

		<b>THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE</b>	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of David Coleman, Chief Legal Officer

Report to	<b>Health Scrutiny Committee for Lincolnshire</b>
Date:	<b>20 February 2019</b>
Subject:	<b>Thames Ambulance Service Limited – Care Quality Inspection Report</b>

**Summary:**

On 13 February 2019, the Care Quality Commission (CQC) published a report following an inspection of Thames Ambulance Service Limited on 23 October 2018. The overall finding of the CQC is that TASL is 'inadequate'.

**Actions Required:**

As part of the Committee's consideration of the Thames Ambulance Service Limited item, to take account of the findings of the Care Quality Commission, following its inspection of the Thames Ambulance Service Limited on 23 October 2018.

## 1. Background

The Care Quality Commission (CQC) has a role inspecting patient transport services and as part of this role inspected Thames Ambulance Service Limited on 23 October 2018. Thames Ambulance Service Limited (TASL) provides non-emergency patient transport services nationwide, with locations in Hull, Grimsby, Scunthorpe, Lincoln, Louth, Boston, Grantham, Spalding, Leicester, Loughborough, Canvey Island, Sussex, Kettering, and Northampton.

During the short-notice announced inspection on 23 October 2018 the CQC inspected the Lincoln Head Office and the Lincoln, Spalding and Grimsby locations.

On 13 February 2019, the CQC published its inspection report following the inspection on 23 October 2019. The CQC's overall ratings for the service are as follows:

Safe	Effective	Caring	Responsive	Well-Led	Overall
Inadequate	Inadequate	Good	Inadequate	Inadequate	Inadequate

The full report of the CQC is available at the following link:

<https://www.cqc.org.uk/location/1-217265480>

### Summary of CQC Findings

The CQC's report includes the following summary of its findings:

- Generally, staff we spoke with during our inspection of the ambulance stations said they had not completed safeguarding or mandatory training and station managers told us they had no access to training data. At the time of our inspection, the provider was unable to tell us staff compliance rates with safeguarding or mandatory training.
- Generally, ambulance staff we spoke with during our inspection said they had no training on the MCA or meeting the needs of bariatric patients. Staff said they had not received handling and moving training and felt unsafe transferring bariatric (morbidly obese) patients. However, we could not corroborate this.
- At the Grimsby ambulance station, managers told us they had no access to staff contact information and didn't know how to contact staff if they needed them to cover shifts or inform them of any changes.
- We found infection control issues at the ambulance stations we visited, this included staff not having access to running water at the Spalding location and staff were unable to clean vehicles, and records of deep cleaning were unavailable. At the time of our inspection, the Grimsby ambulance station had ongoing issues with cleanliness and bird control.

Following our inspection, the provider took action to install pest control equipment to eliminate this. We found visibly unclean vehicles at the Spalding and Lincoln ambulance stations.

- Generally, ambulance staff and managers we spoke with during our inspection did not understand risk at the stations we visited, we found out of date policies in use and some of the ambulance staff had no personal digital assistants (PDA) to support their day to day activities limiting their access to information. This was particularly evident at Grimsby, where nine PDA were out of use.
- Ambulance staff we spoke with during our inspection told us they had no access to equipment for transporting children, despite the provider offering this service and we found limited equipment for this purpose during our inspection.

- Medical gasses at Spalding site were not being stored safely, there were environmental issues with the base being on a second level and staff access to equipment provided.
- Generally, ambulance staff told us they had not received appraisals or supervision, and data supplied by the provider showed appraisal rates below the providers compliance target.
- Generally, ambulance staff we spoke with during our inspection told us of their concerns regarding the safe transport of patients with mental health needs or dementia and questioned how the provider was assessing patient needs and if staff were competent to transfer these patients.
- Generally, ambulance staff told us they did not receive feedback from complaints or incidents, unless they were directly involved. Information sharing was not routine and we found staff lacking in information about the new organisational structure and proposals for the business going forward.
- Managers and ambulance staff were not using key performance data at ambulance station level, generally staff we spoke with were unaware of how this was used or how it impacted on the business or quality of the service.
- The provider monitored call centre handling times and at the time of our inspection we saw compliance against call handling targets was not being achieved. Some ambulance staff we spoke with questioned how work was allocated to the ambulance teams as they often felt patients were not assessed correctly.
- Generally, staff we spoke with at the ambulance stations didn't know the providers vision or strategy, staff did say they wanted to provide good care, but they were not aware of the providers vision or strategy.
- We found limited records of team meetings at the stations we visited, staff told us they have had very few meetings, if any, in the last six to 12 months.
- Leadership was not embedded throughout the service, staff described a culture of significant change, consistent changes in management and a lack of senior management presence throughout the organisation.
- Generally, ambulance staff we spoke with told us that relationships with the transport booking and call handling teams was fractious and there were difficult relationships between front line and office staff. Ambulance staff said that workloads often led to them not getting breaks or correct information about patients.
- Generally, staff told us that staff morale was low at the ambulance stations we visited. Staff said they had no contact with the senior team and that managerial posts had changed so much they were unsure who was in managerial roles.

However, we also found:

- The provider had recruited a fleet manager, we noted an improvement from our last inspection in terms of fleet management and the provider had detailed records of vehicle maintenance and scheduling.
- Staff we spoke with across the providers teams, demonstrated caring attitudes towards patients and a will to provide them with the right level of care and support.
- The complaints team had increased in size and the provider now had a system to log and respond to complaints formally.
- The provider had implemented a corporate risk register, strategic plan, vision and business plan.
- The provider had introduced a quality team and was beginning to review some areas of performance data.
- The provider had increased the number of staff trained to safeguarding level 3 and 4.

## **2. Consultation**

This is not a consultation item.

## **3. Conclusion**

As part of the Committee's consideration of the Thames Ambulance Service Limited item, to take account of the findings of the Care Quality Commission, following its inspection of the Thames Ambulance Service Limited on 23 October 2018.

## **4. Background Papers**

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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