Beverley Ambulance Service Limited

Beverley Ambulance Service Limited

Quality Report

Little Kendale Farm,
Scarborough Road,
Driffield
YO25 5UY
Tel:01377821125
Website:www.beverleyambulance.co.uk

Date of inspection visit: 8 October 2019
Date of publication: 09/12/2019

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	Inadequate
Patient transport services (PTS)	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

Beverley Ambulance Service Limited is operated by the Beverley Ambulance Service Limited . The service provides a patient transport service for NHS and independent health providers.

Beverley Ambulance Service Limited is not commissioned or contracted to provide patient transport services for any commissioners, NHS or private health providers. Patient transport services are provided on an as required basis.

The service also provides private emergency first aid and medical cover at sporting venues and events, medical repatriations and transport on behalf of insurance companies as well as organ transport. These activities are not regulated by the care quality commission and were therefore not inspected.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the service on 8 October 2019.

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.

Our rating of the service was **Inadequate** overall.

- The provider did not have a structured approach to identifying the training needs of staff or have a monitoring system to ensure staff received mandatory and statutory training.
- The provider did not record the qualifications held by staff to show they were suitably trained for their role.
- There was no policy, process or procedure for staff to follow to seek advice from the clinical lead.
- There was no policy or process for staff to follow in relation to dealing with deteriorating patients.
- There was no policy or process for staff to follow as to what action to take if a patient they were transporting had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place.
- The provider did not follow the follow the British institute of cleaning science and national patient safety (2016) colour coding systems for identifying which cleaners to use on which areas of the vehicles or premises.
- There were no facilities at the providers operating base for the disposal of clinical waste.
- The provider did not store medical gasses in accordance with the health and safety executive regulations 1998.
- The provider did not have a supply of consumable items to replace those used on the ambulances.
- There was no transport eligibility criteria of patients' policy to ensure the service was not transporting patients whose medical conditions were such that the staff transporting the patient were not suitably qualified or experienced to transport such patients.
- The provider did not use patient record forms during the booking in process, taking responsibility for the patient, during the patient transport and during the patient handover procedures.
- Staff records were incomplete.
- There was no incident reporting policy, duty of candour policy or safeguarding policy.
- The providers management team and directors did not have a clear understanding of the Health and Social Care Act regulations 2008 (Regulated Activities) Regulations 2014 (Part 3), how they applied to their business and how to comply with them.
- The provider did not have any key performance indicators to measure the quality and safety of the services provided.
- There was no set programme of audits carried out or a process whereby the audit results could be reviewed, and any resultant improvement actions taken.
- There was no risk register.
- There was no induction course for new staff or a training needs analysis carried out.

Summary of findings

- There was no record of staff health clearance checks and proof of identity or eligibility to work in the UK.

Following this inspection significant concerns were identified in relation to regulatory compliance. A notice under Section 31 of the Health and Social Care Act 2008 was issued to the provider suspending registration as a service provider in respect of patient transport services from 11 October 2019 until 25 November 2019.

We told the provider that it must take 47 actions to comply with the regulations to help the service improve. We issued the provider with one requirement notice and four enforcement notices that affected patient transport services. Details are at the end of the report.

Name of signatory

Sarah Dronsfield

Deputy Chief Inspector of Hospitals (North East), 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)	Inadequate 	Patient transport services was the regulated activity carried out by the provider. Beverley Ambulance Service Limited was not commissioned or contracted to provide patient transport services for any commissioners, NHS or private health providers. Patient transport services were provided on an as required basis. In the reporting period July 2018 to July 2019, there were 595 patients transported on behalf of a local NHS hospital trust. The provider told us all the patients were adults and were low acuity. The service did not carry out any patient transports on behalf of private health providers in the reporting period.

Inadequate

Beverley Ambulance Service Limited

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Beverley Ambulance Service Limited

Beverley Ambulance Service Limited is operated by the Beverley Ambulance Service Limited. The service opened in 2014. It is an independent ambulance service based in Driffield, East Yorkshire.

Beverley Ambulance service provided a patient transport service primarily serving the communities of the East Riding of Yorkshire. This service was delivered privately on behalf of a local NHS hospital. The service also provides private emergency first aid and medical cover at sporting venues and events, medical repatriations and transport on behalf of insurance companies and organ transport.

The service was previously inspected by the Care Quality Commission in March 2017.

The service employed four staff, which included the registered manager who was also a director and emergency medical technician (EMT), a second director who was an advanced care assistant (ACA), one emergency care assistant (ECA) who was responsible for the company administration and an advanced care assistant (ACA). The service had an associated clinical/ medical director who was the safeguarding lead. They worked on a consultancy basis.

The service had not transported any children in the reporting period July 2018 to July 2019 and they did not transport patients with mental ill health.

All management functions for this service were managed from the providers registered location in Driffield, East Yorkshire.

Beverley Ambulance service was registered for one regulated activity. This was in respect of transport services, triage and medical advice provided remotely.

The registered manager had been in post since December 2014.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,a CQC assistant inspector, and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Detailed findings

Facts and data about Beverley Ambulance Service Limited

The service was registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the providers operational base in Driffield. We spoke with five staff including; the registered manager, a company director, an ECA, ACA and the clinical lead. We inspected two patient transport ambulances.

The service did not use bank or agency staff. The service did not use or store controlled drugs.

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

The service had been inspected once before at a previous registered location in March 2017. Following that inspection, the service was given five must do and three should do actions and two requirement notices in relation to regulation 12 and 17. The service submitted an action plan to deal with the issues highlighted. During this inspection we found some of the required actions resulting from the 2017 inspection had not been completed these are highlighted in this report.

Activity (July 2018 to July 2019)

- In the reporting period July 2018 to July 2019 there were 595 patient journeys undertaken on behalf of a local NHS hospital trust. There were no patient journeys undertaken on behalf of any private health providers.

Track record on safety

- No Never events.
- No clinical incidents with no harm, low harm, moderate harm, severe harm or death.
- No serious injuries.
- No complaints had been recorded.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not rated	Inadequate	Inadequate	Inadequate

Notes

Patient transport services (PTS)

Safe	Inadequate
Effective	Inadequate
Caring	Not sufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

Patient transport services was the regulated activity carried out by the provider.

Beverley Ambulance Service Limited was not commissioned or contracted to provide patient transport services for any commissioners, NHS or private health providers. Patient transport services were provided on an as required basis.

In the reporting period July 2018 to July 2019, there were 595 patients transported on behalf of a local NHS hospital trust. All the patients were adults. All the patients were low acuity.

The service did not carry out any patient transports on behalf of any private health providers in the reporting period.

Summary of findings

We found the following issues that the service provider needs to improve:

- The provider did not use patient record forms during the booking in process, during the patient transport or handover so there was no method to assess and respond to patient risk.
- There was no evidence of a structured approach to identifying the training needs of staff, a monitoring system to ensure staff received mandatory and statutory training.
- There was no evidence in staff files of qualifications held by staff to show they were suitably trained for their role.
- The providers safeguarding policy did not comply with the intercollegiate guidelines (2018) and was out of date and clearly copied from an NHS provider with references to out of date legislation and staff roles which did not exist in the providers management team.
- There was no policy or process for staff to follow to identify and manage patients' whose health deteriorated during a patient transport.
- There was no policy or process for staff to follow as to what action to take if a patient they were transporting had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place.

Patient transport services (PTS)

- The provider did not follow the follow the British institute of cleaning science and national patient safety (2016) colour coding systems for identifying which cleaners to use on which areas of the vehicles or premises.
- There were no facilities for the disposal of clinical waste at the providers premises.
- Medical gases were not stored in accordance with the health and safety executive regulations 1998.
- The service did not have a specific risk assessment or control of substances hazardous to health (COSHH) information in relation the storage of medical gases.
- There was not a supply of consumable items to replace those used on the ambulances and there was no evidence of a stock control system.
- Both the ambulances inspected did not have harness or chairs to use to transport children.
- The provider did not have a policy regarding the eligibility criteria of patients.
- The providers incident reporting policy and duty of candour policy had clearly been copied with references to staff and reporting systems which did not exist in the providers company.
- The provider did not record the response times or collection of patients to their arrival at the required destination, before or after their appointment time, and the time waiting for their return.
- There was no induction course for new staff, no training needs analysis done and no formalised staff appraisal system.
- The service did not use patient record forms so there was no way to evidence if any assessment, planning and delivering of care had been made by staff or how patients' individual needs were identified or met.
- The provider did not record how many patients transports they made by day/month/year, response times, journey times and how many times they declined the transport.
- The service did not have a system to identify and meet the information and communication needs of people with a disability or sensory loss.
- There was no evidence reasonable adjustments were made so that people with a disability could access and use the services on an equal basis to others.
- The Registered Manager had no understanding of their responsibilities in carrying on or managing the regulated activity and that services provided meet the standards required in the regulations.
- There was no effective governance, audit activity, no quality measures and no KPI`s.
- The provider did not have an effective system to identify, record, mitigate, review and action either patient risk or corporate risk.
- The booking process where patient names and details would be written of pieces of paper and disposed of following the patient journey posed an information governance risk of the paper with the information on being lost or disposed of inappropriately.

We found the following areas of good practice:

- Both patient transport ambulances appeared visibly clean and had a stock of in date consumable items with stickers displayed on equipment indicating when the next test was due.
- The equipment asset register completed by an external contractor evidenced all items requiring to be tested had been and when the re-test date was.
- Managers told us patient transports were planned and carried out to account for the patient's hydration, feeding and toileting needs particularly on longer journey times.
- Both the patient transport ambulances inspected did carry water for patients to drink.

Patient transport services (PTS)

Are patient transport services safe?

Inadequate

We rated safe as **inadequate** because;

- There was no monitoring system to ensure staff received mandatory and statutory training and there was no evidence in staff files of qualifications held by staff to show they were suitably trained for their role.
- Staff we spoke with did not know how to report a safeguarding incident and the providers safeguarding policy did not comply with the intercollegiate guidelines (2018) and was clearly copied from an NHS provider.
- There was no policy or process for staff to follow to identify and manage patients whose health deteriorated during a patient journey.
- There was no policy or process for staff to follow as to what action to take if a patient they were transporting had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place.
- The only evidence of infection prevention control (IPC) auditing was in relation to hand washing. There was no evidence of any other IPC audits.
- The provider did not follow the follow the British institute of cleaning science and national patient safety (2016) colour coding systems for identifying which cleaning products to use on which areas of the vehicles or premises.
- There were no facilities for the disposal of clinical waste at the providers premises.
- Medical gasses were not stored in accordance with the health and safety executive regulations 1998.
- There was not a supply of consumable items at the providers base to replace those used on the ambulances and there was no evidence of a stock control system.
- Both the ambulances inspected did not have harness or chairs to use to transport children.
- The provider did not use patient record forms during the booking in process, taking responsibility for the patient, during the patient transport or handover so there was no method to record, assess and respond to patient risk.
- The providers incident reporting policy had clearly been copied with references to staff and reporting systems which did not exist in the providers company.
- The providers duty of candour policy had clearly been copied as it was not service specific.

However, we did find the following good practice;

- Both patient transport ambulances appeared visibly clean and had a stock of in date consumable items and with stickers displayed on equipment indicating when the next test was due.
- The equipment asset register evidenced all items requiring to be tested had been and when the re-test date was.

Mandatory training

- The service provided mandatory training in key skills through an external provider, however, there was no evidence the provider had a system in place which provided managerial oversight of mandatory training arrangements.
- The service used an on-line external training provider. The training covered 37 modules including infection control, safeguarding, duty of candour, incident reporting.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment. The regulation had not been met because in the training files for ten members of staff there was evidence only six members of staff had completed the training course in the last year.
- During this inspection there was no evidence of a monitoring system to ensure staff received mandatory and statutory training or when refresher training was due. We were therefore unable to evidence if any staff were up to date with their mandatory and statutory training.
- The providers training policy did not have a date when it commenced. There were references in the document to out of date information.
- Managers told us staff were offered additional training days/sessions at one of the independent health providers who Beverley Ambulances Station provided patient transport service (PTS) to. We did not see any evidence of staff having attended any of this training.

Safeguarding

Patient transport services (PTS)

- We saw evidence the safeguarding lead was trained to safeguarding level three.
- The safeguarding lead was general medical council registered and copies of their training qualifications and certificates were on line which allowed the provider to check them.
- During the inspection we reviewed the safeguarding training of the four employed staff. We were unable to establish if the registered manager had received safeguarding training as there was no specific safeguarding certificates in their staff file. There was evidence of having attended an ambulance skills and essential education course.
- There was evidence the director, who was an advanced care assistant (ACA) and the PTS driver, who was an ACA were trained to safeguarding level three.
- The emergency care assistant (ECA) was not safeguarding trained.
- During inspection we reviewed the providers safeguarding policy and procedures which had a review date of November 2020.
- The policy content was out of date with references to; working together 2010 and the Criminal Records Bureau (CRB).
- The policy had clearly been copied from a trust policy. There was reference on page three about the executive lead for the company being the executive director of delivery. This position does not exist in the Beverley Ambulance Station.
- The reporting procedure was reviewed, and it outlined to staff to discuss with parents of a child or with vulnerable person and to obtain permission to make referral if safe and appropriate.
- This information was incorrect as the parent of carer could be the person carrying out the abuse. Staff should be instructed to make a referral if they felt the situation fitted the reporting criteria and not delay or seek permission to make the referral.
- There was section on the policy document where staff had to sign and date to say they had read and understood the content of the safeguarding policy before handing the signed document to the provider safeguarding lead. We did not see any evidence any staff had signed the document.
- Staff we spoke with told us they had never made a safeguarding referral; however, they were able to describe what a safeguarding incident was.
- Staff we spoke with were unsure of the safeguarding reporting procedure outlining they would speak to managers before making a referral. This could result in an unnecessary reporting delay resulting in potential increased harm to the person concerned.

Cleanliness, infection control and hygiene

- The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection.
- We inspected two ambulances used for patient transport both appeared visibly clean internally and externally. Both were not in use at the time of the inspection.
- The equipment carried on both ambulances appeared visibly clean.
- Both ambulances had hand cleansing gel, decontamination wipes and gloves available for staff to use and a sharps box.
- There was clean linen available in only one ambulance and only one ambulance had a bag for clinical waste.
- We saw evidence of vehicle deep cleaning records for both vehicles in June, July August, and September 2019.
- There was no evidence deep cleaning having been done. The deep cleaning was completed by a local garage who did valeting only, cleaning the cab and not the patient transport area. Deep cleaning of the back of the ambulance was done monthly by the providers staff using domestic cleaning products.
- This was a risk because ambulances were constantly being used by services and it is extremely common for the interior to come into contact with blood, vomit, and other bodily fluids. With this regular exposure to bodily fluids there is a risk of spreading infections or diseases to other passengers travelling in the vehicles.

Patient transport services (PTS)

- The provider did not follow the British institute of cleaning science and national patient safety (2016) colour coding systems colour coding systems for identifying which cleaning products to use on which areas of the vehicles or buildings.
- The provider used a domestic cleaning product and a mop and bucket which was kept in the residential garage to clean the vehicles. There was supply of disposable mop heads, however, there was no system to dispose of the used mop heads which were placed in the domestic waste bin.
- We checked the vehicle daily cleaning records and it was clear the vehicles had not been cleaned every day.
- One ambulance had been cleaned on 11 occasions in July, eight times in August and ten times in September 2019. The other ambulance had been cleaned on 20 occasions in July, 14 times in August and 12 times in September 2019.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. The regulation had not been met because there was no evidence of vehicle cleanliness audits.
- During this inspection there was evidence of vehicles being cleaned, however, there was no evidence of vehicle cleanliness audits being carried out.
- There was no process or policy for cleaning an ambulance if a patient was unwell during a journey. If an ambulance required to be cleaned at a hospital following a patient transport manager told us staff would borrow cleaning products from an NHS ambulance provider and clean the vehicle at the hospital requesting the patient transport.
- Staff told us they used anti-bacterial wipes to maintain cleanliness of their vehicle during the course of a shift. We saw evidence both ambulances we inspected did have a supply of wipes for staff to use.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. The regulation had not been met because there was no evidence of hand hygiene audits.
- During this inspection there was evidence of hand hygiene audits being carried out.
- We saw evidence of had hygiene audits were carried out in February 2019 and July 2019 where four staff were observed on each occasion by one of the directors. Staff were recorded as complying national health service hand washing procedures.
- There was no evidence of any other infection prevention control audits being carried out.
- As the providers operating base was a residential property we did not see any evidence of notices advising staff on hand washing techniques or hand cleaning products being available for staff to use at the termination of their shift.
- There were no facilities for the disposal of clinical waste at the providers base. There was not a sharps bin or bins for the collection and disposal of clinical waste. There were no facilities such as a sluice for the disposal of waste liquids after cleaning vehicles.
- Managers told us staff would dispose of clinical waste and sharps at the hospital requesting the patient transport.
- There was no additional linen stored at the providers operational base. Managers told us staff disposed of used linen and collected replacements at the hospital requesting the patient transport.
- The providers infection prevention control policy was reviewed. The document contained out of date references, for example on page 16, reference was made to the Health Protection Agency.
- We could not evidence if ambulance crews were made aware of specific infection and hygiene risks associated with individual patients because the provider did not use patient record forms.
- There was no process or policy for staff to follow to seek advice and support regarding infection control matters.
- Infection control training for all staff was delivered on line through an external training provider, however, we were unable to evidence if staff had received this training.

Environment and equipment

Patient transport services (PTS)

- The providers operating base and environment had not been properly designed and maintained as an ambulance station.
- The providers operating base was a residential farm property. The farm had a yard with a covered area for parking vehicles. The administrative office was in the lounge of the dwelling. Documentation was kept in the lounge in files in a book case or in a locked cupboard. The was a garage at the side of the dwelling but this was too small to park an ambulance in.
- There was not a consumable item store room or store cupboard at the premises. There was not a store room or store cupboard for cleaning products.
- A small amount of consumable items were kept in a plastic box in a cupboard in the kitchen, however, we were told these were not for use on the patient transport ambulances.
- There was no evidence of any consumable item stock control system.
- Managers told us when they thought items needed to be replaced on any of the ambulances they would purchase the required items from a high street retailer.
- We inspected two ambulances used for patient transport. Both were parked outside the dwelling.
- Both had a stock of in date consumable items and electrical equipment which had been tested by an external company. Stickers were displayed on the equipment indicating when the next test was due.
- We saw evidence an external company maintained the servicing and maintenance of the providers medical devices.
- The service was reliant upon the external company to maintain accurate records of when equipment needed re-testing. During inspection we reviewed the asset register from the previous equipment testing which evidenced all items requiring to be tested had been and when the re-test date was.
- On one of the ambulances the defibrillator pads were found to be out of date having expired in August 2019.
- Both the ambulances inspected did not have harness or chairs to use to transport children.
- Managers we spoke with told us they used a local ministry of transport testing (MOT) registered garage for regular servicing and maintenance of the vehicles. The garage would notify the provider one month prior to the MOT becoming due on the vehicles so the MOT test could be booked.
- The provider maintained a diary documenting when the MOT`s were due. The servicing intervals were dependent upon the vehicle's mileage.
- The provider did not have a medical gases store on the premises where they were based.
- When the two PTS ambulances were inspected one carried six oxygen cylinders (one empty, three full and two were a quarter full) and one Entonox cylinder which was full. The other ambulance carried three oxygen cylinders (one full, one empty and one half full) and two Entonox cylinders both three-quarters full.
- Due to the fact empty and almost empty medical gas cylinders were stored with full cylinders in an emergency there was a risk staff would use an empty or partially full cylinder putting a patient at risk of not receiving the correct amount of oxygen.
- In the event of a vehicle collision the excessive amount of medical gas cylinders in each vehicle could increase the risk of explosion or fire or become dislodged becoming a hazard to staff and patients.
- The provider told us they had not set up a medical gases store at their operating base because of cost.

Assessing and responding to patient risk

- There was no evidence staff completed and updated risk assessments for each patient and removed or minimised risks.
- There was no evidence staff identified and quickly acted upon patients at risk of deterioration.
- There was no evidence comprehensive risk assessments were carried out for people who used services because the provider did not use patient record forms or record patient details or risk using any other method.
- There was no policy in place regarding assessing and responding to a deteriorating patient being transported for staff to follow.

Patient transport services (PTS)

- There was no system in place where staff could seek clinical advice from the clinical lead or senior staff or managers if a patient became ill while being transported.
- Staff we spoke with were unsure as to what action to take if a patient they were transporting became ill. We were told staff would take the patient to the nearest hospital or contact a manager to seek advice. These actions could increase the risk to the patient by delaying them receiving treatment.

Staffing

- There was no evidence the service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment because the acuity of the patients transported could not be verified because the provider did not use patient record forms.
- The service employed four staff which were; the registered manager who was also a director and emergency medical technician (EMT), a second director who was an advanced care assistant (ACA), one emergency care assistant (ECA) who was responsible for the company administration and an advanced care assistant (ACA). The service had an associated clinical/ medical director who was the safeguarding lead. They worked on a consultancy basis.
- The service did not use bank or agency staff. There was no set establishment of staffing levels or skills.
- The service did not have a set shift pattern for staff to work. The provider communicated with the local NHS hospital each week and agreed which days/hours they would be available to provide patient transport.
- Staff were then informed on which day work was available. Staff worked on an as required basis. They worked no more than five days per week dependant on workload. If they were required to work a PTS shift this was normally an eight-hour shift.
- The shift times varied depending on what transports the service were asked to provide and how long they would take, therefore there were no set shift times.
- Normally the main shifts worked were 2pm to 10pm. Weekend arrangements varied because the service was not always required to provide the service on weekends.
- When the service was requested to provide cover on a weekend this was on an as required and there was no set shifts. The service made themselves available and waited to be contacted by the NHS hospital requesting the service.
- The service did not work on bank holidays.

Records

- Staff did not keep detailed records of patients' care and treatment. Records were not, up to date, stored securely and easily available to all staff providing care.
- People's individual care records, including clinical data were not written and managed in a way that kept people safe.
- Managers we spoke with told us when the NHS hospital contacted them by telephone the director would write the patients details on a piece of paper and decide whether to transport the patient or not.
- There was no patient eligibility policy which outlined which patients the service would transport and which ones they would not.
- If the director receiving the call decided they could provide the transport, they would telephone the ward where the patient was being discharged from and obtain the medical details recording these on a piece of paper.
- There was no evidence as to how or why the director decided to accept or decline the transport request.
- The director told us patient risks and do not attempt cardiopulmonary resuscitation (DNACPR) orders and end of life care planning was recorded on the same piece of paper and communicated to the PTS driver when patients were being transported.
- We could not evidence this on inspection because the provider did not use patient record forms or maintain or retain the paper records with the patients details on.
- The director would telephone the driver of the providers PTS vehicle and pass on the patients' details. The driver would record the patient details on a piece of paper only if the journey would take over four hours. We were told by managers if the journey was less than four hours the driver would not record the patients details.

- Once the director was made aware by the PTS driver the transport had been completed the handwritten notes were destroyed. There was no evidence of a process for managing and disposing of the handwritten notes.
- Staff did not receive or record handover information when they took responsibility for the patient or passed on handover information at the end of the patient transport.
- Staff told us any record of any incidents or events involving patients while being transported would be submitted on an incident form. We did not see any evidence of any incidents being recorded.
- The provider did record a unique reference number from the NHS hospital requesting the patient transport service relating to the patient which was used for re-charging purposes.

Medicines

- The service did not use systems and processes to safely record and store patients' medicines.
- The service did not store medicines and their staff did not carry or use them, however, the provider did have a medicines policy which we reviewed during inspection. It had last been updated in November 2018.
- The key principles of the policy were to ensure, compliance with current legislation, adherence to guidance issued by the Department of Health and other national guidance and management of the risks to patients and staff arising from the use of medicines.
- The policy outlined the contents should be read in conjunction with the standard operational procedures (SOPs) for each of the activities concerned with the safe use and security of medicines. The SOPs defined responsibilities, competencies, training and performance standards of staff involved in the activity.
- The provider did not have a policy in relation to patients carrying their own prescribed medication while being transported. Managers we spoke with told us they would lock the drugs in the safe on the ambulance and hand them back to the patient when they reached their destination. Only one of the PTS ambulances had a safe.
- The service did not have a policy or risk assessment in relation to the administration and storage of medical gases.

Incidents

- In the 12 months prior to the inspection the service had not reported any incidents. We were therefore unable to evidence staff knowledge and adherence to the providers incident reporting policy.
- During inspection we reviewed the providers incident reporting policy which had a review date of December 2020.
- The policy provided staff with the background information as to why incident reporting was important and what the objectives of incident reporting were.
- The policy included the staff's responsibilities under duty of candour.
- During inspection we reviewed the providers duty of candour policy which had a review date of December 2020.
- The policy had clearly been copied from a trust policy. There was reference on page 12 to the Director of Quality (Exec Nurse) and all incidents must be reported onto Ulysses (refer to the trusts incident reporting policy).
- The duty of candour places a legal responsibility on every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress and to apologise to the patient or, where appropriate, the patient's advocate, carer or family.
- The policy included the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 and the reporting responsibilities of staff in relation to this.
- We saw an example of a blank incident form which included information the forms were stored in the vehicle folders and should be completed after the incident, in addition to contacting the duty manager at the time of the incident.
- When we reviewed incident forms during inspection we saw two different types being used and there was no evidence which one was the most up to date and current.

Patient transport services (PTS)

Are patient transport services effective?

Inadequate

We rated effective as **inadequate** because;

- The provider did not use patient record forms so there was no way to evidence if any assessment, planning and delivering of care had been made by staff.
- There was no system to record patient outcomes.
- The provider did not record the response times of collection of patients to their arrival at the required destination, before or after their appointment time, and the time waiting for their return.
- The staff files contained no evidence of any interview notes, scoring or references. Three of the staff files had no proof of identity or eligibility to work in the UK.
- There was no induction course for new staff and no training needs analysis done.
- There was no formalised staff appraisal system.
- There were supervision checks carried out, but there was no clear reason why they had been done.
- There was not a system to ensure staff driving licences were checked and recorded and there was no policy regarding the disclosure of driving penalty points by staff.

However, we did find the following good practice;

- Managers told us patient transports were planned and carried out to account for the patient's hydration, feeding and toileting needs particularly on longer journey times.
- Both the patient transport ambulances inspected did carry water for patients to drink.

Evidence-based care and treatment

- There was no evidence people's physical, mental health and social needs were holistically assessed, and their care and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes.
- There was no evidence of processes in place to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making decisions to transport a patient.
- The provider did not have a policy in relation to patient transport eligibility.
- There was no evidence of suitable protocols available for children of all ages and other patient groups.
- There was no evidence staff assessed patient's needs against protocols to provide care and transport.
- There was no evidence the service ensured transport was provided in line with national or local guidelines because they were not contracted by any NHS or private provider and did not work to any key performance indicators.
- There was no evidence staff told patients when they need to seek further help and advised what to do if their condition deteriorated.

Nutrition and hydration

- Managers told us patient transports were planned and carried out to account for the patient's hydration, feeding and toileting needs particularly on longer journey times. However, we were unable to evidence this because the provider did not use or retain patient record forms which is where such information would have been recorded.
- Both the PTS ambulances inspected did carry water for patients to drink.

Pain relief

- The service did not provide pain relief for patients.

Patient outcomes

- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. The regulation had not been met because there was no evidence the service did not carry out audits of patient journeys, aborted journeys, cancellations or escalations of patients transported.
- During this inspection there was no evidence the service carried out audits of patient journeys, aborted journeys, cancellations or escalations of patients transported.

- There was no evidence or information about the outcomes of people's care and treatment both physical and mental where appropriate, being routinely collected and monitored.
- The provider did not record the response times of collection of patients to their arrival at required destination, before or after their appointment time, and the time waiting for their return.
- The provider did not take part in any quality improvement initiatives, such as local and national clinical audits or benchmarking.

Competent staff

- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment. The regulation had not been met because there was no evidence of competencies assessments undertaken for staff.
- During this inspection there was no evidence of competencies assessments undertaken for staff.
- There was no induction course for new staff or a training needs analysis carried out.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. The regulation had not been met because there was no evidence the company had an effective process for ensuring references and disclosure and barring services (DBS) checks were received prior to employment and in two of the ten files reviewed there was no evidence of references being obtained.
- During this inspection we found staff files did have DBS checks, however, there was no evidence of any interview notes, scoring or references. Three of the staff files had no proof of identity or eligibility to work in the UK. This was a risk because the provider could not be assured that staff were trustworthy and of good character and eligible to undertake the role.
- During inspection we reviewed the providers staff handbook which was in date being last reviewed in July 2019.
- The handbook, which was given to staff, contained information where staff would be able to access all policies and procedures needed in relation to their employment. The handbook and corresponding policy documents formed part of the staff contract of employment with the Beverley Ambulance Services Limited.
- During inspection we reviewed the providers driver policy which was in date due for review November 2020.
- The purpose of the policy was to draw attention to certain aspects of driving and vehicle care which could result in reduced accidents and lessen risk to patients, other road users and Beverley Ambulance Station personnel.Reference was made to the ambulance emergency response driver's handbook which every member of stall received when they joined the company.
- The policy had a section on fitness to drive and a link to the DVLA medical guidance document if staff need to seek advice.
- There was no reference to the need of staff to inform the provider if they had acquired driving penalty points and what the implication there were on their employment.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. The regulation had not been met because not all staff driving ambulances had the correct category of driving licence to allow them to drive heavier vehicles.
- During this inspection there was evidence of staff were only allowed to drive ambulances weighing more than 3.5 tons if they had a C1 classification on their driving licence.
- The service had one vehicle which exceeded 3.5 tons in weight which was driven by two members of staff who held C1 driving licence. This vehicle was used for events and long patient transport journeys.
- During inspection we reviewed the providers disciplinary policy due for review November 2020. This had clearly been copied from a trust policy because there was reference to trust throughout the document and on page 14 reference to an NHS ambulance trust.
- Other policies were reviewed, including the recruitment policy which had no document control and the manual handling policy had no review date.

- Managers did accompany staff while they were at work and completed a supervision review. Three reviews were dip sampled during inspection and none were clear as to why the review had been conducted as there were no objectives to be achieved.
- There was evidence staff had been supported to facilitate their development by attending courses to increase their qualifications.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. The regulation had not been met because There was no evidence that appraisals had been undertaken with staff.
- During this inspection there was no evidence staff appraisals were carried out or the provider had an appraisal system.
- We could not evidence how the service would ensure staff only carried out care and treatment they were skilled, competent and had experience to perform because the service did not use patient record forms (PRF`s) and therefore the acuity of the patients transported could not be verified.
- There was no evidence staff had received guidance or training including refresher training, to prepare staff for supporting a patient experiencing a mental health crisis and understood the legal powers in relation to transporting such patients.

Multidisciplinary working

- The service was totally reactive and there was no evidence they were involved in assessing, planning and delivering care and treatment.
- The service did not use patient record forms so there was no way to evidence if any assessment, planning and delivering of care had been made by staff.
- There was no evidence how the service worked with external organisations and providers to make sure that the following is taken account of special notes, advanced care plans / directives, DNACPR orders and Section 136 because they were not commissioned, were totally reactive working on an as required basis and did not keep patient record forms where this information would have been recorded.

Seven-day services

- The service was not commissioned or contracted by any NHS or independent health care provider.
- The service worked with a local NHS hospital on as required basis. The service made themselves available seven days a week but not on bank holidays to provide patient transport if requested.

Health promotion

- The provider did not take part in patient health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Managers we spoke with told us they did not transport patients with mental ill health, however, because the provider did not use patient record forms we could not evidence this.
- There was no evidence in the staff files that staff had received training regarding the mental capacity act 2005 and the transportation of patients experiencing a mental health crisis.
- There was no evidence of a system or policy for staff to follow when a possible lack of mental capacity to make a decision would be assessed and recorded.
- There was no evidence of a process for seeking consent, monitoring and reviewing it to ensure it met legal requirements and followed relevant national guidance.
- During inspection we reviewed the providers mental capacity act 2005 and deprivation of liberty standards policy which were in date due for review November 2019.
- The policy outlined the principles of the mental capacity act and gave guidance on the policies, practice and procedures that should be followed by staff when transporting individuals who may lack mental capacity.

Patient transport services (PTS)

Are patient transport services caring?

Not sufficient evidence to rate

Caring was not inspected. During the inspection there was no regulated activity carried out, therefore caring could not be evidenced.

Compassionate care

- Due to the fact the service which was not commissioned or contracted during the inspection there was no regulated carried out, therefore compassionate care could not be evidenced.

Emotional support

- Due to the fact the service which was not commissioned or contracted during the inspection there was no regulated carried out, therefore compassionate care could not be evidenced.

Understanding and involvement of patients and those close to them

- Due to the fact the service which was not commissioned or contracted during the inspection there was no regulated carried out, therefore compassionate care could not be evidenced.
- Staff we spoke with told us on long journeys relatives of patients were kept updated via text or a phone call as to where the ambulance was and how the patient was. However, because the provider did not use or retain patient record forms where this information would be recorded we could not evidence this.

Are patient transport services responsive to people's needs?

Inadequate

We rated responsive as **inadequate** because;

- The provider did not use patient record forms it was therefore impossible to evidence how patients' individual needs were identified or met.
- There was no evidence reasonable adjustments were made so that people with a disability could access and use the services on an equal basis to others.
- The provider did not record how many patients transports journeys they made by day/month/year, response times, journey times and how many times they declined the transport.
- The two PTS ambulances inspected did not have any special communication aids to assist in communication with patients whose first language was not English or with patients with hearing or cognitive issues.
- The service did not have a system to identify and meet the information and communication needs of people with a disability or sensory loss.

However,

- The provider had a complaints policy which was fit for purpose, however, were unable to check if staff and managers had followed the policy as the provider had not recorded any complaints in the reporting period.

Service delivery to meet the needs of local people

- The service was not commissioned and operated on an as required basis on behalf of a local NHS hospital trust.
- There was no planning to cope with differing levels of demand due to the nature of the service provided.
- The provider was contacted by telephone with an initial enquiry from the transport manager of a local NHS hospital trust as to their availability to provide patient transport between Monday to Friday. This call was made every week. Staff at the hospital who organised patient transport were then made aware of the services availability and would request the service as required.
- During weekends if patient transport was required the provider would be contacted by a senior matron at the hospital or the site team in the hospital transport support department as the transport office which organised the patient transport bookings between Monday to Friday was closed on weekends.
- The service would only complete the patient transport booking once the funding had been approved by the hospital requesting the service.

- Although the service had not transported patients on behalf of private health care providers they did have a process in place should they be requested to do so.
- The process would be the booking office or ward would telephone the provider to book the transport required giving details of the patients medical and personal needs. The service would take a booking reference number and details of the insurance company funding the transport at the time of booking.

Meeting people's individual needs

- The service did not have a system to identify and meet the information and communication needs of people with a disability or sensory loss.
- There was no evidence reasonable adjustments were made so that people with a disability could access and use the services on an equal basis to others.
- As the provider did not use patient record forms there was no evidence the service was delivered and coordinated to ensure that people who may be approaching the end of life were identified, including those with a protected equality characteristic and people whose circumstances may have made them vulnerable, and that this information was shared.
- There was no system to record, highlight and share this information with others when required, and gain people's consent to do so.
- The service had identified the three largest ethnic minority groups within the local population as Polish, Lithuanian and Latvian, however, we did not see any communication aids in the vehicles we inspected related to these population groups.
- Staff we spoke with told us they used google translate on a mobile app, communication sheets with various languages on in the vehicles to communicate with patients, relatives and carers when English was not their first language.
- However, when we inspected the two PTS ambulances there were no special communication aids to assist in communication with patients whose first language was not English or with patients with hearing or cognitive issues.
- We were shown two vehicle document folders which were kept in the providers office which did have communication aids in them.
- Managers we spoke with told us if a patient from an ethnic minority travelled with a relative who could speak English they would ask them to translate the information from staff to the patient.
- Staff we spoke with told us if a patient they were transporting required to pray they would stop the vehicle in a dignified place to facilitate this, however, the staff could not provide any examples when they had done this.

Access and flow

- The service had no control over the access and flow of patients because they responded to calls from the local NHS hospital trust to provide the transport.
- If the providers ambulance was available and the director taking the booking felt they could carry out the transport they would do so.

Learning from complaints and concerns

- In the 12 months prior to the inspection the service had not received any complaints. We were therefore unable to evidence staff knowledge and adherence to the providers complaints policy or how any learning from complaints had been shared.
- During the inspection we reviewed the providers handling comments, concerns, compliments and complaints policy and procedure which was in date and due for review November 2019.
- The purpose of the policy was to provide an open, fair and accessible process for handling comments, concerns, compliments and complaints received about care provided by Beverley Ambulance Services.
- The policy outlined every complaint received would receive a written response that would include: an apology, an explanation of why it happened and the actions that had been taken following the compliant investigation.
- The policy outlined staff reporting and management responsibilities.

Patient transport services (PTS)

- When we inspected the two PTS ambulances only one was found to have leaflets which explained to patients, relatives or carers how to make a complaint.
- The policy did not include situations when the provider who had requested the patient transport service retained responsibility for the complaint and the investigation or how Beverley Ambulance Service staff would be involved in the investigation.
- The policy did not include what arrangements were in place for the independent review of complaints, for example, Independent Sector Complaints Adjudication Service (ISCAS), of which membership was voluntary.

Are patient transport services well-led?

Inadequate

We rated well-led as **inadequate** because;

- The Registered Manager had no understanding of their responsibilities in carrying on or managing the regulated activity and that services provided met the standards required in the regulations.
- The provider did not have a vision or strategy to work to.
- There was no effective governance and there was limited audit activity, no quality measures and no key performance indicators.
- Some provider policies were obviously copied from other providers and contained out of date legislation and information which evidenced there was no system or process for managers to review and update provider policies.
- The provider did not have an effective system to identify, record, mitigate, review and action risk either patient risk or corporate risk.
- The provider did not have a system to record, manage or review any information obtained as part of their regulated activity.
- The service did not have a specific risk assessment or control of substances hazardous to health (COSHH) information in relation the storage of medical gases.
- The patient booking process where patient names and details would be written on pieces of paper and disposed of following the patient journey posed an information governance risk of the paper being lost or disposed of inappropriately.

Leadership

- The Registered Manager had no understanding of their responsibilities in carrying on or managing the regulated activity and that services provided meet the standards required in the regulations.
- The service was led by the managing director supported by a director/manager. The medical director worked in a consultancy capacity for the provider and was also the safeguarding lead.

Vision and strategy

- The service did not have a clear vision and a set of values, with quality and sustainability as the top priorities.
- There was no robust, realistic strategy for achieving the priorities and delivering good quality sustainable care.
- The providers core values were outlined in the statement of purpose document, these were; we will strive to meet values, provide common ground for co-operation to achieve shared aspirations. The service commits to providing these values every day in our engagement with patients, public and colleagues providing healthcare services.
- The providers core values were not on their intranet page.

Culture

- During inspection we reviewed the providers whistle blowing policy. This was dated in 2014 and did not have a review date.
- The policy outlined how employees of the Beverley Ambulance service could raise concerns internally and how to disclose information which the individual believed showed malpractice or impropriety.
- The policy included how to make an anonymous disclosure and how any disclosure would be treated with confidentiality.

Patient transport services (PTS)

- The providers statement of purpose outlined their commitment to respect and dignity by valuing each person as an individual, respecting their wishes and commitments, endeavouring to understand their priorities, needs, abilities and limits.
- The providers statement of purpose outlined their commitment to quality of care which was to earn the trust of the patient, insisting on quality and striving to get the basics right every time, making staff aware of safety, confidentiality accountability, using good communication, being a dependable service with professional integrity.
- The providers statement of purpose outlined how they would be compassionate by all staff responding with humanity and kindness to each person's pain, distress, anxiety or need. Staff would do whatever they could, however small, to give comfort and relieve suffering.
- The providers statement of purpose outlined how the service worked together by putting patients first in everything they did. It recognised valuing excellence and professionalism and all staff had a part to play in giving people an excellent experience when using the service.
- The providers commitment to respect and dignity, quality of care, compassion and working together was not displayed on their intranet page.
- There was no evidence how the providers statement of purpose and commitments within it were shared with staff, how they would be implemented and integrated into the regulated activity, how they would be measured or how they would be result in improved patient safety.

Governance

- Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.
- The service did not record any minutes of any board meetings, governance meetings or local team meetings.
- We saw evidence of meetings being held the details of which were handwritten in a note book. There was no set agenda and no tracking of actions.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. The regulation had not been met because there was no evidence of a central log of complaints and audit results.
- During this inspection there was evidence of central log of complaints and audit results because the provider had not recorded any complaints in the year preceding this inspection and they only carried out hand hygiene audits.
- Some provider policies were obviously copied from other providers and contained out of date legislation and information which evidenced there was no system or process for managers to review and update provider policies.

Managing risks, issues and performance

- Leaders and staff did not use systems to manage performance effectively. They did not identify and escalate relevant risks, issues or identified actions to reduce their impact. The provider had no plans to cope with unexpected events. Staff did not contribute to decision-making to help avoid financial pressures compromising the quality of care.
- The service did not have a risk register.
- There was evidence of 14 work related activities having being risk assessed with control measures. There was no evidence of a system or process whereby staff would be made aware of these risks or how to mitigate them.
- At the previous inspection in 2017 the provider was issued with a requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. The regulation had not been met because there was no evidence of risk assessments for lone working or chemicals used for cleaning.
- During this inspection there was no evidence of risk assessments for lone working or chemicals used for cleaning.
- The service did have control of substances hazardous to health (COSHH) information in relation to cleaning vehicles, however there was no evidence of a system or process whereby staff would be made aware of the information.

- The service did not have a specific risk assessment or control of substances hazardous to health regulation (COSHH) 2002 information available for staff in relation the administration or storage of medical gases.

Managing information

- The service did not collect reliable data and analysis it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated and secure.
- We were advised of the booking process where patient names and details would be written of pieces of paper and disposed of following the patient journey. This posed an information governance risk of the paper being lost or disposed of inappropriately.
- During inspection we reviewed the providers information governance policy which was in date and due for review in November 2019.
- The policy covered all aspects of information used within the organisation including, patient/client service user information, personnel information and corporate information.
- The policy covered all aspects of handling information including, structured record systems both paper and electronic, transmission of information including by fax, email, post and telephone.
- The policy outlined the responsibilities of staff in relation to the management of information.
- The policy did not include how patient information should be recorded and disposed of.

Engagement

- Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not collaborate with partner organisations to help improve services for patients.
- During inspection we saw the providers patient feedback form had an address, e mail address, office phone number and mobile phone number for patients to use to provide feedback.
- Due to the size of the company staff surveys were not carried out.

Sustainability

- The provider held regular meetings with their accountants to provide advice to make the company sustainable. The clinical lead audited the income and expenditure independently monthly ensuring the companies sustainability.
- The provider did not have an equipment replacement programme. Managers told us equipment was replaced as and when necessary.

Learning, continuous improvement and innovation

- All staff were not committed to continually learning and improving services. They did not have a good understanding of quality improvement methods and the skills to use them. Leaders did not encourage innovation and participation in research
- There was no evidence the service sought to innovate and explore new ways of working i.e. doing things differently.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must have a structured approach to identifying the training needs of staff. This is in relation to Regulation 12.
- The provider must have a monitoring system to ensure staff received mandatory and statutory training. This is in relation to Regulation 12.
- The provider must have a system to evidence the qualifications held by staff to show they were suitably trained for their role. This is in relation to Regulation 12.
- The provider must have a policy, process or procedure for staff to follow as to how to seek advice from the clinical lead. This is in relation to Regulation 12.
- The provider must have policy or process for staff to follow in relation to dealing with deteriorating patients. This is in relation to Regulation 12.
- The provider must have a policy or process for staff to follow as to what action to take if a patient they were transporting had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place. This is in relation to Regulation 12.
- The provider must have a policy in relation to the management of prescribed medicines carried by patients being transported. This is in relation to Regulation 12.
- The provider must carry out infection prevention control audits. This is in relation to Regulation 12.
- The provider must follow the British institute of cleaning science and national patient safety (2016) colour coding systems for identifying which cleaners to use on which areas of the vehicles or premises. This is in relation to Regulation 12.
- The provider must have a system to record which cleaning products had been used on which areas of the vehicles or premises. This is in relation to Regulation 12.
- The provider must have facilities at their operating base for the disposal of clinical waste. This is in relation to Regulation 12.
- The provider must ensure vehicles are cleaned daily and vehicle cleaning is audited. This is in relation to Regulation 12.
- The provider must store medical gasses in accordance with the health and safety executive regulations 1998. This is in relation to Regulation 12.
- The provider must have a supply of consumable items to replace those used on the ambulances and a stock control system. This is in relation to Regulation 12.
- The provider must have a process whereby consumable items on patient transport vehicles are checked to identify those items which are near to going out of date and replace them. This is in relation to Regulation 12.
- The provider must have a process to assess, responded and record patient risk. This is in relation to Regulation 12.
- The provider must have an eligibility criterion of patient's policy. This is in relation to Regulation 12.
- The provider must use patient record forms during the booking in process, taking responsibility for the patient, during the patient transport and during the patient handover procedures. This is in relation to Regulation 12.
- The provider must have a system for identifying and monitoring the mandatory and statutory training needs of staff. This is in relation to Regulation 12.
- The provider must have an induction course and carry out training needs analysis for new staff. This is in relation to Regulation 12.
- The provider must have a formalised appraisal system. This is in relation to Regulation 12.

Outstanding practice and areas for improvement

- The provider must carry out regular supervision checks, with objectives to achieve, with staff while operational. This is in relation to Regulation 12.
- The provider must ensure staff files and training records are complete. This is in relation to Regulation 12.
- The provider must record the details of staff driving licences. This is in relation to Regulation 12.
- The provider must have a policy in relation to staff disclosing to the provider when they acquire driving penalty points. This is in relation to Regulation 12.
- The provider must use only one version of an incident report form. This is in relation to Regulation 12.
- The providers must have an incident reporting policy. This is in relation to Regulation 12.
- The provider must have a safeguarding policy which complies with the intercollegiate guidelines (2014). This is in relation to Regulation 13.
- The provider must ensure staff are aware of how to report a safeguarding incident. This is in relation to Regulation 13.
- The provider must have a policy, process or procedure for staff to follow as to how to seek advice from the safeguarding lead. This is in relation to Regulation 13.
- The providers management team and directors must have a clear understanding of the Health and Social Care Act regulations 2008 (Regulated Activities) Regulations 2014 (Part 3), how they applied to their business and how to comply with them. This is in relation to Regulation 17.
- The provider must have a vision or company strategy to work to. This is in relation to Regulation 17.
- The provider must have key performance indicators to measure the quality and safety of the services provided. This is in relation to Regulation 17.
- The provider must have a system or process in place to record the risk to patients had been considered, recorded, reviewed or actioned. This is in relation to Regulation 17.
- The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. This is in relation to Regulation 17.
- The provider must have a set programme of audits to be carried out and a process whereby the audit results can be reviewed, and any resultant improvement actions taken. This is in relation to Regulation 17.
- The provider must have a risk register. This is in relation to Regulation 17.
- The provider must have a specific risk assessment and control of substances hazardous to health (COSHH 2002) information in relation the storage of medical gases. This is in relation to Regulation 17.
- The provider must have training policy with the date it went live, review date and information and references which are current and up to date. This is in relation to Regulation 18.
- The provider must have an induction course for new staff and carry out a training needs analysis. This is in relation to Regulation 18.
- The provider must have a system to ensure staff driving licences are checked and recorded. This is in relation to Regulation 18.
- The provider must have a formal staff appraisal system. This is in relation to Regulation 18.
- The provider must have a system to record staff job interview notes or scoring in the staff files. This is in relation to Regulation 18.
- The provider must record and have evidence of staff health clearance checks and proof identity or eligibility to work in the UK. This is in relation to Regulation 18.
- The provider must ensure all staff files are up to date in relation to the recording of the individual training/ professional development/appraisals/ and qualifications. This is in relation to Regulation 18.

Outstanding practice and areas for improvement

- The provider must have a system or process whereby staff could seek and obtain additional qualifications or to meet the professional standards which were a condition of their ability to practise or a requirement of their role. This is in relation to Regulation 18.
- The providers must have a duty of candour policy which is service specific. This is relation to Regulation 20.

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 20 HSCA (RA) Regulations 2014 Duty of candour **(1) [Registered persons] must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.** The providers did not have a duty of candour policy because the document we reviewed on inspection had clearly been copied from another provider as it was not service specific. There was reference on page 12 to staff and reporting policies which did not exist in the company.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **(1) Care and treatment must be provided in a safe way for service users.** **(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include-** **(a) assessing the risks to the health and safety of service users of receiving the care or treatment;** The provider did not use patient record forms, therefore, there was no evidence of assessing the risks to patient. There was no policy or process in relation to dealing with deteriorating patients. There were no polices in relation to do not attempt cardiopulmonary resuscitation (DNACPR) orders for staff to follow. There was no eligibility criteria of patient's policy to ensure the service was not transporting patients whose medical conditions were such that the staff transporting the patient were not suitably qualified or experienced to transport such patients. **(b) doing all that is reasonably practicable to mitigate any such risks;** The provider did not have an effective system to identify, record, mitigate, review and action risk. There was no system in place for staff to obtain advice from the clinical lead.

This section is primarily information for the provider

Enforcement actions

(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

There was no evidence of a structured approach to identifying the training needs of staff. There was no monitoring system to ensure staff received mandatory and statutory training. There was no evidence of qualifications held by staff to show they were suitably trained for their role. There was no induction course for new staff, there was no training needs analysis of new staff done and there was no formalised appraisal system. There was evidence of supervision checks but there was no clear reason why they had been done. There was not a system to ensure staff driving licences were checked and recorded. There was no policy in relation to staff disclosing to the provider when they acquired driving penalty points. There was no evidence of any interview notes, scoring or references in staff files, in addition three of the staff files had no proof of identity or eligibility to work in the UK.

(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

Medical gases were not being stored in accordance with the health and safety executive regulations 1998. Both vehicles had excessive numbers of medical gas cylinder stored in them. The defibrillator pads on one on the ambulances inspected were found to be out of date. There was no consumable items store cupboard with a supply of replacement items.

(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

This section is primarily information for the provider

Enforcement actions

There was no supply of consumable items at the providers base to replace those used on the ambulances. There was no evidence of a stock control system.

(g) the proper and safe management of medicines;

There was not a policy in relation to the management of prescribed medicines carried by patients being transported.

(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

There no were facilities for the disposal of clinical waste at the providers operating premises. The only evidence of infection prevention control (IPC) auditing was in relation to hand washing. There was no evidence of any other IPC audits being carried out.

The provider did not follow the British institute of cleaning science and national patient safety (2016) colour coding systems for identifying which cleaners to use on which areas of vehicles or the environment.

The provider used a domestic cleaning product and a mop and bucket which was kept in a residential garage to clean vehicles. There was evidence of vehicle deep cleaning being recorded but no auditing. The deep cleaning was done by a local garage who did valeting but they did the cab areas only. Deep cleaning of the back of the ambulance was done monthly by the providers staff using domestic cleaning products. There was not a system of recording which cleaning products had been used to clean which areas in the vehicles. There was no process or policy for cleaning an ambulance if a patient was unwell during a journey.

This section is primarily information for the provider

Enforcement actions

(i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure

that timely care planning takes place to ensure the health, safety and welfare of the service users.

The provider did not use patient record forms (PRF`s) and there were no key performance indicators so there was no evidence that timely care was taking place. There was no evidence of hand over information being given or received and no analysis of this information to improve patient care.

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 **(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.** **(2) Systems and processes must be established and operated effectively to prevent abuse of service users.** **(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.**

The service had a named safeguarding lead who worked on a consultancy basis. There was no evidence of a policy or process for staff to follow as to how to seek advice from the safeguarding lead or what the out of hours procedure was for obtaining safeguarding advice.

Staff we spoke with did not know how to report a safeguarding incident through the correct reporting procedures. The safeguarding policy was out of date and did not comply with the intercollegiate guidelines (2014).

This section is primarily information for the provider

Enforcement actions

This was a risk because staff were not aware of the more recent process in relation to raising a safeguarding concern or alert. The policy had clearly been copied from an NHS provider because the policy referred to out of date legislation and staff roles which did not exist in the providers management team.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** **(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to-** **(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);** The Registered Manager had no understanding of their responsibilities in carrying on or managing the regulated activity and that services provided meet the standards required in the regulations. The provider did not have a vision or company strategy to work to. There were no key performance indicators to measure the quality and safety of the services provided. **(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;**

This section is primarily information for the provider

Enforcement actions

The lack of PRF`s meant it was impossible to evidence the risk to patients had been considered, recorded, reviewed or actioned. There was not a set programme of audits to be carried out. The service did not have a risk register. The service did not have a specific risk assessment or control of substances hazardous to health (COSHH 2002) information in relation the storage of medical gases. There was no patient eligibility criteria or policy to ensure patients were suitable to be transported by the Beverley Ambulance Service. This was a risk because the service could be transporting patients whose medical conditions were such that the staff transporting the patient were not suitably qualified or experienced to transport such patients.

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

The service did use or retain PRF`s or use any other method of recording detailed patient information so there were no evidence of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

(d) maintain securely such other records as are necessary to be kept in relation to-(i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity;

Managers and staff told us patient information was recorded on pieces of paper, which were not patient record forms, and once the journey was concluded the paper containing the patient information was destroyed. For journeys of less than four hours the driver on the PTS ambulance would not record any patient information.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Transport services, triage and medical advice provided remotely

Regulation 18 HSCA (RA) Regulations 2014 Staffing

(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

(2) Persons employed by the service provider in the provision of a regulated activity must- (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

The providers training policy did not have a date when it commenced. There were references in the document to out of date information. There was no induction course for new staff, there was no training needs analysis of new staff done, there was no formalised appraisal system, there were supervision checks but there was no clear reason why they had been done. There was not a system to ensure staff driving licences were checked and recorded. Four staff files were reviewed (which is all the staff). There was no evidence of any interview notes or scoring in the staff files. None had health clearance checks or driving licence checks or registration with professional bodies. Three had no proof of identity or eligibility to work in the UK. All the files had gaps in the training/professional development/appraisals/ and a lack of evidence in qualifications.

(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

(c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

This section is primarily information for the provider

Enforcement actions

There was not a system or process whereby staff could seek and obtain additional qualifications or to meet the professional standards which were a condition of their ability to practise or a requirement of their role.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

Why there is a need for significant improvements	Where these improvements need to happen
• The provider did not have a structured approach to identifying the training needs of staff or have a monitoring system to ensure staff received mandatory and statutory training. • The provider did not record the qualifications held by staff to show they were suitably trained for their role. • There was no policy, process or procedure for staff to follow to seek advice from the clinical lead. • There was no policy or process for staff to follow in relation to dealing with deteriorating patients. • There was no policy or process for staff to follow as to what action to take if a patient they were transporting had a do not attempt cardio pulmonary resuscitation (DNACPR) order in place. • The provider did not follow the follow the British institute of cleaning science and national patient safety (2016) colour coding systems for identifying which cleaners to use on which areas of the vehicles or premises. • There were no facilities at the providers operating base for the disposal of clinical waste. • The provider did not store medical gasses in accordance with the health and safety executive regulations 1998. • The provider did not have a supply of consumable items to replace those used on the ambulances. • There was no transport eligibility criteria of patients' policy to ensure the service was not transporting patients whose medical conditions were such that the staff transporting the patient were not suitably qualified or experienced to transport such patients. • The provider did not use patient record forms during the booking in process, taking responsibility for the patient, during the patient transport and during the patient handover procedures. • Staff records were incomplete.	These improvements need to happen across all the domains of the Patient Transport Service.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

- There was no incident reporting policy, duty of candour policy or safeguarding policy.
- The providers management team and directors did not have a clear understanding of the Health and Social Care Act regulations 2008 (Regulated Activities) Regulations 2014 (Part 3), how they applied to their business and how to comply with them.
- The provider did not have any key performance indicators to measure the quality and safety of the services provided.
- There was no set programme of audits carried out or a process whereby the audit results could be reviewed, and any resultant improvement actions taken.
- There was no risk register.
- There was no induction course for new staff or a training needs analysis carried out.
- There was no record of staff health clearance checks and proof of identity or eligibility to work in the UK.