accessible vehicles and cars from dedicated ambulance stations and bases.

The provider employed a wide range of staff including registered managers, area managers, station managers, ambulance care assistants, call handling and control room staff, and planners.

The provider did not hold controlled drugs (CDs) at its locations for use on patient transport services.

Summary of findings

- The provider had systems and process in place for staff to report incidents. However, incident investigations were not always detailed with evidence of wider learning.
- We were not assured that the service had enough staff with to provide the right care.
- The service did not always ensure that policies reflected national guidance.
- The provider monitored response time, however, commissioner's key performance indicators were not met.
- Staff had not participated in the appraisal processes to discuss their performance and learning needs.
- Frontline staff worked well together to support the needs of patients, however there was sometimes conflict between control room staff and frontline staff.
- The service did not always plan and provide services in a way that met the needs of local people.
- The service did not always take into account patients' individual needs.
- Waiting times were not always in line with good practice.

Patient transport services (PTS)

- The service did not always systematically improve service quality and safeguarded high standards of care.
- The service had made improvements to working practices with further improvements planned. However, performance remained below commissioner targets.

However, we also found:

- There were systems and processes in place to monitor and oversee staff compliance with mandatory training completion.
- Staff had received training on how to recognise and report abuse.
- The service controlled infection risk well
- The service had suitable premises and equipment for the range of services it provided.
- Staff completed risk assessments for each patient.
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- Leadership and management of the service had been through a number of changes. The senior management team had been restructured and station managers had been introduced, which had increased staff confidence in the leadership of the service.
- The service had a vision of what it wanted to achieve and plans to turn this in to action.

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had systems in place to identify local risks and plans to eliminate or reduce them.
- The service collected and managed information, using secure electronic systems with security safeguards.
- The service had improved patient and staff engagement process.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement

We rated it as **requires improvement.**

Incidents

- **The provider had systems and process in place for staff to report incidents.** However, incident investigation records were not always fully detailed, and evidence of wider learning was not fully embedded.
- The provider had an incident reporting policy in place for staff to follow. The policy was within the review date and set out responsibilities for staff at all levels. The policy referenced relevant legislation and national guidance.
- The service used paper-based incident reporting forms. The station managers reviewed all of the incident reporting forms, prior to forwarding them to head office in Lincoln. Each office had a local incident log to enable oversight incidents reported locally.
- The provider-wide action log recorded actions allocated to an appropriate manager which needed to be completed prior to closure. We reviewed the action log from April 2018 to March 2019 which showed all actions had been completed in a timely way.
- Staff were expected to submit incident reports within 24 hours. Senior managers for the provider reviewed the incident forms and allocated the investigation to an appropriate manager.
- Staff had access to the incidents and serious incidents handbook. The hand book provided additional information about documenting incidents including providing statements of fact. Staff we spoke with were aware of what constituted an incident and demonstrated knowledge of the incident reporting processes.
- We reviewed the minutes for the rapid review panel held in March 2019. The panel reviewed incidents and decided on the required actions to investigate the incidents. We saw that the actions discussed were added to the central action log and completed in a timely way.
- The Grimsby office staff reported 27 incidents from July 2018 to February 2019. Data provided showed that 16 incidents were graded as no harm, nine were low, two were moderate and no severe. None of the incidents met the serious incident criteria. The main themes of the incidents reported were accident, injury or ill health of a patient, staff behaviour and vehicle issues.
- The Hull office staff reported 22 incidents from July 2018 to February 2019. Data provided showed that 11 incidents were graded as no harm, nine were low, two were moderate and no severe. The main themes of the incidents reported were accident, injury or ill health of a patient, inappropriate planning and staff behaviour. No incidents reported met the serious incident criteria.
- Incident investigations were inconsistent with the information recorded about the time the actions were completed. We reviewed three incident reports and found that incidents related to delays attributed to other providers were completed in a timely way. However, incidents related to staff attitude and conduct had limited information included within the investigation to provide assurance that action had been completed. None of the incident report forms had a closure date.
- Senior managers had oversight of all serious incidents which were investigated at provider level. Root cause analysis investigations were reviewed by the 'rapid review panel' (RRP) to ensure appropriate actions and learning was identified. This process was led by the provider's director of quality and clinical governance. We reviewed a serious incident root cause analysis report completed by the senior management team. The report included relevant information and clearly identified learning following the incident. However, the actions resulting from learning did not have a completion date or detail as to how the provider planned to share the wider learning. Staff we spoke with gave examples of learning from incidents such as a road traffic collision in another locality, however we were not assured of any formal process and wider learning was not fully embedded.
- The provider held bi-monthly quality and clinical governance meetings, where managers discussed incidents reported. We reviewed the meeting minutes from February 2019, which demonstrated that staff awareness of incident reporting had increased. The

minutes noted this was due to the introduction of station managers and increased staff engagement. This was confirmed during staff interviews at both offices we visited.

- The service had a policy for the process duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires the 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. The policy set out the roles and responsibilities of staff in the duty of candour. Staff and managers, we spoke with understood the of duty of candour and how to apply this.

Mandatory training

- **There were systems and processes in place to monitor and oversee staff compliance with mandatory training completion.** The service had improved mandatory training compliance through a recovery action plan.
- Staff had access to mandatory training with modules including; equality diversity and inclusion, health and safety at work, fire safety, incident reporting, conflict resolution, infection prevention and control, manual handling objects, patient positioning, moving and handling equipment, paediatric restraint systems, prevent, customer care and communication, information governance, whistleblowing and CQC, dementia awareness, first aid at work, emergency first aid at work, basic life support and driving.
- Data provided showed that 88% of staff had completed the required mandatory training programme in Grimsby. Staff from the Hull office had achieved 90% compliance with Mandatory training which met the provider target of 90%.
- The provider had completed a training needs analysis to identify the training needs for all staff roles within the organisation. Different modules for different roles were implemented, for example, office staff had different first aid training to patient facing staff.
- Grimsby and Hull offices had work-based assessors to provide oversight and compliance in work-based activities. The assessors completed work based assessments during their own shift patterns. The station managers we spoke with told us that the completion of assessments could be difficult at times due to operational demand.
- Bariatric training was not offered to all staff. The service operated a vehicle and staff with additional training, dedicated to the transportation of bariatric patients in Lincolnshire. Staff we spoke with told us they had seen bariatric equipment at head office but did not have access to this equipment at the offices in Grimsby and Hull.
- New staff members completed a week of induction training at the provider head office in Lincoln. The induction included mandatory training and a driving assessment. One new member of staff we spoke with confirmed they had completed the induction training.

Safeguarding

- **Staff had received training on how to recognise and report abuse.** Staff demonstrated knowledge of the reporting processes in place upon identification of a safeguarding concern.
- Safeguarding training was provided as part of induction processes and repeated on a three-yearly basis. The service provided safeguarding adults level two and safeguarding children level two training for all operational staff. Data submitted prior to our inspection (March 2019) showed the staff completion rate for both modules was 88%. The provider had a target for 90% compliance with this training. During the inspection local records showed that 88% of staff in Grimsby and 90% of staff in Hull had completed this training. Staff we spoke with told us they had completed safeguarding training during their mandatory training update. One new member of staff had completed this training during their induction training.
- The provider had two named safeguarding leads with training to level four safeguarding children and adults. The service's director of quality and clinical governance and the head of quality and clinical governance had completed level four safeguarding training. There was a 24-hour safeguarding team within the service, for staff to contact at all times in the event of requiring advice or raising a safeguarding concern. The provider had an additional four members of staff had also completed

safeguarding trained to level four, and 25 members of staff had received safeguarding level three training who provided cover through an escalation rota for additional support.

- Staff could request safeguarding support 24 hour a day seven days a week by telephone or email. Team members with level three safeguarding rotated on the silver and gold command to ensure staff had access to safeguarding advice during their shift. These members were a point of contact to escalate safeguarding concerns. Staff told us they escalated concerns to their station manager, who supported them to raise their concerns through the incident reporting process and to the local authority safeguarding boards.
- The provider had a safeguarding adults policy in place which set out the expectations of staff and the type abuse. The policy was within the review date and referenced national guidance and legislation.
- At both Grimsby and Hull, we saw information on display to support staff through safeguarding referral processes in the event of the identification of a concern. In addition, ambulance vehicles contained information packs with reference to a safeguarding flowchart and contact numbers for internal escalation within Thames Ambulance Service and local authority contact numbers.
- The electronic patient transport records system had flags attached to patients with known safeguarding concerns. Staff had access to this information prior the conveyance of a patient.
- The provider had processes in place to complete disclosure and barring service (DBS) checks for all staff as part of their pre-employment checks. We reviewed human relations (HR) records which demonstrated these checks had been mostly completed. We saw that four (9%) staff members required an up to date DBS check in Grimsby and three (7%) staff required these checks in Hull. Station managers told us that these staff members had transferred into the service when the provider was awarded the PTS contract.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The provider had an infection prevention and control policy in place which set out the responsibilities of staff at all levels. However, the policy lacked detail in cleaning processes such as vehicle cleaning and the process for conveying patients with known health care associated infections. The policy did not make reference to any other policy or guidance documents. However, the service's 'infection control procedure' contained information for staff on the cleaning and steps to take in event of a known infectious patient travelling on a vehicle.
- The service had two standard operating procedures (SOPs) in place to provide guidance to staff on the cleaning of child seats and booster seats. We saw both SOPs were within the review date.
- Staff received infection prevention and control (IPC) training. This formed part of the provider's mandatory training programme.
- The provider had an infection prevention and control audit programme in place. These audits included vehicle spot checks including equipment, deep cleaning, control of substances hazardous to health (COSHH) compliance, staff uniform compliance, hand hygiene and housekeeping compliance. The provider set a 95% compliance target for these measures. Data provided for the Grimsby office showed compliance with the infection prevention and control audits was between 97% and 100% from November 2018 to February 2019, the exception of vehicle deep cleaning in February 2019. In February 2019 the Grimsby office scored 90% for vehicle deep cleaning.
- Staff had access to hand washing and vehicle washing facilities at both offices. Vehicles contained hand cleansing gel and staff also carried personal issue hand cleansing gel.
- We saw that all ambulance care assistants wore uniforms with short sleeves to ensure compliance with being bare below the elbow. Ambulance care assistant staff were responsible for laundering their own uniforms.

Patient transport services (PTS)

- Patient transport vehicles contained personal protective equipment such as but not limited to; gloves and aprons. This helped to prevent and control the spread of healthcare associated infections.
- We inspected three vehicles at the Grimsby office and two at the Hull office. All vehicles had an infection prevention control kit, which contained items including but not limited to; aprons, various clinical and non-clinical waste bags. We saw body fluid spill kits were available for use and within expiry dates.
- The three vehicles at Grimsby office and one vehicle at the Hull office were visibly clean and free from dirt. One of the vehicles at the Hull office had been returned following a roadside breakdown, on the day of our inspection. This vehicle was visibly dirty inside and outside of the vehicle. The Hull station manager told us that staff would clean the vehicle prior to being used.
- Staff cleaned the vehicle they had used during their shift. We observed staff completing the cleaning schedule. Staff wiped surfaces with appropriate multi-surface wipes within the cabin and staff swept and washed the floor of the cabin. The outside of the vehicle was washed to remove dirt.
- The provider set out a 12-week vehicle deep cleaning schedules. The provider had secured a contract with an external company to complete deep cleaning prior to our inspection.
- Both offices were visibly clean and free from dirt and clutter. Equipment and consumables were stored above floor level to enable effective cleaning to take place. Following previous inspections of the Grimsby office we raised concerns about bird faeces in the vehicle garage. Since the last inspection in October 2018 the provider had placed netting to the roof of the garage area to prevent birds sheltering within the building and the floor of the garage had been cleaned.
- Data provided for the Hull office showed an inconsistent completion of infection prevention and control audits. The only measure that was completed from November 2018 to February 2019 was the vehicle deep cleaning. The office only submitted data for all nine measures for January 2019, where five measures did not meet the provider's 95% compliance target.
- Staff used disposable linen (blankets and quilts) for patient transportation. This reduced the risk of the spread of healthcare associated infection. We saw that linen was stored appropriately and had appropriate stock levels.

Environment and equipment

- **The service had suitable premises and equipment for the range of services it provided.**
- There were effective systems and processes in place to ensure that equipment was available, maintained and safe for use.
- The provider had a central spreadsheet for all vehicles used to transport patients. The spreadsheet contained planned vehicle servicing and MOT to ensure all vehicle checks and servicing was completed in line with legislation and the manufacturer's instructions. Both offices had a white board in the manager's office, which set out each vehicle registration, MOT date, road fund tax date and servicing for quick reference and oversight. Vehicles declared 'off road' (VOR), were clearly marked to prevent use.
- The provider used an external company to service vehicles, complete MOTs and any defect repairs. Local staff were responsible for ensuring vehicles were serviced on time, reporting defects during or after their shift to ensure repairs were timely.
- Staff accessed personal digital assistants (PDAs) to receive journey and patient information. Each office had enough PDAs for each vehicle located at the office with individual charging points. PDAs and vehicle keys were securely stored at both offices.
- Child car seats and restraints were available at the Grimsby office and these were stored appropriately. The child seat and booster seat we reviewed had fabric covers. One of the managers we spoke with told us that the cover could be washed and spare covers were available.
- The provider had specialist equipment to transport bariatric patients. Staff we spoke with told us they had access to a bariatric wheelchair and larger vehicles. The office required a 48-hour notice period for the

transportation of bariatric patients. This allowed the station manager to complete risk assessments and order the specialist equipment from the head office in Lincoln.

- Staff completed monthly site compliance audits. The overall audit score was generated from eight measures, such as building, environment, waste management, vehicle cleaning area, vehicles, notice boards, governance, compliance and fire risk. We reviewed the audit completed in March 2019 for the Grimsby office, which scored 67% overall. The provider had a target compliance rate of 85% which meant that the Grimsby office did not meet the provider's compliance target for environmental audits. The office was compliant in six out of eight measures, however the office scored 76% for compliance and 50% fire risk, which reduced the overall score. We saw the Grimsby office had taken action to resolve the fire safety issues and the compliance audits. The Hull office scored 57% in the environmental audit in February 2019 and only met the provider compliance target of 85% in two measures, environment and vehicles. The station manager had implemented changes to improve the audit performance such as ensuring the office had adequate lighting.
- We reviewed 26 consumable single use items including such as oxygen masks, eye wash solution and first aid kits. The five vehicles we reviewed were well stocked, and all single use consumables were within their expiry dates. There were first aid boxes at each office stored in accessible areas.
- Both offices had appropriate fire extinguishers within the buildings and working fire alarm systems. However, the station manager at the Grimsby told us there was some confusion about the dates on the fire extinguishers including vehicle fire extinguishers, as two expiry dates were displayed. The station manager had a contractor booked to review all fire extinguishers in May 2019. We saw a risk register entry for this concern on the offices risk register. The fire extinguishers we reviewed at the Hull office were within their expiry date.
- Staff disposed of domestic and clinical waste appropriately. We observed clinical waste bins within both bases. Managers we spoke with told us that an external company collected clinical waste monthly, however, they would complete an early collection if this was required. Domestic waste was collected by the local authority.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- The provider had an inclusion and exclusion criteria in place to ensure patients could be safely transported. Eligibility screening was undertaken through an integrated module within the electronic records system at the point of booking. All patient journeys were booked centrally at the call centre in Lincoln. Booking staff completed questionnaire with patients to assess their eligibility for patient transport services which had been agreed with the provider's commissioners.
- The provider had processes in place to complete risk assessments for the conveyance of complex bariatric patients. These risk assessments were completed by staff with specialist training. All the staff we spoke with at the Grimsby office told us that the station manager completed the complex patient risk assessments for the office. Data sent by the provider showed that the service had completed four bariatric journeys from December 2018 to April 2019.
- Complex bariatric risk assessments included information such as; patient mobility, positioning requirements, home access and patient weight. This information informed the number of staff and the equipment required to carry out the journey safely. Data provided by the service showed that 14 staff from the Grimsby office and two staff from the Hull office had completed assessment and conveyance of bariatric patients training.
- The provider had a manual handling and moving and positioning people safely hand book for staff. This document provided information about the correct moving and handling techniques for patients and gave details of manoeuvres that were unacceptable and could cause harm to patients and staff.
- The service in Grimsby and Hull completed 33 journeys for children under the age of 12 years old from

December 2018 to April 2019. Data provided showed that staff had undertaken 18 journeys from Grimsby and 15 journeys from Hull. All of the staff we spoke with had completed training in fitting child restraints.

- Staff had received training in the use of child restraints to reduce the risk of harm caused by the incorrect fitting of the restraints. Staff were expected to complete this competency which was signed off by a trainer after staff had demonstrated the correct fitting of child restraints. This training was included within the provider's mandatory training programme.
- Staff completed basic life support training as part of the provider mandatory training programme, in the event of clinical deterioration during transportation. Staff contacted emergency ambulance control through the 999 for local NHS ambulance if patient deteriorated during the conveyance.
- The service had a policy in place for patients transported who had an active do not attempt cardiopulmonary resuscitation order (DNACPR) in place. Information around DNACPR orders, if available, was passed to crews through (PDAs) as part of booking. The DNACPR policy was within the review date and included guidance for staff around the validity, different types and what to do in the absence of DNACPR orders.
- The service had a major incident plan in place which provided guidance for staff in the event of a major incident such as loss of communication systems, flood or fire.

Staffing

- **We were not assured that the service had enough staff with to provide the right care.**
- Data provided by the service prior to our inspection showed one vacant posts for the Grimsby office and five vacant posts at the Hull office. However, we were not assured that the service had enough staff to complete patient journeys in line with the key performance indicators (KPIs) set by their commissioners. Data provided by the service showed that Grimsby had 21 KPIs to meet and of these only four KPIs had been met consistently from December 2018 to April 2019. The Hull office had nine KPIs to meet and none of these had been met consistently in the same time period. This meant that patients had long waiting times and did not always get to their appointments on time.
- The provider used a modelling tool for staffing requirements. The tool considered activity data and vehicle utilisation levels to calculate the number of vehicles and staff required based on the number of patients to be conveyed, their mobility category and specific clinical requirements and appointment times. This enabled the provider to determine the number of unit hours (resources per hour of the day) required. We were not assured that the service had enough staff to meet commissioners KPIs.
- The Grimsby office employed 42 members of staff who worked to a shift rota. Most of the staff members undertook pre-booked journeys for outpatient clinic appointments and for renal dialysis treatments. There was a team of staff that completed patient discharge journeys. At the time of our inspection the office did not have any vacancies.
- The Hull office employed 43 members of staff and had five vacant posts. Staff worked to a shift rota with varied shift times and night shifts to cover the patient discharge elements of the patient transport contract. The station manager told us that they found recruitment difficult as the commissioners had given notice of the termination of the contact in December 2019.
- The staff turnover rate for both offices was low. Data provided by the service showed that the turnover rate for Grimsby office staff was 2.78% in April 2018. For the same period the staff turnover rate for the Hull office was 0%.
- The provider reported barriers to recruitment varied across different parts of the organisation. The provider told us that the recruitment of staff in highly populated areas was more difficult due to the greater choice of careers on offer. The provider also told us that the uncertainty about future contracts with commissioners was an additional barrier to recruiting and retaining staff.
- The provider had undertaken measures to improve staff recruitment rates, by the use of social media to advertise posts, partnership working with local colleges,

attendance at job fairs, holding interviews in local job centres, developing an apprenticeship scheme, and offering a number of different roles within the organisation.

Records

- **Staff kept records of patients' care and treatment.** Frontline staff had access to these records and logged patient transport times.
- The provider had systems and processes in place to record patient information and staff had access to this information in a timely way. Call centre staff based in Lincoln completed patient records at the time of the transport booking. This information was completed electronically, and frontline staff had access to these records.
- Staff received patient information through the PDAs. Staff we spoke with told us they could access the information once they logged onto the journey. Staff that worked as part of the discharge crews, told us that some information such as risk assessments and patient mobility were not always correct. One member of staff told us there was some time miscommunication between hospital staff and call centre staff.
- Frontline staff activated the electronic patient record on their PDA before they collected patients for a journey. The electronic record system recorded collection and completion times once staff confirmed collection or journey completion. Frontline staff did not add any other information to the patient record. Staff had to contact the control room to update information about patients.

Medicines

- **The service followed best practice when storing oxygen.**
- The service carried oxygen on vehicles. We saw that oxygen cylinders were stored and secure appropriately in five vehicles reviewed. In all cases, oxygen cylinders were within their expiry date.
- Oxygen cylinders were stored in an upright position in secured metal cages at both offices.
- Other medicines were not required for patient transport services. Staff kept medicines supplied to patients on discharge from hospital, with the patient and their belongings.

Are patient transport services effective?

Inadequate

We rated it as **inadequate.**

Evidence-based care and treatment

- **The service did not always ensure that policies reflected national guidance.**
- Policy documents did not always provide information based on national guidance and best practice. We reviewed the infection prevention and control policy which did not reference national guidance and did not provide the information required for staff to prevent and control healthcare associated infections. The policy did not direct staff to relevant related infection prevention and control procedural documents or cleaning procedural documents. This meant a risk that staff would not access all appropriate information and therefore may not follow the required policy guidance.
- The provider had a range of policy and procedural documents in place for staff to follow. All policies and procedures were reviewed at provider wide level. Staff had access to polices at both offices through a desktop computer that could be used by all staff and via personal digital assistants (PDAs).
- The service had a monthly office audit programme which monitored staff compliance with policy and procedural documents. These audits included cleanliness and environmental safety.

Nutrition and hydration

- Due to the nature of services provided, the service did not routinely offer food or drink to patients.

Response times / Patient outcomes

- **The provider monitored response time, although commissioner's key performance indicators were not met.**

Patient transport services (PTS)

- Due to the nature of services provided, monitoring of patient outcomes was limited for patient transport services (PTS).
- The provider monitored their performance against key performance indicators (KPIs) set out by their commissioners. The Grimsby and Hull offices served the North and North-East Lincolnshire area.
- The Grimsby office met six out of 22 KPIs consistently from October 2018 to March 2019. The service screened 98% of patients for eligibility, which met the 95% target set out by the commissioners. The service did not achieve compliance for patients arriving for their appointments at an appropriate time. Patient collection times were also outside the commissioner's target.
- The Hull office consistently met two out of nine commissioner KPIs out of from October 2018 to March 2019. Patient collection times were outside the commissioner's targets.

Competent staff

- **Staff had not participated in the appraisal processes to discuss their performance and learning needs.**
- Station managers had booked staff appraisals and had plans in place to complete a backlog of staff appraisals. Staff had received letters about their appraisal and packs had been distributed. However, no staff members had participated in performance review in the 12 months prior to our inspection. Data provided prior to our inspection reflected that no staff had participated in the appraisal process. Staff we spoke with confirmed this, some staff members had not completed an appraisal since they moved to the organisation in 2017.
- All new staff completed two weeks of induction training before completing patient journeys. The induction training was provided at the head office in Lincoln where staff completed training such as but not limited to; infection prevention and control, basic life support safeguarding and driver training. Each new member of staff had a competency booklet to complete which was signed off by a trainer once the competency was complete. The competency booklet covered each module of the induction training.
- The service provided additional training for staff in the conveyance of bariatric patients. The provider had a competency document signed off by a training once the competencies were complete. Two staff we spoke with worked within the discharge team which completed journeys for patients following discharge from hospital. These two staff members told us they had completed training to use specialist bariatric equipment.
- The station managers for Grimsby and Hull had been in post since January 2019. Both managers had received role specific training in areas such human relations and governance processes.
- Station managers completed the staff driving licence and confirmation of DBS checks. This information was sent to the human relations at head office.

Multi-disciplinary working

- **Frontline staff worked well together to support the needs of patients, however there was sometimes conflict between control room staff and frontline staff.**
- Patient transport service bookings were co-ordinated through the control centre in Lincoln, where staff selected available transport for each booking. Staff we spoke with told us they sometimes found it difficult to contact the control centre to verify patient information. However, staff told us they had completed incident report forms when they had issues contacting the control room and felt things were improving.
- Frontline staff spoke of issues they had meeting the KPIs for some patient journeys due to inappropriate allocation. The examples staff gave us were the allocation of patient journeys for appointments before the start of a staff member's shift time, or the allocation of a journey before vehicle checks were completed which limited the time to meet the KPI.
- Following our last inspection in October 2018 station managers had been appointed for both offices. The station managers had oversight of office issues and performance. They also provided staff with a point of contact to escalate concerns and communicate information to and from the senior leadership team. Staff we spoke with told us that communication with the senior leadership team had improved.

Patient transport services (PTS)

- Station managers and contact managers attended monthly contact monitoring meetings to discuss performance against KPIs and issues related to discharge delays when patients were not ready to leave at the time of the booked transport.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients who lacked the capacity to make decisions about their care.
- The electronic records system held information about patients with identified special needs and requirements which included people living with dementia and learning disabilities.The provider had a process in place for control centre staff to contact the safeguarding leads for advice when requests were made to transport patients without capacity who may have behavioural difficulties due their condition.
- Staff had access to the do not attempt cardio-pulmonary resuscitation (DNACPR) procedure. The procedural document provided information to ensure DNACPR orders were valid and what to do in the absence of a DNACPR order.
- Recommended summary plan of emergency care and treatment (ReSPECT) were in use across both offices alongside the DNACPR documents. The ReSPECT documents were expected to eventually replace the DNACPR documents, the service was awaiting confirmation from their commissioners. Staff had received information about the forms.
- The service provided training upon induction on the Mental Capacity Act, Deprivation of Liberty Standards and consent. Staff we spoke with understood the importance of consent and mental capacity.

Are patient transport services caring?

Good

We rated it as **good**

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- During our inspection we were unable to observe care provided by staff to patients. However, we reviewed 25 patient feedback cards.
- The provider participated in the NHS friends and family test. The results of the friends and family test was presented within the patient experience survey in December 2018. Both the Grimsby and Hull offices had a return rate of less than 1% with 11 surveys returned for Grimsby and one survey return for Hull.
- The patient survey showed that 73% of patients would recommend the service to their friends and family. This was lower than the provider wide result of 89%.
- Patient feedback was varied. We reviewed feedback from patients.Patients wrote comments such as “Excellent all-round friendly service thanks”, “Nice staff”, “Really good, everything was smashing. However, one patient reported a long wait.
- Staff we spoke with were patient focused and spoke with compassion about a patient who lived alone. Staff reported they checked to ensure patients had heating and food at home following a discharge from hospital. Staff told us they escalated any concerns they had about a patient’s home environment to their station manager or the control room to raise safeguarding referrals.
- Staff facilitated family and carer escorts to provide a familiar face particularly with confused patients, such as, patients living with dementia.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff demonstrated compassion and emotional support they had provided to patients in distress. We reviewed an incident report completed by two staff members following the conveyance of a patient that was distressed. We reviewed an incident form where staff had provided information about the reassurance they had provided the patient about his reduced mobility.

Patient transport services (PTS)

- We reviewed comments made by patients through the patient experience survey. One patient wrote “Staff are always caring, chatty, cheerful & thoughtful”.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff we spoke with told us they chatted with patients during their journey and informed them of any traffic delays or their expected time of arrival either at home or their appointment.

Are patient transport services responsive to people’s needs?

Requires improvement

We rated it as **requires improvement.**

Service delivery to meet the needs of local people

- **The service did not always plan and provide services in a way that met the needs of local people**.
- Office managers and contract managers had regular engagement with their commissioners to discuss performance against key performance indicators (KPIs). However, there had been limited improvement in patient transport delays since our last inspection in October 2018.
- Managers did not have clear plans in place to improve service performance against KPIs. Following our inspection, we requested the action plans in place to improve performance for both offices and we did not receive these. Managers we spoke with were not able to clearly talk about any actions taken to improve performance.
- The service had employed office managers to improve oversight of performance. The office managers had been in post since January 2019 which meant they had limited time to demonstrate improvements required to improve services for patients.

Meeting people’s individual needs

- **The service did not always take into account patients’ individual needs.**
- Call handlers at the control room in Lincoln completed eligibility checks at point of booking to ensure that patients were suitable for transportation by the service. Bookings included information on patient needs, including physical disability, sensory impairment, language needs and mental health needs. However, staff at Grimsby and Hull offices told us that the notes they received from control did not always reflect the needs of patients. Staff gave examples of patient mobility, that patients were not able to mobilise to the level recorded in the booking records. We were informed post inspection that bookings were directly made by patients and therefore the information recorded reflected the information patients provided. There was a process for staff to contact the central control to abort any booking if necessary and rebook appropriately to reflect any specific patient requirements.
- The control room sometimes planned journeys to accommodate more than one patient at a time on a vehicle. This meant that staff could not always consider the individual needs of patients, for example if the journey meant that some patients were in the vehicle for longer periods and did not reach the destination in good time.
- Staff at the Hull office told us that they sometimes disagreed with control about how many staff members were assigned to patient journeys, where patients had complex physical or mental health needs. For example, staff in Hull told us that one person was assigned to transport a patient with mental health needs, and that when staff raised concerns, control would not assign a second person.
- The service provided training upon induction on manual handling, moving and positioning patients. The service provided training on bariatric lifts to staff in Grimsby. However, there were no bariatric lifts in use at the Grimsby office at the time of inspection. Staff we spoke to in Grimsby did not raise any specific concerns about transporting bariatric patients, which was an improvement since our last visit.

Patient transport services (PTS)

- Staff we spoke with told us that they had not recently provided transport for children. Staff knew how to access child car seats and child harnesses from the storerooms on site.
- The service had a range of leaflets to assist staff in communicating with patients with sensory impairments. However, we did not see many of these leaflets in a physical format on office and they were not kept in all vehicles.
- Staff inductions included equality and diversity training, and longer-term staff in Hull told us they had additional training updates.
- The service had a third-party translation service that staff could access by phone. However, we did not see any instruction leaflets for this service on vehicles. Some members of staff told us that they would use a picture chart to communicate with patients who did not speak English. We saw that these charts were available on several vehicles, but not on all the vehicles we checked.
- Staff inductions included dementia awareness training. Staff in Hull told us that they had dementia awareness training as part of their top-up mandatory training, and that they found this useful. Staff in Grimsby and Hull spoke with kindness about patients with dementia.

Access and flow

- **Waiting times were not always in line with good practice.**
- The service monitored non-emergency patient transport activity which formed a key performance indicator which was reported to local commissioners. Data supplied for the North and North-East Lincolnshire area from April 2018 to February 2019, showed that the service achieved an average of 74% compliance with same day collections within the target of 150 minutes.
- Staff we spoke with in Grimsby and Hull said that the control room often planned and assigned journeys without considering the time needed to check vehicles, or travel between locations. This led to longer waiting times for patients. For example, staff told us that the control room assigned journeys less than five minutes after the start of their shift, when the service policy is to spend at least eight minutes completing vehicle checks.
- Staff told us that mismanagement of journeys negatively affected patients. For example, one staff member said that control room assigned a journey to them some time after the patient was due to be picked up. When they arrived at the location, it was an elderly patient who had been waiting for several hours without being contacted.
- Crews who completed patient transfers and discharges told us that they had problems with patients who were being discharged from hospital and were not ready when they arrived to transfer the patients. This caused additional pressure on the service as staff had to wait or abort the journey.
- Staff we spoke with told us that the organisation required a 48-hour notice period to transport bariatric patients. This was in line with contractual arrangements. This allowed staff with specialist training to complete risk assessments. Staff in Grimsby told us that their station manager completed risk assessments for complex patients including bariatric patients.
- The service had arrangements in place to use third party organisations to provide patient transport at times of high demand. Managers completed a compliance assessment for each third party used, which covered areas such as safeguarding and safety equipment such as child harnesses. We reviewed one of the compliance assessments and found these assessments were complete. However, we did not see any restrictions such as the third party not completing child conveyance if they had no child harnesses in place.

Learning from complaints and concerns

- The service had systems and processes in place to manage complaints. However, the service had limited evidence that leaning from complaints was shared with staff.
- There was limited evidence that managers shared learning from complaints with staff. We reviewed staff meeting minutes for both the Grimsby and Hull offices from February to April 2019 and found that complaints had not been discussed with staff.
- The service had a centralised Patient Experience Team (PET) at the headquarters in Lincoln, which service users and their family members could contact to provide

comments, complaints or concerns. The PET gave complaints a risk rating and forwarded the information to the relevant station manager and contract manager for investigation.

- Data provided following our inspection showed that patients raised 11 concerns about the service provided by the Grimsby office from January to March 2019. Of these complaints, six concerns were upheld or partially upheld. Patients had raised 15 concerns about the service provided by the Hull office during this period, of these eight were upheld or partially up held.
- The service had recently designed a new patient feedback and complaints form. We saw the new forms at the two offices, for example, in offices and staff rooms, but we did not see them on any of the vehicles we checked.
- At the Hull office the station manager had recently brought in a new target for staff members to gather at least one patient feedback form per week to improve responses.

Are patient transport services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership of service

- **Leadership and management of the service had been through a number of changes.** The senior management team had been restructured and station managers had been introduced, which had increased staff confidence in the leadership of the service.
- The role of station manager had been introduced following our last inspection in October 2019. Both station managers had been in post since January 2019. The station managers were responsible for the local management such as staff management, audit and performance.Staff we spoke with told us that they felt supported by their station managers and more engaged with the organisation.
- Station managers reported to the head of operations and the head of operations reported to the director of operations. There was a clear line of escalation from the office to the executive board.
- The Grimsby and Hull offices had a named contract manager responsible for the oversight of the key performance indicators set out by the commissioners. Contract managers reported to the director of operations. Station managers liaised with contact managers discuss local performance against commissioner's key performance indicators and actions to improve performance against these measures.
- The provider was led by the chief executive officer who was supported by the executive management team. The executive management team included the director of finance, director of operations, director of work force and a project director. Each of the directors held a directorate portfolio such as the director of quality and clinical governance was responsible for areas such as the oversight of safeguarding, quality and audit.
- Staff we spoke with told us that the executive leadership team were more visible. Staff from the Hull office told us that the executive team had visited the office to speak with staff following a notice of termination of the contact from commissioners.

Vision and strategy for this service

- **The service had a vision of what it wanted to achieve and plans to turn this in to action.**
- The provider had a three-year strategy in place, published in 2018. The strategy document set out the organisation vision underpinned by four organisational objectives and a set of staff values.
- The staff values were displayed within offices. We saw the organisation objectives and staff values on display in staff areas of both offices. Staff we spoke with knew the organisational values.

Culture within the service

- **Managers across the service promoted a positive culture.**
- There had been an improvement in staff morale since the last inspection in October 2018. Staff we spoke with praised their station managers and felt they could raise

any concerns they had. They felt supported by the local managers and told us they had improved working conditions since their appointment. Staff felt more empowered to raise issues such as communication between frontline staff and the control room by completing incident reports. Staff told us they had started to see improved communication and working relationships with control room staff with these actions.

- Two members of staff we spoke with told us how their station manager had provided support and reasonable adjustments following life changing events.
- Station managers provided feedback to staff if they raised concerns. Staff we spoke with told us that they received feedback following the completion of an incident report or raising a concern. This had led to staff feeling valued members of the team. One member of staff told us "it is 100 times better than it was when I started work in December 2017".
- The human resources team had conducted interviews with staff to explore their concerns and communication issues. Staff we spoke with told us that since these interviews there had been improvements in communication across the organisation.
- Due to the short period of improvement in the culture and communication, we were unable to make a judgement about the sustainability of the positive changes reflected by staff.

Governance

- **The service did not always systematically improve service quality.**
- The service had limited evidence of improved quality of services, due to their performance against commissioner's key performance indicators. We found that policy documents did not appropriately support evidence based processes such as the prevention and control of healthcare associated infections. However, we saw improvements in local management support which positively impacted on staff attitudes and improved engagement with incident reporting.
- The service had systems and process in place to provide information to the executive board for the oversight of performance, safety and quality assurance. Staff had clear lines of accountability with an escalation process in place.
- Station managers met with the clinical governance lead for the north to discuss local safety and quality performance. Clinical governance leads attended quality and clinical governance group meetings chaired by the director of quality and clinical governance. We reviewed the quality and clinical governance group meeting for December 2018 and February 2019, which demonstrated discussions included agenda items such as incidents, risks and complaints.
- Station managers met with the contracts managers to discuss performance against the commissioner's key performance indicators. Contract managers attended operational meetings chaired by the director of operations.
- The provider had mechanisms in place to provide executive board oversight for the operational meeting and quality and clinical governance group meetings. The director of quality and clinical governance and the director operations reported into monthly executive board meetings.
- The service had implemented office level staff meetings to share the key messages from the board and the senior leadership team. We reviewed minutes held in Grimsby and Hull offices from February to April 2019. The minutes demonstrated that staff could raise their concerns or any issues they had. However, there was limited evidence of shared learning regarding incidents and complaints.

Management of risk, issues and performance

- **The service had not identified all local risks.** Although the service had local risk registers in place and plans to eliminate or reduce the identified risks.
- Each of the offices we visited had office level risk registers in place, station managers were responsible for updating ongoing risks. We reviewed the risk register for the Grimsby office and found five risks had been identified. We found three risks had mitigations in place but the risk rating had not changed. An example of this was one risk rated as extreme for a not having a CQC registered manager in place, had been resolved with a registered manager in post, however the risk rating had not been downgraded to reflect this change. Data the provider sent us following the inspection demonstrated that the risk register for Grimsby was updated with all risks down graded to low with the mitigation in place.

- The Grimsby station manager told us the main risk for the office related to fire safety. The office had undertaken repairs to the fire alarm system and had a fire marshal in place. However, the manager was not clear if fire extinguishers for the office and vehicles were compliant with fire regulations. A contractor had been booked to review all of the fire extinguishers.
- The Hull station manager told us the main risk was for staff recruitment following the commissioners giving notice on the PTS contract, which was due to end in December 2019. This meant staff recruitment and retention was difficult. However, the risk register showed that the recruitment of staff was rated a medium risk whereas the highest risk was no access to hot water for vehicle cleaning except from the kitchen in the office.
- The Grimsby office risk register did not include the risk of not meeting commissioner's key performance indicators. We identified this as a risk due to the sustainability of service. However, we saw this was risk was included on the corporate risk register.
- The safety and quality lead reviewed office risk registers and escalated significant risks to the safety and quality group for inclusion on the directorate risk register. The directorate risk register reported into the corporate risk register and was broken down in to the each of the director's area of responsibility. An example of this was the director of operations was responsible for the eight identified operational risks such as key performance indicator achievement and staff recruitment and retention.
- The provider had 14 risk entries on the corporate risk register. These risks included staff training. We saw that mitigation was in place and the risk rating had been reduced as a result of the mitigation in place and staff compliance with mandatory training had improved.

Information Management

- **The service collected and managed information, using secure electronic systems with security safeguards.** However, there was limited evidence that information related to performance was used to improve the service**.**
- The service collected electronic and paper based information to monitor safety, quality and performance. This information was reviewed by managers to inform changes to working practices in relation to office cleanliness. However, there was limited evidence, performance against KPIs had improved since the last inspection in October 2018.
- The service used an electronic patient records system which staff could access securely through personal digital assistants (PDAs). Staff could access policy and procedural documents through these devices and a computer terminal at the office.

Public and staff engagement

- **The service had improved patient and staff engagement process.**
- The provider had developed an employee engagement committee. One member of staff we spoke with was a member of the employee engagement committee. The committee worked on strategies to improve communication between staff in different departments of the organisation. For example, improved communication between frontline staff and control room staff.
- The provider conducted staff surveys annually, the last staff survey was published in September 2018. The survey results identified areas for improvement; in staff training and development, executive team engagement with frontline staff, and staff confidence in the leadership of the organisation. Staff we spoke with during the inspection felt the organisation were addressing the issue identified by the staff survey. All staff we spoke with told us the organisation had improved in these areas.
- Each office had notice boards to provide key messages to staff. Information on notice boards included, previous team meeting minutes, the office risk register and fire safety procedures.
- The provider had a staff engagement new letter called 'battenburg'. We reviewed a copy of the newsletter which included a message from the chief executive officer, a thank you message from the Grimsby station manager and an article detailing the role of work based assessors.

Patient transport services (PTS)

- Monthly team meetings were introduced in January 2019 and held at each of the offices we visited. These meetings had a fixed monthly agenda for staff to discuss items such as incident learning, safeguarding, performance and risks.
- The organisation participated in the NHS friends and family test using a patient feedback form. However, the return rate for Grimsby and Hull offices was low. The Hull office manager had set a target for one patient feedback return per member of staff every week to improve the local response rate.

Innovation, improvement and sustainability

- **The service had made improvements to working practices with further improvements planned.** However, performance remained below the commissioner's targets.
- The service developed an electronic application for staff to completed vehicle checks through the PDAs, to prevent control room staff allocating journeys to frontline staff until vehicle checks had been completed. This application was being trialled in one of the satellite offices prior to the roll out to all other offices.
- The service had worked with an external company to develop an electronic human resources system. The station managers had user names and passwords for the system however, we were unable to see this in use as station managers had not had the necessary permissions to access the records.
- During this inspection we observed improvements with the cleanliness of offices, clinical governance and staff morale following the changes in local and executive management. However, these changes were in their infancy and had not led to an improvement in key performance indicators set out by commissioners. As a result, we were unable to determine if these changes were sustainable and would lead to future improvements in performance.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure policy documents reflect national guidance and best practice, to guide staff in their responsibilities.
- The provider should develop recovery plans to improve service performance to meet key performance indicators.

Action the hospital SHOULD take to improve

- The provider should improve the incident investigation process, records and evidence leaning from incidents.
- The provider should improve the performance to improve the quality of the service to patients.
- The provider should ensure staff have an annual appraisal to discuss their performance and learning needs.

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