Thames Ambulance Service Limited

# Homelands House

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Homelands House is operated by Thames Ambulance Service Limited. The service provides patient transport services (PTS).

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 February 2017 along with an unannounced visit on 03 March 2107.

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.

**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 issues that the service provider needs to improve:

- Incident reporting systems and processes were not robust and did not operate effectively. There was a lack of incidents being reported, and investigating and learning from incidents needed to be better.
- Staff could not demonstrate they understood the term Duty of Candour and their role in regard to the legislation.
- Staff were not trained appropriately in vehicle deep cleaning and they did not always use personal protective equipment (PPE) during deep cleaning processes; the management of healthcare waste had not been risk assessed and the service was not disposing of mopheads used for cleaning areas where a patient had an infection via an orange-bag system. This meant that the service was not following national waste management standards and guidance.; staff did not have access to a change of uniform at work in the event their uniform became contaminated; patient's risk of infection was not routinely assessed at each patient booking; and staff were unaware whether there was an infection control lead for the organisation.
- Managers did not have oversight of the MoT and servicing status of any of the vehicles used for PTS. They told us that a local car garage took responsibility for this.
- Whilst daily vehicle checklist forms were completed by staff, we saw that where items or equipment were recorded missing or faulty, the subsequent action taken was not recorded.
- We requested a copy of the policy for the management of medical gases; however, this was not provided so we were not assured that the management of medical gases was safe.
- Only 79% of staff were up-to-date with adult safeguarding training, and staff were unaware whether there was a lead for safeguarding within the organisation.
- Safeguarding policy and procedures did not reflect necessary national best practice guidance, nor the relevant local authority contact details and referral forms.
- We were unable to determine whether the service had suitable systems and processes in place for the investigation of safeguarding incidents because the service could not evidence that a thorough investigation had taken place by way of a report.
- 79% of staff were compliant with mandatory training requirements. This was below the services target compliance rate of 85%.
- Staff had not received training on, nor was there a policy and procedure in place for the management of violence and aggression.
- Patient booking records did not contain sufficient patient identifiable information, nor sufficient information regarding the patient's medical condition.

# Summary of findings

- There was a lack of risk assessments undertaken for those considered high risk, such as those patient's transported who were detained under the Mental Health Act. In addition, there was no policy and procedure in place in relation to the management of such detained patients.
- Staff had not received training on mental health, learning disability, dementia, and older people with complex needs, despite people living with these conditions who regularly used the service.
- The majority of policies and procedures we looked at were under review and, or, were missing necessary evidence-based practice and accurate information.
- The service did not assess and monitor their performance in terms of response times, waiting times, number of patients spending more than (locally defined) standard time on vehicles and rate of same day bookings. There was also no benchmarking of service performance against other similar providers.
- We requested staff appraisal rates from the service however these were not provided; therefore we could not be assured that staff appraisals were conducted.
- Staff said that additional training opportunities need to get better.
- Whilst staff confirmed that managers regularly assessed their driving ability, there was no record kept to show this.
- 79% of staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), and staff had insufficient understanding of the related legislation and unlawful and lawful restraint. However staff demonstrated to us that they would not restrain a patient in anyway, and if they were asked to they would seek immediate support and advice from a manager within the service.
- There was a lack of patient feedback systems in place and the service could not show that it improved the quality of its care as a result of feedback.
- Information about how to make a complaint was not made available to patients in PTS vehicles, and there was a lack of guidance available to staff as to how to manage a complaint.
- There were no formal and agreed eligibility criteria in place for people who used the service.
- Staff were not provided with learning aids to assist effective communication for those living with dementia or a learning disability, nor were there translation service available.
- There was no governance framework in place to outline governance arrangements within the organisation.
- The service risk register did not make reference to the person accountable for each risk and there was no specific date that each risk was to be, or had been reviewed.
- Team meetings with a manager did not happen, and meetings between the two managers were neither formal nor minuted.
- Staff did not receive one to one meetings with their line manager.
- Monthly staff newsletters had not been distributed since October 2016.
- We saw that building work had commenced for the development of a new ambulance parking area and dedicated cleaning bay. However there was no strategic plan or record to support this.
- We had concern about one manager's lack of understanding in relation to: audit, the service's strategy, plan and core values, known service risk, certain policy and procedures, number of complaints and incidents reported, and they did not demonstrate they were able to ensure good governance of the service.
- The services Statement of Purpose (SoP) as required by the Care Quality Commissions (Registration) Requirements 2009 did not meet Regulation 12 of those regulations.

However, we also found areas of good practice:

- Staffing levels and skill mix was appropriate to meet patient need, and staff received adequate time off between shifts.
- Other providers who worked with the service gave us positive feedback, and told us that the service was very responsive and performed well.
- Staff demonstrated they were caring people, who strived to provide high quality and individualised care to people who used the service. They also told us that they enjoyed working for Thames Ambulance Service Limited.

# Summary of findings

- 100% of patient driving staff that had completed their First Person on Scene Intermediate (FPOS-I) or Enhanced (FPOS-E) training.
- There had only been one complaint made about the service between January 2016 and January 2017.
- Staff had monthly peer meetings called “Speak Out” which provided an opportunity for staff to give feedback and ask questions as a group to management.
- There were provider-wide “Monthly Performance, Quality and Audit reports” which were well formatted, and provided good oversight of the issues covered, allowing different locations to be compared in terms of performance.

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. We also issued the provider with three requirement notices. Details are at the end of the report.

**Ted Baker**

Deputy Chief Inspector of Hospitals (Central Region)

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Patient transport services (PTS) | | We have not rated patient transport services (PTS) at Homelands House because we were not committed to rating independent providers of ambulance services at the time of this inspection. |

# Homelands House

## Detailed findings

**Services we looked at**
Patient transport services (PTS)

# Detailed findings

## Contents



## Background to Homelands House

Homelands House is operated by Thames Ambulance Service Limited. Thames Ambulance Service is part of The Thames Group, a nationwide independent ambulance service, offering emergency and non-emergency patient transport services (PTS) across the country, both in the public and private sector.

The Homelands House service first opened in July 2016. It is an independent ambulance service, providing PTS services only. The service primarily serves the communities within East Anglia.

The service has had a registered manager in post since October 2016.

This is the first inspection we have carried out for this service.

We carried out an announced inspection on 20 February 2017 along with an unannounced inspection on 03 March 2017.

## Our inspection team

The team that inspected the service comprised a CQC Inspection Manager, CQC Lead Inspector,and two other CQC Inspectors, one of which was a registered paramedic. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

## Facts and data about Homelands House

The service operated from a number of areas within "Homelands House", a privately-owned building. The areas which the service occupied here included a staff room, two offices, toilet facilities, a storage room, an outside medical gas storage area, a vehicle cleaning area, and outside parking. The service worked on an "adhoc" basis and had no contracts in place with other providers or stakeholders. The majority of work stream came from local acute trusts (LATs) however the service also accepted some private work.

The service is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely

During the inspection, we visited Homelands House and checked all the areas here used by Thames Ambulance Service Limited. We spoke with nine members of staff including; the registered manager and operations

manager. We asked the service if we could speak with people who used their service, if those people were happy to do so, however, the provider did not respond to this information request. Therefore,

We did not speak with any service users. We also reviewed documents including ten patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity (January 2016 to January 2017)

- There were 2453 patient transport journeys undertaken between January 2016 and January 2017

Two managers, 17 patient transport drivers, and one administrative member of staff worked at the service.

At the time of our inspection the service had six patient transport vehicles in use, five were ambulances and one was a car.

Track record on safety (between January 2016 to January 2017)

- Two incidents, one serious and one which related to a concern about a member of staff
- No serious injuries
- One complaint

# Patient transport services (PTS)

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |
| Overall | |

## Information about the service

The service operated from a number of areas within Homelands House, a privately-owned building. The areas which the service occupied here included a staff room, two offices, toilet facilities, a storage room, an outside medical gas storage area, a vehicle cleaning area, and outside parking. The service worked on an "adhoc" basis and had no contracts in place with other providers or stakeholders. The majority of work stream came from local acute trusts (LATs) however the service also accepted some private work

## Summary of findings

Overall, we have not rated patient transport services as Homelands House because we are not committed to rating independent providers of ambulance services at the time of inspection.

We found that:

There was no singular incident reporting form in place, and the multiple forms used led to staff confusion as to what constituted an incident.

Staff had not received appropriate infection control and prevention training, and we were concerned about waste management.

Safeguarding policies and procedures for children and adults did not reflect best practice standards, nor was there up to date information regarding the local authorities safeguarding team.

The service did not analyse their response times, nor any other patient outcome data. There was no benchmarking of service performance against similar providers.

Staff did not receive yearly appraisals with their line manager.

There was a lack of patient feedback systems in place and the service could not show that it improved the quality of its care as a result of feedback.

Staff were not provided with learning aids to assist effective communication to those living with dementia or a learning disability, nor were there translation services available.

# Patient transport services (PTS)

The service risk register did not contain information about the person accountable and there was no specific review dates for each risk.

There were no scheduled and minuted meetings between the two service managers, and team meetings did not occur.

However:

Staffing levels and skill mix was appropriate to meet patient need and staff received adequate rest time between shifts.

Vehicles were clean, well organised and contained necessary equipment to keep people safe.

Staff demonstrated they were caring people, who strived to provide high quality care to people who used the service.

All staff had received training on bariatric moving and handling practices.

100% of patient driving staff had completed their First Person on Scene Intermediate )FPOS-1) or Enhanced (FPOS-E) training.

## Are patient transport services safe?

**Incidents**

- Records showed that two staff related incidents had been reported between January 2016 and January 2017, of which one was a complaint about a member of staff's driving and another had been classified as a serious incident which related to a safeguarding concern. We were concerned that this number of reported incidents was low, particularly since staff had described to us other incidents that had taken place during this same time period. For example, a manager told us that there had been an additional safeguarding incident.
- There was an up-to-date "Incident Reporting and Serious Investigation (SI) Policy and Procedure" in place which had been reviewed in February 2017. This contained information about staff responsibilities in relation to incident management, corporate accountability, and incident and SI procedure. It was written across the document that the policy and procedure was under review however two managers confirmed the policy was still in use.
- There was a paper-based incident reporting system in place, with accident, incident and safeguarding forms. There was no singular incident reporting form used.
- We spoke with three members of staff. We were concerned that the incident reporting system was not fully understood by staff. For example, one staff member told us they have had to report a safeguarding issue in the past but that this was "not an incident", and another told us that the incident reporting system was, "complex". Furthermore, the provider's "Incident Reporting and Serious Incident Policy and Procedure" (version five) last reviewed February 2017 did not make this clear. A manager confirmed that this policy was the one in use at the time of inspection.
- Managers told us that all completed incident, safeguarding and accident forms were given to them by staff within 24 hours of the concern arising, and verbally they were made of the concern straight away. Following receipt of the completed relevant form, the manager sent all forms directly to the Associate Director of

Quality and Clinical Governance, who was responsible for receiving and logging incidents, and appointing investigating officers and reporting to the Clinical governance group accordingly.

- We were concerned that six members of staff were unable to give examples of learning from incidents when we asked. This included a manager. This meant that we were not assured that lessons learnt were shared locally and throughout Thames Ambulance Service Limited, to make sure action is taken to improve safety.
- Staff were informed about changes in policy or procedure following national safety alerts. We saw evidence of this in the staff room where a notice explained to staff that there had been a change to procedure in relation to an automated electronic defibrillator (AED). This notice was dated February 2017.
- A manager explained to us that a panel of staff, "The Rapid Review Panel", assisted in the identification of potential or actual SIs following an incident form being received. In the event of an SI this was escalated immediately to the operations manager and Medical Director or Chief Operating Officer (COO). If required the COO initiated an emergency Executive Board meeting/ conference call to discuss the course of action required.
- We requested the RCA investigation report for the serious incident which was reported July 2016 and related to safeguarding, however, the provider did not provide us with a copy of this. This meant that we could not be assured that a thorough investigation had taken place and whether the provider was following its own SI procedure as set out in the provider's policy.
- The incident log the provider sent us, titled "Incidents, serious incidents and complaints for Ipswich January 2016 to January 2017", showed that that this reported SI was "closed" and therefore the investigation completed. A senior manager during our inspection also confirmed this. This contradicted what a local manager told us; as they said that the incident was still under investigation. This meant we also had concerns about how SI information was communicated to and understood by local management.
- Four members of staff we asked demonstrated that they had satisfactory understanding of the term Duty of Candour, however one manager could not tell us what Duty of Candour meant and what their role involved in relation to this. The Duty of Candour is a legal duty on health organisations to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- There was a Duty of Candour policy in place which was up-to-date, due for review in June 2017, and contained necessary information to support staff in decisions relating to the application of the duty.

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

- A manager told us that the service did not use a clinical quality dashboard.
- We did however see that "Monthly Performance, Quality and Audit Reports" were developed by head office and disseminated locally. The reports contained information from all Thames Ambulance Service Limited locations, including Homelands House. There were six parts to the report; audit outcomes for the whole provider; audit outcomes per location; overview of safeguarding referrals for the month; analysis of serious incidents, complaints and any legal issues; occupational exposure and IPC hazards or incidents; and overview of training compliance.
- We checked the "Monthly Performance, Quality and Audit Reports" reports for November and December 2016 and January 2017. We have discussed the outcomes of these reports further throughout this report under applicable subheadings.

**Cleanliness, infection control and hygiene**

- There was an up-to-date "Infection Prevention and Control Policy" last reviewed February 2017 which staff had access to.
- We checked three patient transport vehicles and found that the vehicles and the equipment contained within them were visibly clean. There was also fully stocked personal protective equipment (PPE) on all the vehicles, including gloves and aprons, and hand sanitising gel.
- We asked to see the cleaning records to show whether vehicle and equipment cleaning had taken place between patient use and at the end of the shift. A manager confirmed that this cleaning was not recorded by staff. We also saw that there were no cleaning schedules in place, like a tick list, to show staff what to clean after each patient. This meant that we could not be assured that cleaning was taking place after each patient used the service and at the end of the shift.

# Patient transport services (PTS)

- At the beginning of each shift, as part of staff's daily vehicle checklist, staff did however check and recorded whether the vehicle they were going to take out was visibly clean. We checked ten recently completed checklists and found that these were fully completed and made reference to cleanliness.
- The service employed an external cleaner three times per week to undertake cleaning activities within the staff room, toilets and offices. During our inspection we observed these cleaning activities be carried out.
- Vehicles were deep cleaned every six weeks at minimum, or after the service had transported a patient who was classed as being high risk in terms of infection, such as patients with diarrhoea.
- We checked the deep cleaning records for three vehicles from September 2016 to February 2017 and saw that deep cleaning was carried out regularly and as a minimum six weekly. We also saw that there was a step by step checklist for deep cleaning which staff followed, this ensured thorough and standardised cleaning schedules.
- Two members of staff told us that they performed the deep cleaning of vehicles and that they hadn't received any formal training for this. They said they were shown how to carry this task out by other members of staff when commencing employment with the provider. They also told us that they did not wear PPE, or change their uniform after a deep clean is completed. Furthermore the provider's "Infection Prevention and Control Policy" (version seven) last reviewed February 2017, did not make reference to deep clean processes, uniforms, what training was required for staff and what PPE equipment should be used for deep cleaning. A manager confirmed this lack of training and PPE usage. This meant that we were not assured that there were formal and reliable systems in place to prevent and protect people from healthcare-associated infection.
- We raised our concerns about the lack of formalised deep cleaning training to a senior manager, who told us that they were in the process of arranging training for staff which would be delivered by an external cleaning company, and we were later provided with evidence to show this. However no training dates for staff had been arranged at the time of our inspection.
- Four members of staff told us that they did not have a change of uniform at the base, which meant if their uniform became contaminated during work, they would have to continue wearing the contaminated uniform until they got to their home. There was no guidance for staff about this in the provider's "Infection Prevention and Control Policy" (version seven)
- Staff told us that they were responsible for the cleaning or their uniforms.
- We observed that mop-heads, which were used for deep cleans and general cleaning duties were disposed of directly into a skip, located outside the base. Two members of staff confirmed this was routine practice. Mop-heads are a type of "healthcare waste"; that is, "any waste produced, and as a consequence of, healthcare activities" (National Institute of Health and Clinical Excellence (NICE), Healthcare-associated infections: prevention and control in primary and community care, CG139, 2017). Standards published by the "Department of Health (DH), Environment and Sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste: 2013" explicitly make reference to the ambulance service and PTS, which state: a risk assessment should be conducted to determine types of hazardous, infectious and domestic waste produced by the service, and these types of waste must be segregated, described, classified and disposed of appropriately in line with regulations such as the Hazardous Waste Regulations. According to these standards, "where infectious waste is generated, it should be disposed of in the orange-bag waste stream".
- A manager confirmed no risk assessment had been undertaken for the disposal of waste, we saw no reference to waste management procedures in the provider's infection prevention and control policy (version seven), and the service was not disposing of mopheads used for cleaning areas where a patient had an infection via an orange-bag system. This meant that the service was not following national waste management standards and guidance as detailed above.
- At our unannounced inspection on 03 March 2017 a manager told us that mophead disposal practice had changed, whereby mopheads that were classified domestic waste were disposed of in a black bin bag and placed into the skip, and likely infectious waste was orange-bagged. However this manager also confirmed that no risk assessment had been carried out nor had changes been formally made to the infection control and prevention.

# Patient transport services (PTS)

- We checked the booking forms of five patients who had used the service, completed by the other organisation making the booking for example a hospital. However we found there was no area on this booking form which reminded booking staff to consider IPC risk. There was also no mention of IPC risk recorded anywhere else on any of the forms. Staff told us that when they collected the patient they would check with hospital staff and record this in the separate booking transfer form. However this meant that staff were not aware of IPC risk prior to collecting patients.
- We saw that PTS staff had hand-held sanitiser clipped onto their uniforms.
- There were numerous monthly IPC audits undertaken for the service. This included vehicle spot checks for cleanliness, hand hygiene, number of vehicle deep cleans performed each week, weekly cleaning of vehicles and station and premises housekeeping audits. We reviewed audit results for November and December 2016 and January 2017 which showed good compliance with IPC standards measured.
- IPC audit results from January 2017 showed that 100% of all PTS vehicles had a clean cab and saloon area, 100% of equipment in the ambulances were clean and 92% were up to the exterior cleanliness standard.
- Hand hygiene results for this same reporting period represented a score of 90% as one out of ten staff audited did not wash their hands as required. The audit report also stated that this, "Crew member [was] reminded of the Thames IPC Policy and the importance of good hand hygiene", which showed immediate action was taken as a result of audit to improve service provision.
- Records showed that 100% of staff were compliant with their annual and mandatory IPC training.
- Three members of staff confirmed that there was no dedicated lead within the service for infection prevention and control. A manager was also unaware whether there was a lead for the provider either.

**Environment and equipment**

- There were six PTS vehicles used by the service, five were ambulances and one was a car. We randomly checked three of these vehicles and found that necessary equipment was present and appeared in good working order, the vehicles were neat and tidy and that single-use equipment was in date and that packaging was intact.
- On the vehicles there was equipment to keep patients safe. This included slide sheets, PAT slides, standard safety belts, and wheelchair tracking which ensured wheelchairs were secure during transit.
- We checked the servicing records for 98 pieces of equipment used by the service and which required servicing, such as moving and handling equipment. We found that equipment was serviced regularly by an appropriate external company, and had passed the service.
- We requested records from the service on two occasions to show that PTS vehicles were up-to-date with servicing and MoT requirements. However this information was not provided to us in a timely manner. We asked a manager why this was the case and they told us that this was because a local car garage took responsibility for maintaining these records and calling the service when each vehicle was due for checking. This meant that the provider was not ensuring that its fleet of vehicles used was properly maintained, due to a lack of oversight of vehicle maintenance and because no formal arrangements were in place to show the car garage was taking responsibility for such legal motor requirements.
- Staff told us that when equipment or vehicles became faulty, they were labelled accordingly, this was reported and the equipment or vehicle was taken out of use. We saw one ambulance which was out of use with a sign in the window indicating this.
- The service operated from a number of areas within "Homelands House", a privately-owned building which contained other and non-related organisations. The areas which the service occupied here included a staff room, two offices, toilet facilities, a storage room, medical gas storage area, vehicle cleaning area, and outside parking. We checked all these area and found that environments were clean, tidy and well organised.
- We saw that vehicle keys were stored securely behind locked doors.
- Staff completed a vehicle check at the start of each shift, using a daily vehicle inspection checklist. This included external checks such as tyres, internal electrics such as lights and radio, and patient equipment including oxygen. We reviewed the checklist for ten vehicles and found that these were fully completed. However we also noted that when items of equipment were missing or another issue was identified, there was no record on the sheets what action had been taken.

- We checked three PTS vehicles and saw that equipment was standardised throughout. Staff we spoke with also confirmed this for the other PTS vehicles used.

**Medicines**

- The service used Nitrous Oxide (Entonox) and Oxygen. We saw that these were stored safely and securely in an outside shelter.
- We also saw that medical gases were transported securely in the three PTS vehicles we checked; cylinders were fixed in upright positions to the wall of the ambulance.
- We reviewed a risk assessment which had been carried out in November 2016 for the storage, transportation, delivering and administration of Oxygen.
- We requested a copy of the provider's medical gas management policy and procedure on two occasions, however, this was not provided. We later saw that a key area that required addressing was the "policy and procedure for the management of medical gases and their storage", from a recent audit report undertaken by a national company who specialise in the manufacturing of cleaning and hygiene products, systems and training for healthcare. This report was dated January 2017.
- We checked nine oxygen cylinders and found these were in date.
- Monthly medical gas audits were also carried out to determine the number of Oxygen and Entonox cylinders delivered and returned, to ensure stock was accounted for. Audit results between November 2016 and January 207 demonstrated that the provider had oversight of all medical gases in use and returned.
- The service did not use or store any other drugs, including controlled drugs.

**Records**

- We saw that records, containing patient information, were managed in accordance with the Data Protection Act 1998. Records were kept securely in locked filing cabinets behind locked doors, preventing the risk of unauthorised access to patient information.
- Some staff, such as managers and administrative staff, had computer access to a shared-computer drive.
- We saw that computers were password protected and locked when not in use.
- Staff confirmed that they did at times transport patients with Do Not Attempt Resuscitation (DNAR) orders in place. They told us that they check that the order is up-to-date before collecting the patient and communicate the order verbally to the next organisation as required. One member of staff gave an example where they had found that a patient's DNAR form had not been dated, and subsequently this member of staff refused to transport the patient from the hospital until the issue had been rectified.
- We reviewed five booking forms for patients and found that the forms lacked necessary patient information which we have reported on fully under the "assessing and responding to patient risk" subheading. This meant that patient records were not complete.
- Staff told us that patient records were transported in an envelope during transport to ensure patient confidentiality.

**Safeguarding**

- Records showed that 100% of staff were up-to-date with level one and two safeguarding children's training, however, only 79% (15 out of 19) staff were up-to-date with their adult safeguarding training.
- At the time of our inspection the "Safeguarding children and young people policy and procedure" last reviewed September 2016, and, the "Safeguarding Vulnerable Adults Policy and Procedure" dated October 2016 were under review. Staff still had access to these policies and procedures which contained information about types of abuse, how to report abuse and made reference to legislation such as The Children's Act (1989, 2004). The children's policy however did not make reference to staff training and competency requirements as referenced in The Royal College of Paediatrics and Child Health's Intercollegiate Document issued in March 2014. Furthermore, the policies did not refer staff to the correct local safeguarding team and referral form types were incorrect. Essex County Council details and forms were used opposed to Suffolk County Council.
- We spoke with six members of staff about safeguarding. All of which correctly described what constituted a safeguarding incident, and when and how they would raise a safeguarding concern.
- Two members of staff were able to give us an example of how they had effectively managed a safeguarding incident in the past.
- We were unable to determine whether the service had suitable systems and processes in place for the investigation of safeguarding incidents because despite

us requesting on two occasions, the provider did not send us the internal investigation report for the safeguarding incident it had reported in July 2016. This meant we were not assured that there were robust systems and processes in place to prevent abuse of service users. However the incident log we reviewed did show that the service had escalated the incident appropriately to the local policing authority.

- We were concerned that none of the six members of staff we asked, including the manager, knew whether there was a dedicated safeguarding lead within Thames Ambulance Service Limited.

**Mandatory training**

- There was a mandatory training programme in place for all staff and subjects covered included: First Person on Scene Intermediate (FPOS-I) or Enhanced (FPOS-E), Infection Prevention and Control (IPC), Manual Handling, AED and Oxygen Therapy, Basic Life Support, Child Protection, Safeguarding Adults, Data Protection, Equality and Diversity, Mental Capacity, and Health and Safety incorporating Fire Awareness.
- Staff received training through web-based and face-to-face learning, through the Thames Group training and development department.
- Records showed that 79% (15 out of 19) staff were up-to-date with all mandatory training. This was below the services target compliance rate of 85%.
- 16 members of staff had completed enhanced driver training according to records the service showed us.
- All staff we asked told us they had received recent training on how to safely transfer bariatric patients to and from ambulances

**Assessing and responding to patient risk**

- There was an up-to-date "Deteriorating Patient During Patient Transport Procedure" in place created January 2017 to guide staff about the management of a patient whose wellbeing deteriorated during their transport. However one manager we spoke with was not aware that this procedure document existed.
- We spoke with five members of staff about how they would manage a situation where a patient's health and wellbeing deteriorated during transport. All members of staff told us that they would stop the vehicle and call 999 for paramedic support, and they would perform basic life support as required. This was in line with the provider's agreed procedure.
- There was no policy or procedure in place to guide staff how to manage disturbed behaviour, violent or aggressive patients. A manager confirmed this.
- Staff had not received training in conflict resolution. Four members of staff told us this including one manager. Another manager told us they had received this training in the past through the provider but they were not sure if it was provided to all staff. This meant that we were not assured that staff were equipped to deal with violent or aggressive patients.
- We checked five booking forms which were completed for each patient prior to transport. We found that on all five forms there was insufficient information recorded including, a lack of patient identifiable information, and about each patient's medical needs and whether that patient posed an infection risk. For example, two of the patient's required cardiac monitoring during transfer from one hospital to another hospital. However the reason for this monitoring had not been recorded and when we asked the two members of staff responsible for collecting these patients on the day of our inspection, they told us that they wouldn't know this information until they collected the patient and received handover from hospital staff. Both of these members of staff also told us that this was routine practice and they only found out most patient information at the time of collection. This lack of patient information meant there were potential missed opportunities to undertake risk assessments and plan care accordingly and safely.
- Records from January 2016 to January 2017 showed that the service had transported two patients detained under the Mental Health Act without police or mental health staff presence. We discussed this with a manager who told us that no risk assessments had been carried out by the service before the patients were transported. When we asked the provider to tell us what section of the act each patient had been detained under they did not provide this information. We also saw that there was no policy and procedure in place to for the transfer of patients detained under the act, which a manager also confirmed to us. This meant we could not be assured that these patients and future patients were transported safely.
- Staff had not received training in mental health or dementia. Five members of staff confirmed this. This lack of training meant we were not assured that staff would be able to identify and respond to patients living with conditions that may pose behaviour challenges.

# Patient transport services (PTS)

### Staffing

- Staffing levels were based upon service demand.
- Records we looked at for the month of January and February 2017 showed that actual staffing levels reflected planned levels.
- Sickness rates between January 2016 to January 2017 showed that there had been 23 episodes of staff sickness.
- The service employed 15 full-time and two bank PTS staff, one full-time administrative member of staff, and two managers.
- We were told by a manager that if a member of staff was unexpectedly absent then the shift was covered by bank staff or other staff taking overtime work.
- Staff worked a four shift on and four shift off duty pattern. Full time working hours equated to 41.5 hours per week and daily hours were dependent on bookings.
- We spoke with eight members of staff all of whom told us that staffing levels were safe, and that on average they worked an 11 hour shift within Working Time Directives (WTD) with adequate break times.
- Out of normal office hours staff had access to on call duty managers at all times.

### Response to major incidents

- There was a "Business Continuity Plan" in place which was up-to-date and was last reviewed in July 2016. This plan provided a clear course of action in the event of a major interruption to the service. This included but was not limited to loss of IT infrastructure, fire or severe adverse weather.
- A provider "Major Incident Plan" was also in place had been last reviewed in February 2016 and included the role of the PTS.
- We asked two managers whether staff were provided with training on major incidents, they told us that staff received this training every two or three years and that it was incorporated into their First Person on Scene Intermediate (FPOS-I) or Enhanced (FPOS-E) training.

## Are patient transport services effective?

### Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards and legislation were identified, developed and ratified through the Thames Ambulance Service Limited executive team.
- We checked ten policies and procedures and found that most of them were under review at the time of our inspection. We identified concerns with most of the policies we reviewed of which we have discussed further under each relevant subheading within this report. For example, the adult safeguarding policy in use did not refer staff to the correct local safeguarding team and referral form types were incorrect, and the infection prevention and control policy and procedure did not provide information about ambulance deep cleaning procedures and staff uniform practices. This meant that policies and procedures were not up-to-date and did not contain necessary information.
- Staff had access to policies and procedures in paper format. We saw that these were kept in the staff room. Three members of staff told us that staff working remotely had a work phone allocated to them and they could contact the manager in the office if they needed information regarding policy and procedure.
- We saw that managers had access to electronic copies of all of the Thames Ambulance Service Limited policies and procedures via a computer shared drive, and managers told us they were responsible for updating the paper copies held for staff as needed.

### Assessment and planning of care

- PTS bookings were managed by the administrative member of staff, overseen by two managers.
- Bookings were made from another organisation, for example a hospital where their staff had already conducted a needs assessment for the patient they were requesting patient transport for. These booking forms had areas to prompt and remind staff to record information about each patient's condition including any "special alerts" such as if a patient was living with a mental health disorder. We however had concerns that there was a lack of information on these forms which we have reported further under "assessing and responding to patient risk", and that the service did not carry out any assessments for patients prior to collecting them.
- We saw that PTS staff had daily jobs sheet, which contained the bookings they were responsible for on

that day in relation to outpatient transport jobs only. We saw two of these job sheets and found that relevant information was present on them about each patient's condition including space for any "special alerts".
- Staff told us that they always checked whether patients had adequate food and drink for long journeys, or if the patient had a medical condition such as diabetes before departing the collection area.

**Response times and patient outcomes**

- Records showed that there were 2453 patient transport journeys undertaken by the service between January 2016 and January 2017.
- The service did not analyse their response times (time from collection of patients to their arrival at required destination, before or after their appointment, and the time waiting for their return), nor, any other patient outcome data, for example, number of patients spending more than (locally defined) standard time on vehicles and rate of same day bookings. A senior manager confirmed this.
- There was also no benchmarking of service performance against other similar providers.
- A senior manager confirmed that there were no audits undertaken in relation to response times and patient outcomes. The provider's audit programme was limited to infection control, vehicle maintenance, Control of Substances Hazardous to Health (COSHH), staff uniform compliance, medical gases and record keeping, of which we have reported on under the "safety" section of this report.

**Competent staff**

- We asked the provider to send us records to show how many staff had received an appraisal in the past year. However despite requesting this information twice this was not provided. Therefore we were not assured that there was regular appraisal of staff performance, that staff learning and development needs were identified, planned for and supported.
- A manager told us that they had not received an appraisal in the last year by their line manager.
- Five members of staff told us that they did not receive regular one to one meetings with their line manager. A manager confirmed the absence of this support for staff. A manager did however tell us that they operated an "open door" policy and that staff could speak to them as required, of which staff we spoke with confirmed this.
- There was a structured induction programme in place for all new staff and those who had been promoted. We saw that there was an up-to-date "Staff Induction Policy and Procedure" (version six dated August 2016) in place, which set out an induction framework and induction checklist for line managers. Three members of staff we asked told us they had completed an induction programme on commencing employment with Thames Ambulance Service Limited. We asked the provider to send us records to show that staff had completed an induction programme however this was not provided.
- The organisation carried out pre-employment driver competence checks on all drivers. This was led by a qualified driving assessor. We asked five members of PTS about this and all of them confirmed they had received such an assessment before commencing employment for Thames Ambulance Service Limited.
- A manager told us that following staff's initial driving competence check, a manager regularly accompanied drivers in PTS vehicles to re-check driving competence; however, they also told us that there was no record kept to show this. Staff we spoke with confirmed this happened.
- Driver licence checks were carried out every six months, which was in line with organisations "Safer Recruitment Policy"; version six dated February 2016. This policy stated that the maximum permissible number of penalty points on a drivers licence was six.
- A robust pre-employment checking system was in place for staff to assess if applicants were suitable for the role they were applying for. This included Disclosure and Baring Service (DBS), referencing and occupation health checks. DBS checks were carried out three yearly thereafter. We checked employment records for all staff employed to work at the service which confirmed this practice.
- The service did not however require drivers to pass a pre-employment eyesight test to determine visual ability. Two managers confirmed this.
- Records showed that staff had received some additional training dependent on their job role for example all staff we spoke with told us they had received training in bariatric moving and handling.
- However two members of staff told us that they believed that additional training could be improved. One member of staff told us, "continuous professional development needs improving, for example we don't get any training in mental health". We also saw minutes

from a staff peer meeting called "Speak Out" dated January 2017, where staff raised concern that there was "a lot of disappointment where training is concerned". For example, staff stated they required more safeguarding training to carry out their role effectively. When we asked staff about this they said that this was due to safeguarding training being delivered via e-learning and not being made applicable to their role.
- 100% of patient driving staff that had completed their First Person on Scene Intermediate (FPOS-I) or Enhanced (FPOS-E) training.
- Through talking with managers, we were assured that there were systems in place to identify and effectively manage poor or variable staff performance. We also saw an incident log which made reference to an incident reported in 2016 relating to an allegation of unsafe staff driving. Records showed that appropriate action had been taken by the provider to identify this concern and manage it effectively.

**Coordination with other providers and multi-disciplinary working**

- We received feedback from other providers who worked with the service. Feedback about the service was positive and showed that the service was responsive, staff were polite, caring and friendly and same day bookings were available. One provider told us that, "Thames are very good", and that they are "quick to respond" to booking requests.
- A manager told us they met regularly with the local acute trusts (LAT) that the service worked with, however, that no record of these meetings was kept.
- Staff told us that they had a positive-working relationship with other providers, and that generally LATs were good at sharing information in terms of patient's condition and needs, if the need was serious.

**Access to information**

- PTS staff had daily job sheets for patients being collected from outpatient departments. These sheets detailed necessary patient information including the patient's name, date of birth, address and drop-off or pick up locations. There was also a section which included any special notes, which may have included issues such as if the patient was living with dementia, had a do not attempt cardiopulmonary resuscitation (DNACPR) order, was diabetic or had restricted mobility.
- We checked two job sheets and found these contained all the relevant information required.
- We were concerned however about patient booking forms; that is forms that were used for hospital transfers other than outpatient department collections. These forms did not contain sufficient information about the patients' needs. We have commented fully on this concern under the "assessing and responding to patient risk" subheading within the "safe" section of this report.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- 79% of staff (15 out of 19) had received training on the Mental Capacity Act (MCA, 2005), and on Deprivation of Liberty Safeguards (DoLS, 2010) which was incorporated into Adult Safeguarding training. This was below the services target compliance figure of 85%.
- We asked five members of staff about the MCA, DoLS, and unlawful and lawful restraint. However they were unable they understood these issues sufficiently. For example, one member of staff told us that they thought lawful restraint was entirely for "protecting yourself". Although all members of staff said they would never restrain a patient without the patient's consent, and if asked to do so where a patient lacked mental capacity, they would escalate to a manager for further guidance and support.

## Are patient transport services caring?

**Compassionate care**

- We asked the service to provide us with the contact details of people who had used the service, if people were happy to speak with us, however the service did not respond to this data request.
- The service did not conduct any patient surveys or hand out comment cards. A senior manager confirmed this. Therefore we were unable to review written patient feedback in this form.
- We were also not provided with any other patient feedback despite requesting this during our inspection.

**Understanding and involvement of patients and those close to them**

# Patient transport services (PTS)

- There were no formal and agreed eligibility criteria in place for patients, which meant that we were not assured that patients and other providers would understand the service provision offered by Thames Ambulance Service Limited.

**Emotional support**

- Through discussion with nine members of staff we spoke with, all staff demonstrated that they would act in a caring and supportive way to patients and those close to them.
- Staff told us that they encouraged patients to bring family members or carers on their journeys.
- We were given numerous examples by staff which showed staff supported patients to cope emotionally where required. For example, one child's parents had requested that the same PTS staff from the service transported their child every time the child required transport. This was because this child lived with learning disabilities and became distressed during transport, and the parents of the child commended how the child had been at ease and calm due to the kind nature of the staff from service.

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

**Service planning and delivery to meet the needs of local people**

- The service provided non-emergency patient transport services (PTS) for patients who were unable to use public or other transport due their medical condition. This included but was not limited to those attending outpatient appointments, being discharged from hospital and those attending hospital for treatment such as renal dialysis.
- The service was a private PTS that operated on an adhoc basis. Work stream came via other organisations such as the Local Acute Trusts (LAT), care homes and self-funding patients within East Anglia.
- The service did not have any contracts in place with any LATs or Clinical Commissioning Groups (CCG) in the region.

**Meeting people's individual needs**

- We were concerned that staff had not received training on dementia, learning disability, conflict resolution and older people with complex needs. A manager confirmed this. However staff we spoke with indicated that if they were transporting a patient with any of these conditions they would find out as much as possible about the individual's needs and plan the journey accordingly. They were also able to give us examples to demonstrate this.
- We checked three PTS vehicles and saw that there were no learning aids available to assist effective communication for those living with dementia or a learning disability. Four members of staff confirmed they had no other access to such tools.
- A manager told us there was no access to translation services for people using the service who could not speak English. We then asked two members of staff what they would do in such a scenario. One member of staff told us that they were aware of a recent transfer where the patient only understood and spoke Polish. This member of staff told us that, "it was lucky the other driver spoke the same language otherwise we would have just had to get on with it".
- Staff told us that if a patient had staff gender preference then this could be arranged.

**Access and flow**

- Patient transport bookings were made either by patients or, on behalf of them by other health and social care organisations.
- Bookings were made by telephone directly to the service, or via email or fax.
- The service did not measure performance outcomes, so we are unable to report how responsive the service was in regard to time from collection of patients to their arrival at required destination, the waiting time for return journeys, number of patients spending more than (locally defined) standard time of vehicles and same day booking rates.

**Learning from complaints and concerns**

- Between January 2016 and January 2017 there had been one complaint raised about the service. This involved a member of the public raising concern about a member of staff's driving standards. We asked the service to send us a copy of the investigation into the complaint and the response to the complainant.

However we found that following the investigation no lessons learnt were considered and Thames Ambulance Service Limited had not provided a response to the complainant.
- There was an up-to-date "Complaints and Compliments Policy and Procedure" in place dated June 2016. We found that this policy did not clearly guide staff how to manage a complaint effectively.
- We spoke with four members of staff and they explained to us that if a patient was unhappy about the service they received they would give the patient their managers work telephone number.
- There was no written information within patient transport vehicles about how to make a complaint about the service. We checked three vehicles.
- We did however find that people were able to make a comment or complaint via the Thames Ambulance Service Limited website, which had information about how to make a service complaint and who to contact if "you" are unhappy with the service's complaint response.
- Four members of staff and a manager were unable to give us an example of how the service had made improvements subsequent to a comment or complaint being made about the organisation.

## Are patient transport services well-led?

### Leadership / culture of service related to this core service

- An Executive Management Team (EMT) led the organisation and this team included the chief executive officer (CEO), the chief operating officer (COO), the finance director, human resources (HR) director and a director of training and development.
- At local level the service was overseen by a regional operations director and led by two managers, one of which was the CQC registered manager.
- We had concern about one manager's lack of understanding in relation to: audit, the service's strategy, plan and core values, known service risk, certain policy and procedures, number of complaints and incidents reported, and they did not demonstrate they were able to ensure good governance of the service.
- We spoke with six members of staff all of whom told us that managers were visible, approachable and supportive to them. PTS staff also told us they had access to an on call manager 24 hours a day seven days per week.
- Staff also told us that there was an open and honest culture within the organisation, and that they were encouraged to report risk and raise concerns.
- Records showed that managers had received recent supervisory management training.
- All staff we spoke with told us they liked working for the service, and some employees had worked for the service for a number of years.

### Vision and strategy for this this core service

- There was not a clear vision and strategy for the service. Whilst managers told us there were plans to develop the service, in terms of building an ambulance wash bay, and we saw work had commenced, they told us that there were no formal plans in place in relation to this.
- We observed a notice in one of the offices which outlined the organisations core values. We asked three members of staff, including a manager, and they were not aware that the organisation had agreed values in place. One staff member we spoke with was aware of these core values and where to find them. This meant that staff did not know the provider's agreed values.

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

- There was no local governance framework in place to outline governance arrangements within the service. A manager confirmed this.
- We reviewed last two clinical governance meeting minutes for Thames Ambulance Service Limited dated January and February 2017. We saw that these meetings were well attended by appropriate staff, were minuted and that the meeting agenda was standardised.
- There was a service risk register in place which identified and showed action taken to mitigate known risk. However, the person accountable for each risk was not identifiable and there was no specific date that the risk was to be, or had been reviewed. There was however evidence that risk had been managed effectively, for

example, one issue identified in August 2016 was that the service was required to be able to trace medical gases. Subsequent to this we saw that monthly audits were in place to ensure this.

- We asked a manager to give us examples of identified risk on the service's risk register. This person however was unable to give us an example and told us, "we don't really have any risk here it's not a problem". This meant they were not familiar with the risk register content and actual risk within the area they managed.
- Managers were not aware whether there was a local or provider-wide audit strategy and plan. However they were aware that audits were regularly completed and presented within the provider's "Monthly Quality, Performance and Audit Report". Managers told us that they were prompted for data regularly from head office to assist data collection for audit purposes.
- There was a lack of risk assessment and risk management processes were not robust. We have discussed this further under the "safe" section of this report. This included the issue that patient risk assessments had not been carried out for patients who were detained under the mental health act using the service, and waste management processes.
- There was a lack of service user feedback systems in place. We have commented on this further under the "responsive" section of this report.
- The service did not measure performance outcomes in terms of key performance indicators (KPIs) and how responsive the service was in regard to time from collection of patients to their arrival at required destination, the waiting time for return journeys, number of patients spending more than (locally defined) standard time of vehicles and same day booking rates.
- The services Statement of Purpose (SoP) as required by the Care Quality Commissions (Registration) Requirements 2009 did not meet Regulation 12 of those regulations. In particular, the SoP did not contain required information such as the range of service users' needs which those services intended to meet, sufficient information about the provider and registered manager or details of the locations where services were provided, as set out in Schedule 3 of the Regulation. This SoP was also undated therefore we were not sure when this was last reviewed.
- Staff told us that team meetings with a manager did not happen. We also saw that staff had raised concern to local management in February 2017 via staff peer meetings called "Speak Out" sessions, they said, "We never have official staff meetings with management. We feel there should be regular meetings with minutes notes taken" in February 2017.
- We were also concerned that the services two managers told us that they did not have regular meetings between them which were minuted.

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

- Recent to our inspection a new staff engagement session had been implemented called "Speak Out". This session was peer led and provided an opportunity for staff to engage with the service as the minutes were disseminated up to managers for necessary action. Staff were separated into two teams, the blue and green team, and meetings were held monthly for each team and arranged by staff. We saw three sets of minutes for these sessions which were held January and February 2017. These meetings were well attended.
- Staff told us that they did not receive one-to-one meetings with their line manager.
- A senior manager told us that Thames Ambulance Service Limited newsletters were distributed to all staff monthly. However five members of staff told us that they did not receive newsletters monthly. One staff member told us, "I saw one once about six months ago.
- We requested the last three newsletters from the provider and where only sent one dated October 2016. This newsletter was detailed and contained necessary and relevant information for staff including updates about each of the provider's locations, and reminders on practice standards expected including how to handover patient care to other organisations.
- There were limited opportunities for public engagement with the service. People who used the service and those close to them could make a comment, compliment of complaint via the organisations website.
- The service did not routinely engage with the public or people who used the service. A senior manager told us that there were plans to distribute feedback questionnaires to patients in the future; however, at the time of our inspection this system was not used.
- We reviewed that latest Thames Ambulance Service Limited staff survey results from November 2016. Overall 314 staff members were asked to complete the survey, however, the response rate was only 27% (85

responses). Areas identified as needing improvement from the survey report were: “more team meetings required; more staff training required; and communication could be more effective between management and staff” and that the survey was going to be repeated in January 2017. However we were not assured this survey had been repeated as planned, since the service only sent us records for the November 2016 staff survey despite us asking for the latest survey reports.

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

- There were plans to make improvements to the service’s premises, including the development of an ambulance cleaning area within the existing building. At our unannounced inspection on 03 March 2017 we saw that outside building work had already commenced outside. However a manager told us there was no strategic plan or record to support these improvements.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

- The registered person must give the Commission a statement of purpose containing the information listed in Schedule 3.
- The provider must ensure it assesses the risks to the health and safety of services users who are detained under the Mental Health Act, and do all that is reasonably practicable to mitigate risks.
- The provider must ensure that all patients' needs are assessed at the earliest opportunity to ensure planning and delivery of care is safe.
- The provider must improve its incident reporting and investigation process, and ensure learning from incidents is embedded into practice.
- The provider must ensure that vehicles it uses to transport service users are properly maintained, safe and used in a safe way.
- The provider must improve its infection, control and prevention systems and processes including ensuring staff receive appropriate training, maintaining cleaning records and reviewing its waste management procedures.
- The provider must ensure that safeguarding systems and processes are improved and operated effectively, including safeguarding investigations.
- The provider must operate a robust governance framework which allows it to effectively assess and monitor the services it is providing.
- The provider must improve auditing and performance monitoring systems.
- The provider must ensure it operates feedback systems for people who use the service and those close to them.
- The provider must show that it is evaluating and improving practice in the respect of the processing of information, including from patient feedback, complaints and incidents.
- The provider must ensure that information about how to make a complaint is visible to service uses, and review the service's complaints process.
- The provider must ensure that staff received one to one meetings and regular appraisal.
- The provider must maintain records to show that staff driver competency is regularly assessed.
- The provider must review the training opportunities available to staff and consider the staff training concerns we have identified during the inspection.
- The provider must ensure that managers are supported, and have the ability and knowledge to carry out their job role effectively.

### Action the hospital SHOULD take to improve

- The provider should consider introducing a quality dashboard or equivalent.
- The provider should improve record keeping in relation to vehicle checklists and missing or faulty equipment identified on them.
- The provider should review its medical gas management risk assessment and consider all medical gases used by the service.
- The provider should act to improve staff's mandatory training compliance.
- The provider should consider introducing learning aids to assist effective communication for those living with dementia or a learning disability, translation services.
- The provider should consider improving its risk register by ensuring reference is made to person accountable for each risk and that review dates are clear.
- The provider should consider continuing monthly staff newsletters.
- The provider should consider developing a strategic plan for the service, ensuring records are kept to show discussions made about future changes to the service.
- The provider should ensure that all staff are familiar with and know their responsibility in relation to Duty of Candour.
- The provider should review all its policies and procedures to ensure that information contained within them are accurate, up-to-date and reflective of national standards, legislation and best practice

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely | Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose<br><br>12 (1) The registered person must give the Commission a statement of purpose containing the information listed in Schedule 3.<br><br>How the regulation was not being met:<br><br>The SoP did not contain required information such as the range of service users' needs which those services intended to meet, sufficient information about the provider and registered manager or details of the locations where services were provided, as set out in Schedule 3 of the Regulation. The SoP was also undated. |

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems and processes must be established and operated effectively to prevent abuse of service users, and to investigate, immediately act upon becoming aware of, any allegation or evidence of such abuse.<br><br>How the regulation was not being met:<br><br>Policies did not refer staff to the correct local safeguarding team and referral form types were incorrect. Essex County Council details and forms were used opposed to Suffolk County Council.<br><br>Six members of staff we asked, including the manager, did not know whether there was a dedicated safeguarding lead within Thames Ambulance Service Limited. |

This section is primarily information for the provider

# Requirement notices

The children's safeguarding policy did not make reference to staff training and competency requirements as referenced in The Royal College of Paediatrics and Child Health's Intercollegiate Document issued in March 2014.

79% of staff had received training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), and staff had insufficient understanding of the related legislation and unlawful and lawful restraint.

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed. They must receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform. Staff must also be enabled where appropriate to obtain further qualifications appropriate to the work they perform<br><br>How the regulation was not being met:<br><br>We asked the provider to send us records to show how many staff had received an appraisal in the past year. However despite requesting this information twice this was not provided. Therefore we were not assured that there was regular appraisal of staff performance nor that staff learning and development needs were identified, planned for and supported.<br><br>Staff had not received training on mental health, learning disability, dementia, and older people with complex needs, despite people living with these conditions who regularly used the service.<br><br>79% of staff were compliant with mandatory training requirements. This was below the services target compliance rate of 85%.<br><br>There were no records to show that driver competency was regularly assessed. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br><br>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints 16 (1)(3a)(b)<br><br>How the regulation was not being met:<br><br>Between January 2016 and January 2017 there had been one complaint raised about the service. This involved a member of the public raising concern about a member of staff's driving standards. We asked the service to send us a copy of the investigation into the complaint and the response to the complainant. However we found that following the investigation no lessons learnt were considered and Thames Ambulance Service Limited had not provided a response to the complainant.<br><br>There was no written information within patient transport vehicles about how to make a complaint about the service |

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met:<br><br>Staff were not trained appropriately in vehicle deep cleaning and they did not always use personal protective equipment (PPE) during deep cleaning processes<br><br>The management of healthcare waste had not been risk assessed and the service was not disposing of mopheads used for cleaning areas where a patient had an infection via an orange-bag system. This meant that the service was not following national waste management standards and guidance.<br><br>Staff did not have access to a change of uniform at work in the event their uniform became contaminated. |

This section is primarily information for the provider

# Requirement notices

Patient's risk of infection was not routinely assessed at each patient booking.

Staff were unaware whether there was an infection control lead for the organisation.