Unit 1

Quality Report

Snaygill Industrial Estate,
Keighley Road
Skipton
North Yorkshire
BD23 2QR
Tel:01756802112
Website:www.eventfireservices.co.uk

Date of inspection visit: 13-14 May 2019
Date of publication: 09/10/2019

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Unit 1 is operated by Mr. David Ogden . The service provides emergency and urgent care and a patient transport service (PTS).

We conducted a follow up inspection of the emergency and urgent care service following the unannounced inspection on 9 January 2019 and a focussed inspection of the patient transport service (PTS) on 13 and 14 May 2019.

The PTS had not previously been inspected.

Following the unannounced inspection on 9 January 2019 we told the provider it must take 20 actions to comply with the regulations and it should make 15 improvements, even though a regulation had not been breached. We also issued the provider with two enforcement notices that affected emergency and urgent care. The service was rated as inadequate overall.

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.

The main service provided was patient transport. Where our findings on patient transport for example, management arrangements also apply to other services, we do not repeat the information but cross-refer to the patient transport care core service using this statement: See Patient Transport for main findings.

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

Our rating of this service improved. We rated it as **Inadequate** overall because:

- There was no evidence of a holistic understanding of performance with safety, quality, activity and financial information.
- The service did not hold staff meetings or carried staff surveys or routinely collected, reviewed and acted upon staff feedback to improve the service.
- Medicines were not kept with their patient information leaflets as per pharmacy guidance and the controlled medicines log book did not conform to guidance for controlled medicine documentation.
- The contents of the paramedic bags lacked standardisation. The bags did not have the same contents or a stock list to ensure used items were replaced.
- The service did not have an induction procedure for new staff or carried out a training needs analysis of staff to identify training requirements.
- There was no evidence the provider had a system to check staff had read, understood and adhered to company policies.
- There were not robust checks in place to ensure vehicle check lists were completed daily or at the start of each shift and any equipment issues highlighted.
- We did not see any evidence of a detailed operating procedure or protocol to provide guidance for staff on the management of deteriorating patients.
- There was no patient information collected in addition to what was on the patient booking from which was provide by the NHS trust requesting the PTS service.

Summary of findings

However, we found the following areas of good practice:

- There was evidence that all medical devices had been tested in accordance with the manufacture's recommendations.
- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- We reviewed12 staff files, all had enhanced Disclosure and Barring Service (DBS) checks.
- The four patient record forms we reviewed had a pain score and evidence of national early warning score (NEWS) and modified early warning score (MEWS) reviews.
- There was evidence of a multilingual phrase book available for patient's on board both ambulances we inspected.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the Government online system.
- The service had a risk register with 47 current risks identified. The risks were rated by number and severity. There were risk owners, mitigation and dates for finalisation.

Following this inspection, we told the provider that it must take 26 actions to comply with the regulations and that it should make 25 other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices and two enforcement notices that affected both emergency and urgent care and patient transport services. Details are at the end of the report.

Sarah Dronsfield

Head of Hospitals Inspection North East, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Inadequate 	The company provided emergency and urgent care paramedic and first aid medical coverage at both private and public events. The service had transported four patients from an event to hospital during the reporting period 9 January to 1 May 2019, that being the period since the last inspection. The company do not have a contract with any NHS or independent provider to provide emergency and urgent care.
Patient transport services	Inadequate 	Patient transport services was the main proportion of activity. The company provided a PTS service on behalf of another independent ambulance company at an NHS hospital trust. They provided two PTS ambulances and crews daily as required. One ambulance was a conventional patient transport vehicle for low acuity patients transferring them from hospital back to their place of residence. The other ambulance was a high dependency patient transport vehicle which transported high acuity patients between hospital sites or to specialist hospitals dependent upon the medical needs of the patient. They had transported 1,758 patients in the reporting period. The high dependency unit transfers commenced in December 2018 and accounted for 354 of the 1,758 patient transport journeys in the reporting period. The company did not have a contract with any NHS or independent provider.

Summary of findings

Contents

Inadequate

Location name here

Services we looked at
Emergency and urgent care and Patient transport services.

Summary of this inspection

Background to Unit 1

Unit 1 is operated by Mr. David Ogden . The service opened in 2010. It is an independent ambulance service in Skipton, West Yorkshire and operates throughout the UK. The company provides urgent and emergency paramedic and first aid medical coverage at both private and public events, as well as patient transport supplying two ambulances and crew per day on an "as required basis" to another independent ambulance provider. There is no contract in place.

The service was registered to provide the following regulated activities since 12 January 2018:

- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely

Mr David Ogden first registered with the CQC in October 2010. The service has had a registered manager in post since 2010.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, a CQC pharmacy inspector, a CQC assistant inspector, and a specialist advisor with expertise in independent health company ambulance services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Unit 1

The provider is an independent ambulance service in Skipton, West Yorkshire and operates throughout the UK.

The company name is Event Fire Services Ltd and the company trade under the name Oak Valley Events.

The company provided urgent and emergency paramedic and first aid medical coverage at both private and public events. When required the service transported patients from events for treatment in hospital. The service provided a patient transport service working on an as required basis with another independent ambulance provider in the Leicester area. The service supplied two patient transport service (PTS) ambulances and crew per day. There was no contract in place.

The CQC does not currently regulate services provided at events. This element is regulated by the Health and Safety Executive. The part of the service regulated by the CQC is the urgent and emergency care provided by the service when patients are transported to hospital and patient transport.

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely

During the inspection, we visited the NHS trust where the service provided two PTS ambulances and crews and Unit 1 in Skipton which is the services operating base.

In relation to the patient transport service Unit 1 did not have an operational base. The company rented a residential property in the city where the NHS trust is that the service provided PTS services for. Self-employed staff who worked on behalf of Unit 1 travelled from home, stayed at the property returning home after having worked a block of shifts. A small supply of consumable items for use on the PTS ambulances and patient record forms, prior to collection by Unit 1 staff and transporting back to the main operating base, were kept at the property. The two PTS ambulances when not in use were parked near to the residential property on some land owned by a local garage. We did not inspect the residential property or the garage as they were not registered locations.

Summary of this inspection

We spoke with seven members of staff including; the registered manager, the equipment and supplies lead who was also the safeguarding lead, PTS team leader and four PTS staff. During our inspection, we reviewed four sets of patient records and 12 staff files. We inspected three ambulances, two operational and one on standby.

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 has been inspected four times, and the most recent inspection took place in January 2019 which inspected the emergency and urgent care service and found the service was not meeting all the standards of quality and safety it was inspected against. Following that inspection, we told the provider that it must take 20 actions to comply with the regulations and that it should make 15 improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two enforcement notices that affected emergency and urgent care.

Activity (January 2019 to end of April 2019, which is the time since the last inspection) for Urgent Emergency Care.

- In the reporting period January 2019 to end of April 2019 there were 4 emergency and urgent care patient journeys undertaken.

Activity (May 2018 to end of April 2019) for PTS

- In the reporting period May 2018 to end of April 2019 there were 1,758 patient transport journeys. High dependency unit transfers commenced in December 2018 of the 1,758 patient transport journeys in the reporting period 354 were HDU.

Seven registered paramedics, six paramedic technicians, six emergency care assistants and four patient transport drivers were registered to work for the service. The accountable officer for controlled drugs (CDs) was the registered manager.

The service had six ambulances, one was PTS only, two were dual role ambulances and three were urgent emergency care ambulances.

Track record on safety

- No never events
- Clinical incidents none with no harm, none with low harm, none with moderate harm, none with severe harm, no deaths
- No serious injuries

One complaint received in relation to PTS. The matter was investigated by staff at the NHS trust where PTS was provided and not upheld.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate
Patient transport services	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate

Inadequate

Emergency and urgent care

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

Information about the service

The main service provided by this ambulance service was patient transport services (PTS). Where our findings on patient transport for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the PTS section.

The company provided urgent and emergency paramedic and first aid medical coverage at both private and public events. When required the services transported patients from events for treatment in hospital. In the reporting period January 2019 to end of April 2019, which is the period since the last inspection, there were 4 emergency and urgent care patient journeys undertaken.

Summary of findings

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

- During inspection we interviewed the safeguarding lead and were not assured they understood their role.
- The service did not have a system in place to ensure the deep cleaning was effective against bacteria, viruses and fungi infection risks during cleaning.
- The emergency and urgent care vehicle did not have a designated general waste or clinical waste bin. The service used orange bags for clinical waste. This presented a potential infection risk as the plastic bags could split easily.
- There was no evidence that demonstrated the provider formally monitored and recorded adherence to infection control policies and procedures.
- Medicines were not kept with their patient information leaflets as per pharmacy guidance.

However, we found the following areas of good practice:

- There was evidence that all medical devices had been tested in accordance with the manufacture's recommendations.
- There was evidence of a supply of spare pads for the devices which were in date.

Inadequate

Emergency and urgent care

- The service used a red tag system for devices which had been used. The device was tagged and could not be used until recharged and retested.
- All consumables checked on the emergency and urgent care ambulance appeared in date and intact within their packaging.
- During inspection we reviewed four patient records forms (PRF`s) relating to emergency and urgent care. All were completed fully including times, dates, signatures and professional designations.
- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- 12 staff files were reviewed, all had enhanced Disclosure and Barring Service (DBS) checks

Are emergency and urgent care services safe?

Inadequate

Our rating of safe remained the same. We rated safe as **inadequate**, because;

- During this inspection we found the service still did not have a safeguarding policy but relied upon an NHS reporting document which was not service specific and did not carry any service identification such as a company logo.
- During inspection we interviewed the safeguarding lead and were not assured they understood their role.
- Medicines were not kept with their patient information leaflets as per pharmacy guidance.
- The medicine pouch contained one hydrocortisone vial. This did not meet the minimum quantity required (200mg of administration) for acute anaphylaxis.
- The diazepam used by the service was not kept secured or the stock levels recorded in accordance with best practice guidance.
- The controlled drugs register did not conform to NICE guidance for controlled drugs documentation.
- Dextrose tablets were not stored correctly stored in the original packaging with the medicine information leaflet and the oral temperature monitor was found within a bag without any disposable covers.
- There was no evidence that demonstrated the provider formally monitored and recorded adherence to infection control policies and procedures.
- A defibrillator storage bag was ripped and not intact, presenting an infection control risk when attempting to clean the device.
- A portable suction device had the suction tubing already attached to the device, which was not secure in its packaging presenting an infection control risk.

Inadequate

Emergency and urgent care

- The emergency and urgent care vehicle did not have a designated general waste or clinical waste bin. The service used orange bags for clinical waste. This presented a potential infection risk as the plastic bags could split easily.
- The service did not have a system in place to ensure the deep cleaning was effective against bacteria, viruses and fungi infection risks during cleaning.
- The Entonox cylinder in one of the ambulances we inspected had on it a patient sticker showing it had been prescribed to a specific patient.
- The contents of the paramedic bags lacked standardisation. The bags did not have the same contents or a stock list to ensure used items were replaced.
- The risk assessment in relation to the storage of medical gases was an overview and each associated risk was not mitigated.
- During inspection we saw the patient transfer log, containing a patient's name and address was visible and did had not been locked away out of sight between transfers.

However, we found the following areas of good practice:

- During inspection we inspected four paramedic bags and four first aid bags used at events for emergency and urgent care. All the consumable items contained in the bags were in date.
- There was evidence on the medical devices that all had been tested in accordance with the manufacture's recommendations.
- There was evidence of a supply of spare pads for the devices which were in date.
- The service used a red tag system for devices which had been used. The device was tagged and could not be used until recharged and retested.
- The monitor/defibrillator and oxygen pipelines had been serviced within date and were visibly clean.
- All consumables checked on the emergency and urgent care ambulance appeared in date and intact within their packaging.
- During inspection we reviewed four patient records forms (PRF`s) relating to emergency and urgent care. All were completed fully including times, dates, signatures and professional designations.
- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- We reviewed12 staff files, all had enhanced Disclosure and Barring Service (DBS) checks.

Incidents

See Patient Transport for main findings

Mandatory training

See Patient Transport for main findings

Safeguarding

See Patient Transport for main findings

- Managers we spoke with told us because of the nature of event work, when staff who were present to provide emergency and urgent care met the public who may have required medical assistance it would not be known if a protection plan was in place.

Cleanliness, infection control and hygiene

See Patient Transport for main findings

- When we inspected the high dependency unit (HDU) PTS vehicle there was evidence of the scoop stretcher not being cleaned after use as there was used tape still stuck in place from a previous patient.
- The vehicle did not have a designated general waste or clinical waste bin. It appeared the service practice was to tape a plastic clinical waste bag to the bulkhead for use. Then remove it after the end of a shift.
- Seat covers in the saloon cab were not intact, with obvious signs of multiple large tears in the rear saloon seat. The second rear saloon seat adjacent to the stretcher was also exposed with multiple holes in the fabric. This meant the seat covers could not be cleaned properly and were an infection risk.

- The main paramedic bag was made of an infection control wipeable material. All other bags and pouches did not appear to be made from an infection control friendly material
- Hand-cleansing gel was available with the expiry date clearly marked on the exterior in tape. The paper tape used to mark the expiry date was not infection control compliant.
- There was no hand moisturiser. This is important as staff would use it to prevent cracked skin on the hands which could present an infection risk.
- The vehicle was missing moving and handling equipment at the time of inspection so we unable to assess the level of cleanliness of that equipment.
- The defibrillator storage bag was ripped and not intact which presented an infection risk because the exposed interior material could not be cleaned.
- The portable suction device had the suction tubing already attached to the device, which was not secure in its packaging presenting an infection risk.
- The stretcher on board the ambulance appeared clean and the mattress was intact.
- Hand-cleansing gel was available on the vehicle with the expiry date clearly marked on the exterior in tape, however, the paper tape used to mark the expiry date was not infection control compliant because it was not made of wipeable material.
- There was no hand moisturiser for staff to use to prevent cracks in the skin on their hands which could be an infection risk.
- The vehicle had a supply of clean linen, sheets and blankets, stored and folded in an overhead locker. Cleaning facilities for linen were available on station, including red and white linen bags on board the vehicle.
- There was no evidence of a history of daily vehicle cleaning checks on board this vehicle at the time of inspection.
- The vehicle had a supply of detergent cleaning wipes which were in date.
- The vehicle at the provider base was observed just prior to any cleaning taking place. Both interiors had signs of regular cleaning and items were stored away in their respective cupboards.
- Cleaning facilities for linen were available on station, including red and white linen bags on board the vehicle.

Environment and equipment

See Patient Transport for main findings

- During inspection we inspected four paramedic bags used at events and four first aid bags. All the consumable items contained in the bags were in date.
- We found the contents of the paramedic bags lacked standardisation because they all did not have the same contents. The bags did not have a stock list inside to ensure used items were recorded and replaced.
- Dextrose tablets kept inside the blood sugar machine pouch were not in the original packaging or with the patient information leaflet. The oral temperature monitor was found within a bag without any disposable covers. This was removed by the services staff member, who told us it should not have been there.
- Portable appliance testing (PAT) is the name of a process by which electrical appliances are routinely checked for safety. During the last inspection we inspected five automatic external defibrillators (AEDs) during inspection. Three had no evidence of having been PAT tested. One of the AED`s did not have a date when the machine was operational. The pads in all the AED`s were in date.
- During this inspection we inspected nine AED`s, and eight life packs which are monitor defibrillators. There was evidence on stickers on the devices all had been tested in accordance with the manufacture's recommendations.
- There was evidence of a supply of spare pads for the devices which were in date.
- The service used a red tag system for devices which had been used. The device was tagged and could not be used until recharged and retested.

Emergency and urgent care

- The registered manager told us the service was moving toward using a bar code system for medical devices. They said each device would have a bar code and a bar code reader would be used to check the bar code and automatically update a spreadsheet as to the status of each device.
- Medical gases, oxygen and entonox, were stored within the main storeroom. The cylinders were fixed against the wall to prevent falling. During the last inspection the registered manager told us there was a risk assessment for the storage of gas cylinders. This was not available at the time of that inspection.
- During this inspection we found there was no specific risk assessment is relation to the storage of medical gases, however, there was evidence that storage of medical gases was included in the company risk assessment. The risk assessment in relation to the storage of medical gases was a summary and each associated risk was not mitigated.
- Entry to the locked storage room required a keycode to enter. The room was dry, warm and well ventilated. Empty and full gas cylinders were placed within the same shelf, separated by hand written markings on the wall.
- The service used two national providers for supplying and taking away empty cylinders.
- All the medical gas cylinders checked on station at the time of inspection were within date.
- During the inspection we inspected two high dependency ambulances that were dual purpose used for both emergency and urgent care and PTS. One was operational, the other was on standby at the providers headquarters.
- The operational ambulance vehicle was observed to be clean, tidy and well stocked in both the cab area and saloon with consumable items.
- The vehicle was equipped with a spinal board, stretchers, head blocks, cervical collars, splints, traction splints, monitor/defibrillators, basic observations kit, a wheelchair and oxygen pipelines. All appeared visibly clean and had been serviced in accordance with manufactures guidance.
- The vehicle was also equipped with various sizes of moving slings, a reusable slide sheet, turntable and small transfer board
- The vehicle had a small sharps container stored in one of the main paramedic bags and was secured.
- It was not clear if the stretcher was serviced due to the lack of a visible service sticker at the time of inspection.
- The vehicle had a supply of clean linen, sheets and blankets, stored and folded in an overhead locker. The vehicle also had two spare single use blankets and sheets if linen was not available.
- The vehicle had a selection of non-latex gloves, disposable aprons, goggles and face masks. The service used a mixture standard industrial dust masks and filtered dust masks.
- The vehicle appeared to be in full working condition with no obvious signs of damage. All the lights were working.
- There was no evidence of a history of daily vehicle cleaning or equipment checks on board the vehicle at the time of inspection.
- The rear tail lift did not have a record of a LOLER test which did not meet HSE guidance. The LOLER is an annual mandatory requirement under the Health and Safety legislation to test lifting equipment. LOLER stands for lifting operations and lifting equipment regulations.
- The vehicle had a paediatric harness available and was suitable for children of all ages, excluding neonates.
- All consumables checked on the ambulance appeared in date and intact within their packaging.
- The size 00 oropharyngeal airway was missing. The main trauma dressing contained within the large red paramedic bag did not appear to have a date on the packaging to highlight the items expiry date.
- A paediatric miller blade which is a curved laryngoscope blade, contained within the large red paramedic bag, was not in working order.
- The cannula's and hypodermic needles sourced by the service did not meet HSE guidance for 'safety sharps'.

The service was required under the 'HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 to risk assess sharps in healthcare and to adhere to the following statement; 'The employer must substitute traditional, unprotected medical sharps with a 'safer sharp' where it reasonably practicable to do so .All medical gas cylinders on board the ambulance were clean and secure. The large F type cylinder had expired, the last test was done in 2012.

- The Entonox cylinder had on it a patient sticker showing it had been prescribed to a specific patient.
- Staff told us patient records (PRF`s) were locked away between patient transfers in a safe in the rear of the ambulance. However, during inspection we saw the patient transfer log, containing a patient's name and address was visible and did had not been locked away out of sight between transfers.
- There were special equipment and aids to assist communication with patients on the vehicle.
- We inspected an HDU ambulance at the service headquarters which was undergoing deep cleaning and restocking.
- Patient monitoring equipment had been removed from the vehicle at the time of inspection, which was common practice to store medical equipment off the vehicle when not in use. The medical devices stored on station all appeared visible clean.
- The HDU vehicle had a small sharps container stored in one of the overhead lockers, secured from tipping and secured from spillage with a closed lid. The sharps container was not dated. The service utilised a process of dating sharps containers only once when first used due to the infrequency of sharps disposal activity.
- The stretcher on board the ambulance had been serviced within date, however, the stretcher was lacking secure restraints harnesses.
- The vehicle had a supply of clean linen, sheets and blankets, stored and folded in an overhead locker.
- The vehicle had a selection of non-latex gloves, disposable aprons, goggles and face masks.
- The HDU vehicle was in full working condition with no obvious signs of damage.
- There was no evidence of a history of equipment checks on board this vehicle at the time of inspection.
- Managers we spoke with told us crews would only highlight vehicle or equipment faults, otherwise it would be assumed the vehicle was safe and in fully working order. We were told the service was developing a process to include a systematic checklist and evidence gathering.
- The service received a daily electronic report from ambulance crews detailing in free text the vehicle location, mileage, type, who had completed the generic cleaning report, status and finish time
- Any equipment not stored on station whilst the vehicle was not in use appeared to have been serviced, was clean and in working condition.
- This HDU vehicle did not carry any suitable child restraints for the transfer of paediatric patients.
- All consumables checked on the ambulance were in date and intact within their packaging.
- No medicines were stored on the vehicle.
- One small oxygen cylinder was secured in a holster/ bracket made for a much larger oxygen cylinder. This did not ensure the cylinder was protected from coming loose during a crash or sudden braking; it would potentially then become a potential hazard for patients and crew.
- No records were kept on board the ambulance at the time of inspection.
- A language and pictorial aid were available for use on this vehicle for patients when English was not their first language.
- There was a supply of patient feedback forms on board the ambulance for staff to hand to patients.

Assessing and responding to patient risk

See Patient Transport for main findings

Staffing

- There was no alignment of a rota or shifts to meet demand because staff worked on an as required basis. Event medical plans were completed when the service was commissioned to provide medical cover at an event.

- We saw evidence the event medical plans contained an assessment of the number and skill mix of staff required for the event and contained consideration of the driving skills required and capacity to allow patients to be transported off site if required and to deliver emergency and urgent patient care.
- The registered manager told us the number of staff rostered to work at an event was sufficient to enable patients to be treated and transferred to hospital if necessary because staffing was included in the event medical plans and agreed by the event organiser or chair of the safety advisory group (SAG).

Records

- During inspection we reviewed four patient records forms (PRF`s) relating to emergency and urgent care. The four PRF`s were identified by the company logo.
- The four records were completed fully including times, dates, signatures and professional designations.
- The four records had a pain score, allergy status, there was evidence of deteriorating patient pathways, there was evidence of national early warning scores (NEWS) and modified early warning score (MEWS). However, the four PRF`s we reviewed had no hospital handover information recorded, but there was a staff signature indicating the patient had been handed over.
- The PRF`s recorded consent to treatment.
- There was not a detailed method of recording patient information relating to patient infection status, mobility needs, medical needs, property and do not attempt cardiopulmonary resuscitation (DNACPR).
- The registered manager told us the service was moving toward using a computer-based version of a PRF on the company app which was on the mobile phones of staff. We were told the forms would have mandatory fields to complete, including; patient infection status, mobility needs, medical needs, property and do not attempt cardiopulmonary resuscitation (DNACPR), before the form could be completed and sent off.

Medicines

See Patient Transport for main findings

- The medicine pouch contained one dose of hydrocortisone. This did not meet the minimum quantity required of 200mg of administration for acute anaphylaxis.
- The supply of diazepam was not kept secured or the stock levels recorded. This is not a requirement for a schedule four medicine, but it is recommended to be best practice to monitor the movement of controlled medicines which may be abused or used for unlawful purposes. It was not clear at the time of inspection how the service managed and monitored this risk as required under NICE guidance for controlled medicines management.
- The controlled drugs register was stored securely. However, there was inaccurate record keeping and no reporting of controlled drug related incidents.
- The controlled drugs register did not conform to NICE guidance for controlled drugs documentation. There was not accurate record keeping, risk assessments and reporting controlled drug-related Incidents.
- Medicines were stored within a tagged medicine pouch. Medicines were placed into the pouch, checked against a paper checklist, signed and tagged with a unique identification number.
- At the time of inspection, it was not clear if the glucagon on the vehicle we inspected had expired due to a lack of a revised expiry date. Glucagon is required to be stored in a fridge and it had not been. Glucagon not stored in a fridge required an amended expiry date in accordance with manufacturers recommendations.
- After consultation with the registered manager the glucagon stock was removed from the providers vehicles and medicines store room.
- All other medicines checked in the medicine's pouches were in date.
- During inspection we found medicines were kept without their patient information leaflets as per pharmacy guidance.
- There were no denature kits on board the ambulance for the safe disposal of controlled medicines. A denaturing kit is used to ensure controlled medicines are irretrievable and unfit for further use until they are fully destroyed by incineration.

Inadequate

Emergency and urgent care

Are emergency and urgent care services effective?
(for example, treatment is effective)

Requires improvement

Our rating of effective improved. We rated it as **requires improvement.**

We rated effective as requires improvement because;

- There was no evidence the provider had a system to check staff had read, understood and adhered to company policies.
- There was no evidence the provider reviewed and centrally stored emergency and urgent care ambulance response times.
- The service did not have an induction procedure for new staff.
- There was no evidence the provider carried out a training needs analysis of staff to identify training requirements or assessed the competence of staff delivering patient care.
- There was not a system to identify poor or variable staff performance or how this would be managed for staff to improve.
- There was no evidence of any contingency plans to enable staff to access policies, procedures or guidance should the providers mobile phone app failed or there was no mobile phone access.
- The four patient record forms we reviewed during inspection had no hospital handover information recorded. The only handover information was a section titled “Patient handover to” with a section to sign by the person at the receiving hospital.
- The service did not record information about the outcomes of people's care and treatment.

However, we found the following good practice;

- Best practice guidance was used in the development of the service’s policies and procedures which referenced guidance from national bodies.
- The four patient record forms we reviewed had a pain score and evidence of NEWS/MEWS reviews.

Evidence-based care and treatment

- Best practice guidance was used in the development of the service’s policies and procedures which referenced guidance from national bodies. This included guidance from both the National Institute for Health and Care Excellence (NICE) as well the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) which reflected current practice.
- The registered manager told us the service was moving toward uploading all policies, procedures and guidance to a mobile phone app which staff could access through their mobile phones. The registered manager could not tell us when this work would be completed.
- There was no evidence of any contingency plans to enable staff to access policies, procedures or guidance should the app fail or there was no internet access.
- During inspection the registered manager showed us how the app worked and accessed three policies which were in date and had version control. We were unable to review all policies on the app because they had not all been uploaded. In addition, the link to the app on the registered managers phone stopped working when it was being demonstrated to us.
- At the time of the inspection the registered manager told us uploading provider documents on to the app was, “work in progress” and not complete. The registered manager was unable to inform us when the work would be finalised.
- The registered manager told us when staff joined the service they could access the staff handbook through the providers app which gave access to joint royal colleges ambulance liaison committee (JRCALC) guidelines and the service’s policies and procedures. During inspection we saw no evidence as to how the service checked staff had read and understood policies and procedures and adhered to them.

Response times

- The registered manager told us staff kept records of the time they were alerted to a casualty at events, the time the casualty was seen, the time they left the site

on transfer, the time they arrived at hospital, and the handover time. This information was recorded on the PRF`s. There was no evidence the provider reviewed and centrally stored ambulance response times.

- During inspection we reviewed four PRF`s which were fully completed with times, dates and signatures identified. The result of this was we could evidence patients had been seen promptly and there had been no undue delays in their treatment.

Patient outcomes

- The service did not record information about the outcomes of people's care and treatment. There was no method of comparing outcomes for people in this service compared with other similar services and how they had changed over time.
- The service did not participate in any quality improvement initiatives either internally at service level, locally or nationally.
- There was no evidence of monitoring of activities to gather information to improve patient outcomes.

Nutrition and Hydration

- As an emergency provider, this service was equipped to provide treatment pathways in an emergency as detailed in JRCALC, for example, intravenous fluids or glucose rescue medications.

Competent staff

See Patient Transport for main findings

Multi-disciplinary working

- The registered manager told us emergency and urgent care staff provided handover information on the patient record forms handed to hospital staff on arrival and transfer, however, the four PRF`s we reviewed during inspection had no hospital handover information recorded. The only handover information was a section titled “Patient handover to” with a section to sign by the person at the receiving hospital.

Health promotion

- The service did not take part in any health promotion with service users.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

See Patient Transport for main findings

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We inspected but did not rate Caring.

Compassionate care

See Patient Transport for main findings

- Due to type emergency and urgent care service provided during inspection we were unable to observe patient care.
- During the inspection of the urgent emergency care ambulance it was noted the vehicle had curtains which could be pulled across the windows to maintain patient dignity.
- During inspection we reviewed two thank you letters from people who had been at events.

Emotional support

See Patient Transport for main findings

- Due to type of service emergency and urgent care provided during inspection evidence emotional support could not be evidenced.

Understanding and involvement of patients and those close to them

See Patient Transport for main findings

- The registered manager told us staff consulted with patients about the necessity for transfer from an event to hospital and explained the options available to them, that is, whether they could go independently to hospital, call for an NHS ambulance or use the service, depending on the injuries or medical condition they had experienced. In this way the staff gained agreement with the patient and/or their relatives about the transfer.

Emergency and urgent care

- There was no evidence the provider carried out patient surveys to gain feedback from patients or their families.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Our rating of responsive improved. We rated it as **requires improvement.**

We rated effective as requires improvement because;

- There was no evidence the provider had a system to check staff had read, understood and adhered to company policies.
- There was no evidence the provider reviewed and centrally stored emergency and urgent care ambulance response times.
- The service did not have an induction procedure for new staff.
- There was no evidence the provider carried out a training needs analysis of staff to identify training requirements or assessed the competence of staff delivering patient care.
- There was not a system to identify poor or variable staff performance or how this would be managed for staff to improve.
- There was no evidence of any contingency plans to enable staff to access policies, procedures or guidance should the providers mobile phone app failed or there was no mobile phone access.
- The four patient record forms we reviewed during inspection had no hospital handover information recorded. The only handover information was a section titled "Patient handover to" with a section to sign by the person at the receiving hospital.
- The service did not record information about the outcomes of people's care and treatment.

However, we found the following good practice;

- Best practice guidance was used in the development of the service's policies and procedures which referenced guidance from national bodies.
- The four patient record forms we reviewed had a pain score and evidence of NEWS/MEWS reviews.

Service delivery to meet the needs of local people

- The service could provide a generic paramedic and emergency transport service to support most levels of unstable patient transfers, such as electrocardiogram (ECG) monitoring, deteriorating patients and transfer to specialist sites.
- The service provided emergency and urgent care medical coverage at public and private events. This meant the service experienced seasonal fluctuations in activity. There was no planning until the service had tendered for and secured a contract. Resources were then planned accordingly to meet the requirements of the event plan or the SAG.
- The registered manager told us because there was a pool of self-employed staff it allowed the service to respond to increases in demand, for example, if they secured an event contract at short notice, and obtain the required number of staff with the correct skills
- The service did not have any contracts for the provision of emergency and urgent care. They tendered for individual events. There was no evidence the provider had a considered approach for tendering for the work undertaken.

Meeting people's individual needs

- During the inspection we saw there was a multilingual phrase book available for patient's on board the ambulances we inspected for patients where English was not their first language.
- There was no easy read or picture guides on the vehicles we inspected for patients with learning disabilities or who were deaf.
- Due to the type of emergency and urgent care provided there was no ability to plan to meet the needs of people including individual preferences, culture or faith.
- Due to the type of emergency and urgent care provided there was no adaptions for patients with complex needs. The only journey planning was to make staff working at an event aware of where the nearest NHS accident and emergency department was.

Inadequate

Emergency and urgent care

Access and flow

- In relation to emergency and urgent care the service the provider had no control over the access and flow of patients as the service was reactive and not pre-booked.

Learning from complaints and concerns

- The service had not received a complaint in the reporting period in relation to emergency and urgent care.
- During inspection we reviewed the complaints procedure document. The document outlined the services complaints procedures. The document was not dated and there was no review date. The document did have the company logo displayed. The version control on the footer was dated 2 May 2017. The document was not signed.
- There was no evidence of a system being in place to check if staff had read, understood and were complying with the complaints policy.

Are emergency and urgent care services well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as **inadequate.**

See Patient Transport for main findings.

Leadership of service

See Patient Transport for main findings

Vision and strategy for this service

See Patient Transport for main findings

Culture within the service

See Patient Transport for main findings

Governance

See Patient Transport for main findings

Management of risk, issues and performance

See Patient Transport for main findings

Information Management

See Patient Transport for main findings

Public and staff engagement

See Patient Transport for main findings

Innovation, improvement and sustainability

See Patient Transport for main findings

Inadequate

Patient transport services

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

Information about the service

The company provided a patient transport service (PTS) on behalf of another independent ambulance company operating in the Leicester area. The provider had a verbal agreement with the company to provide one PTS ambulance and crew daily. In the reporting period, May 2018 to end of April 2019, there were 1,758 patient transport journeys. High dependency unit (HDU) transfers commenced in December 2018 and of the 1,758 patient transport journeys in the reporting period 354 were HDU related. The company did not have a contract with any NHS or independent provider.

Summary of findings

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

- The provider did not produce any evidence as to how the service could check which staff had read and understood the duty of candour principles.
- There were not robust checks in place to ensure vehicle check lists were completed daily or at the start of each shift, and any equipment issues highlighted to the PTS team leader, so they could be addressed.
- Medicines were not stored in accordance with manufacturer`s recommendations, there was no overarching system to record when medicines stored in bags had expired and staff were not acting in accordance with the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
- During inspection we interviewed the safeguarding lead and we were not assured they understood their role.
- There were no contingency plans to have paper referral forms available in the event of there being no internet access or connection to the provider mobile phone app.
- Safeguarding was included in the staff handbook, however, there was no evidence as to how the service could check levels of staff understanding or if staff had read the information in relation to safeguarding.

Inadequate

Patient transport services

- The vehicle cleaning document was not dated, signed or identified as being the services protocol.
- The service did not have a system in place to ensure deep cleaning was effective against bacteria, viruses and fungi infection risks.
- The patient transport service did not have an operational base.
- There were no minimum or maximum temperature limits set or recorded regarding the storage of medicines.
- We did not see any evidence of an operating procedure or protocol to provide guidance for staff on the management of deteriorating patients being in place, detailing the frequency of observation recordings and the relevant action dependant of the NEWS2 score/thresholds.
- The provider did not produce any evidence of how they would ensure staff were complying with the European working time directives with adequate rest periods.
- Some of the staff files we reviewed did not include references or full employment history.

We found the following areas of good practice:

- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- All the staff mandatory training appeared to be up to date on the training spreadsheet.
- The policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider were in date, had a review date and were version controlled.
- The service had an infection prevention and control (IPC) policy which was in date available for staff to access on the intranet site.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the Government online system which sent out an alert email a month before then two weeks before the vehicle service was due.
- There was a language aid booklet available for use on the vehicle for patients when English was not their first language.
- There was a supply of patient information/leaflets available, including details on how to feedback or complain.
- We found the service had introduced a numbered tagging system for individual medicines bags since the last inspection. The tagging number enabled the identification of which bags had been opened and would require restocking.

Inadequate

Patient transport services

Are patient transport services safe?

Inadequate

We rated safe as **inadequate** because;

- There were not robust checks in place to ensure vehicle check lists were completed daily or at the start of each shift, and any equipment issues highlighted to the PTS team leader, so they could be addressed.
- The vehicle cleaning protocol document was not dated, signed or identified as being the services` protocol.
- Medicines were not stored in accordance with manufacturer`s advice, there was no overarching system to record when medicines stored in bags had expired and staff were not acting in accordance with the Controlled Drugs (Supervision of Management and Use) Regulations 2013.
- We did not see any evidence of an operating procedure or protocol to provide guidance for staff on the management of deteriorating patients being in place detailing the frequency of observation recordings and the relevant action dependant of the NEWS2 score/ thresholds.
- During inspection we interviewed the safeguarding lead and we were not reassured they understood their role.
- During inspection the provider did not produce any evidence that demonstrated they formally monitored, audited and recorded adherence to infection control policies and procedures.
- Evidence in staff files did not provide assurance that all schedule three requirements were met. The staff files contained enhanced DBS checks and driving licence checks but few included references or full employment history.
- The recruitment policy for staff requiring two references was not followed.

However, we found the following areas of good practice:

- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- All the staff mandatory training appeared to be up to date on the training spreadsheet.
- The policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider were in date, had a review date and were version controlled.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the government online system which sent out an alert email a month then two weeks before the vehicle service was due.
- There was a language aid booklet available for use on the vehicle for patients when English was not their first language.

Incidents

- During the previous inspection we reviewed policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider. While each provided guidance as to how incidents were defined, reported, recorded and dealt with, the policies were past the planned review date of January 2018.
- During this inspection we found the policies in relation to clinical adverse incidents, non-clinical adverse incidents and adverse incidents with a third-party provider where in date, had a review date and were version controlled.
- The policies outlined the method of reporting incidents or near miss which was to use the incident report form (IRF), which was available on all vehicles.
- Staff were advised reports should not generally be given verbally unless the incident was serious and required immediate management action, in which case the senior member of Unit 1 staff on duty would be contacted in the first instance, and the form completed later.
- The IRF`s contained prompts for all the relevant information required for an investigation of an incident. Staff were advised the forms should be completed as accurately as possible, ideally immediately after the incident.
- Due to the nature of the urgent and emergency care work no operational staff were on station or deployed

that we could speak too so we were unable to review the practical application of the reporting and review policies in respect of incidents or evidence levels of staff understanding.

- In addition, the service had not recorded any incidents in the reporting period that could be reviewed to evidence the policies and procedures had been followed.
- Providers of healthcare services must be open and honest with patients and people acting for them, when things go wrong with care and treatment, giving them reasonable support, truthful information and an apology
- During the previous inspection we reviewed the services ` duty of candour policy. The policy was not dated and there was no date when the policy became live and there was no review date.
- During this inspection we found we found the policy in relation to duty of candour was in date, had a review date and was version controlled.
- During the previous inspection the registered manager we spoke with told us the service did not carry out any training in relation to duty of candour, but the principles were in the company staff handbook which was available to staff through an app on their mobile phones.
- During this inspection we found duty of candour was not discussed with staff as part of an induction procedure. Staff were expected to have read and understood the information on the providers mobile phone app. The provider did not produce any evidence as to how the service could check which staff had read and understood the duty of candour principles.
- The service had not applied the duty of candour as there had been no incidents when this would be required.
- During inspection we reviewed a complaint investigation form recorded on an incident report. The brief circumstances were no defibrillator pads had been available on the main Lifepak 12 defibrillator on one of the PTS ambulances when a vehicle check was carried out.
- The investigation found staff, who had been working on the vehicle for the two days previously, had not carried out proper vehicle checks. It was found that the pads had been used and no request had been made for spares and no vehicle check list had been received from the second crew to report them missing. The matter was recorded as a 'near miss' incident and it was added to the risk register.
- This incident illustrated there were not robust checks in place to ensure vehicle check lists were completed daily or at the start of each shift, and any equipment issues were highlighted to the PTS team leader, so they could be addressed.

Mandatory training

- All staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was due.
- All the staff mandatory training appeared to be up to date on the training spreadsheet.
- The registered manager told us if a staff member was marked red on the spreadsheet it indicated their mandatory training was not up to date and they would not be offered any work until the training was completed. Staff whose paper files that were out of date or incomplete would also not be given any work.
- The mandatory training requirements included equality, diversity and human rights, moving and handling, safeguarding, infection prevention and control and information governance.
- There was evidence the service checked the Health and Care Professions Council (HCPC) database to confirm paramedics who worked for them were trained and registered. The dates the checks were made were recorded on the database.
- The service was reliant upon the primary employer of the staff who worked on an 'as required' basis for the service to provide mandatory training. When staff registered with the service they were required to provide current mandatory training certificates which were copied and placed in the staff files and recorded on the training spreadsheet.

- All PTS staff mandatory training was recorded on a spreadsheet which highlighted which courses staff had attended and when the date of the refresher was.
- During the last inspection we found all the PTS staff mandatory training appeared to be up to date on the training spreadsheet. However, what was recorded on the training spreadsheet did not tally with what was recorded in the six staff files we checked. In five of the files there was no evidence of safeguarding training having been attended but the training spreadsheet showed the same staff having up to date safeguarding training.
- During this inspection we found the training spreadsheet did match what was recorded in the 12 staff files we reviewed.

Safeguarding

- During the previous inspection we found the service did not have a safeguarding policy.
- During this inspection we found the service still did not have a safeguarding policy.
- During previous inspection we saw evidence the registered manager who was also the safeguarding lead was trained to safeguarding level three. This level of training included deprivation of liberty standards and the mental capacity act.
- At the previous inspection, the designated safeguarding lead who was the managing director, had not undergone any extra training to complete this safeguarding role or had arrangements in place via a service level agreement for supervision by a level four trained professional. The intercollegiate document March 2018/19 stated that the identified safeguarding lead should be trained to level four for children.
- During this inspection we found a senior member of staff had attended and completed a safeguarding level four course.
- When we interviewed the safeguarding lead, we were not assured they understood their role. When asked what they would do upon receipt of a safeguarding referral we were told they would speak with the registered manager and decide what to do next. The registered manager was trained in safeguarding level three and was therefore less qualified than the safeguarding lead.
- During the previous inspection there was no evidence of a suitably trained identified deputy safeguarding lead being available if the lead was on leave or sick. We were told the deputy safeguarding lead would be the registered manager who was not trained to safeguarding level four.
- During the inspection we discussed the safeguarding referral processes with the safeguarding lead. They told us if the medical practitioner attending to the patient had concerns they would either submit a safeguarding report via the accident and emergency department of the receiving hospital or if this were not possible they would submit a report to the safeguarding team at the local council.
- If either of these reporting routes were not possible then the report would be submitted to the service's safeguarding lead.
- During the previous inspection we found, depending, upon the day of the week submission of the safeguarding referral could potentially take longer than the recommended 24 hours.
- During this inspection we found there was still no policy in place in relation to referral times.
- During the previous inspection there was no evidence the service had a form available for staff to complete when making a safeguarding referral. The safeguarding lead told us staff could provide written information on paper or email them.
- During this inspection we found the service did had a form available for staff to complete when making a safeguarding referral. This was the NHS generic referral form which staff could access through a link to the internet on their mobile phones.
- The form did not carry any service identification such as a company logo meaning it would be difficult for the recipient of the form to readily identify who had submitted it.
- The service did not provide safeguarding training but was reliant upon the primary employer of the staff who

worked on an 'as required' basis for the service to provide safeguarding training. When staff registered with the service they were required to provide current safeguarding training certificates which were copied and placed in the staff files.

- During the previous inspection the registered manager told us there was information in the company staff handbook which was given to staff when they joined the company in relation to safeguarding.
- The handbook was reviewed during the previous inspection and information about safeguarding was not part of the document. The provider did produce any evidence as to how they could check staff understanding or if staff had read the information in relation to safeguarding.
- During this inspection we found safeguarding included in the staff handbook which was accessible via the providers mobile phone app, however, there was still no evidence as to how the service could check staff understanding or if staff had read the information in relation to safeguarding.
- Managers we spoke with told us because of the nature of event work when staff met the public who may have required medical assistance it would not be known if a protection plan was in place.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control (IPC) policy which was in date and available for staff to access on the intranet site. This was supported by policies on hand hygiene, the use of personal protective equipment (PPE), equipment cleaning and a vehicle hygiene policy. These included clear guidance for staff on managing patients with infections.
- The service did not provide infection prevention and control training but was reliant upon the primary employer of the staff who worked on an 'as required' basis for the service to provide this. When staff registered with the service they were required to provide IPC training certificates which were copied and placed in the staff files.
- During the previous inspection the staff handbook was reviewed and information about IPC was not part of the document. The provider did not produce any evidence as to how they could check staff understanding or had read the information in relation to IPC.
- At this inspection we found IPC was included as part of the handbook which was accessible via the providers mobile phone app.
- During the previous inspection the provider did not produce any evidence of having carried out any IPC audits. The audits were requested during inspection. We were told by the registered manager the service did not carry out any IPC audits.
- At this inspection we found the service had not carried out any IPC audits. This meant the provider could not be assured the equipment and environment was not carrying an infection risk to patients using the services or staff were adhering to the providers IPC policies.
- During the previous inspection the provider did not produce any evidence that demonstrated they formally monitored and recorded adherence to infection control policies and procedures. The registered manager told us they checked adherence to hand hygiene on site and checked that cleaning procedures were followed but did not document this.
- At this inspection the provider did not produce any evidence that demonstrated they formally monitored and recorded adherence to infection control policies and procedures.
- We saw evidence the service had a system in place to audit the cleaning of vehicles and there was an ambulance deep cleaning protocol which outlined which cleaning products to use, however, which cleaning product had been used was not recorded on the cleaning records we checked.
- The protocol document was not dated, signed or identified as being the services protocol.
- The service did not have a system in place to ensure the deep cleaning was effective against bacteria, viruses and fungi infection risks during cleaning.

- Cleaning equipment was available in the ambulance garage. A colour coding system was used which separated cleaning equipment that was to be used in different areas.
- The vehicles we checked all contained evidence they had been deep cleaned after their last use and the manager told us they made checks that the cleaning was up to date but did not record this. Vehicles and equipment were visibly clean.
- The service used orange bags for clinical waste which were taken from the vehicle after each shift and placed within the secured clinical waste bin outside the main ambulance station garage. This presented a potential infection risk as the plastic bags could split easily None of the vehicles we inspected had a clinical waste bin.
- The service utilised separate sharps boxes for the safe disposal of medicines and sharps. There did not appear to be any record of expiry dates or frequency of changing sharps boxes.
- There was no sharps bin or clinical waste bin in the vehicle. Staff told us any clinical waste was placed in a plastic bag tied around a bulkhead and then removed and placed in a clinical waste bin when they visited the hospital where the PTS was provided.
- During the last inspection there was no process in place for the cleaning of infectious/ soiled linen, for example, a red bag process whereby infectious/ soiled linen would be instantly identified and handled accordingly.
- At this inspection we found there was a process in place for the cleaning of infectious or contaminated linen. There was a supply of red bags for staff to use to for infectious or contaminated linen.
- During the previous inspection we saw evidence of three vehicle deep cleans.The provider did not have a vehicle cleaning policy in place or carried out cleaning audits. We were unable to evidence compliance or non-compliance in respect of vehicle deep cleans in relation of frequency, IPC cleaning products used, standards of cleanliness and any action plans when the levels of cleanliness had fallen below standard.
- At this inspection we found evidence of three vehicle deep cleans being completed. The provider still did not have a vehicle cleaning policy but had a cleaning protocol which outlined which cleaning products to use in which parts of the vehicles. In relation to the three vehicle deep cleans we were unable to evidence compliance or non-compliance of the frequency of vehicle cleaning which IPC cleaning products were used, the standard of cleanliness and any action plans when the levels of cleanliness had fallen below standard.
- The team leader we spoke with told us there was no formal procedure or policy in place for the disposing of soiled or used linen whilst vehicles were operational. The existing practice was to dispose of linen at hospital sites.
- The inside of PTS ambulance, including cab area was visibly clean and tidy. The re-usable equipment, including, splints, BP cuffs, and slide sheets, were visibly clean.
- The trolley was clean and the mattress covering was intact.
- Staff on the PTS ambulance used personal issue hand cleaning gel which was checked during inspection and was in date.
- The vehicle had a supply of non-latex gloves, disposable aprons, goggles, face masks and aprons. The vehicle had a spill kit and supplies of decontamination wipes.
- The PTS team leader told us staff cleaned the PTS ambulances at the NHS trust where they operated from using the trusts cleaning products and sluice to dispose of any waste including the contents of the cleaning buckets.
- The team leader told us if the PTS ambulance needed to be cleaned at the end of the shift; staff would drive it to the residential rented property and clean it there. The waste materials would be poured away down a drain in the street. This presented a risk of infection/ contamination.
- Additionally, we could not evidence if there was a system in place for the disposal of mops or mops heads which had been used during cleaning of ambulances at the rental house.

Environment and equipment

Inadequate

Patient transport services

- The patient transport service did not have an operational base. The company had rented a residential property in the city where the NHS trust was based. The ambulance provider supplied PTS services on behalf of another independent ambulance provider.
- Self-employed staff who worked on behalf of Unit 1 travelled from home and stayed at the property while working their shifts.
- The registered manager told us a small supply of consumable items for used on the PTS ambulances and completed patient record forms, prior to collection by Unit 1 staff for transporting back to the main operating base, were kept at the property.
- The two PTS ambulances when not in use were parked near to the residential property on some land owned by a local garage. We did not inspect the residential property or the garage area as they were not registered locations.
- The providers' main operating base was on an industrial estate in the Skipton area.
- The building from which the service operated had internal and external CCTV coverage and external lighting covering the exterior of the building and car park.
- The ground floor had a small foyer and large first aid store with racks to store general equipment used on the ambulances. There was a small laundry room adjacent to the store room which led to another locked store room. At the rear of the building was a large garage area where the vehicles used by the service were stored. The first floor of the building had a general office, a large meeting/training room with an additional smaller office, and separate kitchen and toilet facilities. There was a mezzanine floor in the garage which was used as a general storage area.
- The premises including the store rooms were visibly clean, tidy and well laid out. The room used to store medical gases and packs of equipment used by paramedics was secured with locks and alarms.
- Access codes were required to enter the storage room. A further code was required to gain entry to the controlled medicines and to the key, opening the medicines cabinet/cupboard.
- The controlled medicines safe had its code changed every six months. The registered manager told us this was reflected within a policy but was unsure which policy. Code changes were shared with staff via a telephone call from the service lead.
- A standard mechanical keypad lock was required to enter the store room. A further small mechanical lock and key were required to gain access to the medicine cabinet/cupboard. Medicines stored within the paramedic backpacks were readily available upon entry to the store room.
- During the previous inspection we found there were no temperature check recordings for the monitoring of the store rooms stocks or medicines.
- Vehicle keys were kept on wall hooks in the first aid room next to the vehicle registration number and the dates when the MOT and service was due. A ministry of transport (MOT) is a test which, by law, must be made each year on all road vehicles that are more than three years old, to check that they are safe to drive. This allowed staff easy access to the keys and managers the ability to identify when the vehicle MOT was due.
- All the services` vehicles were on the ministry of transport (MOT) reminder service from the Government online system which sent out an alert email a month then two weeks before the vehicle service was due.
- Staff told us the vehicle servicing was done at the end of the event season and a checklist was maintained by a local garage which alerted the service when a vehicle service was due.
- During inspection we inspected one PTS ambulance which was on standby ready for deployment at the NHS trust where PTS was provided.
- The vehicle had supplies of clean linen sheets and blankets, stored and folded in an overhead locker.
- The vehicle appeared to be in full working condition. There were no obvious signs of damage. All the lights were working.
- Staff told us they used their own personal mobile phones to receive PTS information from the hospital tracker.

- The automated external defibrillators (AED) carried on the ambulance had a service sticker which showed the device was in date. There was one set of AED pads which were in date. The equipment was serviced, portable appliance tested (PAT) tested, secured and visibly clean.
- The vehicle harnesses and chairs were rear impact protection seats and were safe for transporting children.
- All consumable items checked on the ambulance were in date and intact in their packaging.
- Patient records and personal information was kept secure in a key pad coded safe in the rear of the ambulance. Staff we spoke with told us the safe was emptied at the end of each shift and the completed records were stored at the rental house awaiting collection and transportation to the Unit 1 operating base in Skipton.
- There was not a local PTS base; this meant there was no resilience in relation to the supply of equipment or consumables in the eventuality of stock shortage, vehicle breakdown or equipment failure due to the absence of a local storage facilities.
- Both the registered manager and PTS team leader told us any replacement equipment would have to be supplied from Skipton which is a considerable distance from the NHS trust where PTS were provided.

Assessing and responding to patient risk

- Following the last inspection, the provider was given a 'must do' action to develop a standard operating procedure or protocol to provide guidance for staff on the management of deteriorating patients.
- The provider had submitted, prior to this inspection, a PTS deteriorating patient policy which became effective in January 2019 and was due for review in January 2020.
- We did not see any evidence of guidance for staff on the management of deteriorating patients detailing the frequency of observation recordings and the relevant action to take depending of the NEWS 2 score/ thresholds.
- The patient report form contained a NEWS2 tool for the early recognition of the deteriorating patient. There was an opportunity for a clinician to repeat multiple NEWS2 scores on the PRF. There were no training records for staff indicating who was trained in the use of NEWS2 tool.

Staffing

- The only employed staff were the registered manager, deputy manager, equipment and supplies lead and an administration assistant. All operational staff were self-employed and worked for the service on an 'as required' basis. None of the operational staff had employment contracts or set hours of work.
- The registered manager told us there was a pool of approximately 25 staff who were registered to work for the service. This number varied as staff left and others registered to work for them.
- The self-employed staff worked both in PTS and emergency and urgent care.
- The registered manager told us staff who wished to work for the service completed a formal registration form and references were obtained prior to commencing work for the service.
- The registered manager told us the existing skill mix of staff was not considered when staff registered to work for the service.
- During the last inspection the registered manager did not produce evidence to show they recorded the hours worked by staff or were aware of the number of hours worked by staff in their primary employment.
- There was no evidence the provider was complying with the European working time directives demonstrating staff had adequate rest periods between shifts to ensure they were not fatigued and were safe to perform their role. At this inspection this information could still not be produced.
- The service used a closed social media page to alert staff when work was available. The registered manager told us the members of staff who volunteered first and were suitably qualified would be asked to work. In summary, work was allocated on a first come first served basis.
- There was evidence in the staff records PTS staff were suitably qualified for the role.

Patient transport services

Records

- During inspection we reviewed the patient directives policy which was in date. The policy defined how staff should deal with patients who had an advanced order dictating restrictions on their care, including do not resuscitate orders and advanced directives. The policy had links to 12 other policies.
- There was nothing in the policy to indicate how the service would check/audit levels of compliance or if staff had read and understood the policy.
- Staff received a notification on their mobile phones from the hospital tracker team and received verbal handovers from hospital staff to ensure the patient was transported safely and to highlight any individual needs. This information was documented by staff on the high dependency vehicle but not on the PTS ambulance.
- There was not a detailed method of recording patient information relating to the transfer of patients, for example, patient infection status, mobility needs, medical needs, property and do not attempt cardiopulmonary resuscitation (DNACPR).

Medicines

- During inspection we reviewed the medicines management policy which was in date. The policy set out the standards and guidance for the organisation, which aimed to ensure staff were able to comply with the law and Department of Health guidance with regards to the principles of medicines management.
- There was no evidence the service had a system in place to check if staff had read, understood and were adhering to the policy.
- There were no set minimum quantities for each medicine to be placed in the bag and there was no system in place, for example, an expiry date on the outside of the bag, for staff to know when the medicines expired. We found paramedic and technician bags did not have enough quantities of medicines to be used in an emergency for anaphylaxis.
- At the last inspection, controlled drugs were found to be securely stored, however, there was no evidence of regular controlled drugs checks. There was no way of monitoring stock levels, or administration. In addition, if a discrepancy in the stock was apparent, there was no way of identifying how this could have occurred. This was not in line with guidance on the safe management of controlled medicines.
- During this inspection we found one member of staff recorded the batch numbers and expiry dates for medicines in each bag, however, we found inaccuracies in how they were recorded. Although expiry dates were recorded, there was no overarching system to highlight to staff when the medicines expired.
- We found one medicine audit had been completed, which included auditing one of the paramedic medicines bags and one controlled drugs audit. The audits highlighted the need for a system to identify out of date medicines, however, no subsequent action had been taken in response to this
- We found that medicines were stored securely with access being restricted to authorised personnel.
- However, medicines were not stored in accordance with the manufacturer's recommendations as stock was stored out of the original box and placed inside plastic containers, which did not protect the medicine from light.
- At the previous inspection we found a refrigerated injectable medicine, glucagon, was being stored at room temperature. The medicine can be stored at room temperature however its expiry date would be reduced. The service failed to record this and had not replaced the glucagon from the previous inspection. We could not be assured the medicine was fit for use.
- Following discussion with the registered manager the glucagon was withdrawn from use.
- The provider had a controlled drugs policy; however, staff did not always follow it. For example the policy stated paramedics should ensure when vials of morphine sulphate were withdrawn from the station's controlled drug (CD) safe using their unique CD personal identification number (PIN), the withdrawal should be witnessed by a crew mate and documented. We saw evidence of morphine sulphate withdrawal not having a witness signature.
- The service stocked tranexamic acid, which is not covered under Schedule 17 or 19 of the Human Medicines regulations 2012.

Inadequate

Patient transport services

- Tranexamic acid is a medication used to treat or prevent excessive blood loss from major trauma, postpartum bleeding, surgery, tooth removal, nosebleeds, and heavy menstruation. It is also used for hereditary angioedema. It is taken either by mouth or injection into a vein.
- The service would require a patient group direction (PGD) to allow non- prescribing healthcare professionals to administer this medication in line with JRCALC guidelines, without the PGD in place, the service could not legally obtain, store or administer this medication.
- There was no evidence the service had ever employed a pharmacist in addition to the medical director to meet the minimum PGD status requirements.
- The provider recorded the ambient temperature of the medicines room. The medicines room was not temperature regulated. During inspection it was noted the medicines room was seven degrees Celsius lower than the outside temperature and we were told the only way to keep the room above freezing during winter was by using the central heating system. We were, therefore, not assured the provider took appropriate steps to store medicines in accordance with the manufacturer's guidance.
- The provider used the joint royal colleges ambulance liaison committee (JRCALC) guidelines for the administration of medicines. At this inspection staff did not have access to patient information leaflets, if required, to guide staff on the safe administration of the medicine as medicines were stored without the leaflets
- The services had stocks of DOOP kits (Destruction of Old Pharmaceutical) waste, available for the safe destruction of controlled medicines at the provider's station. These were appropriately stored prior to incineration.
- The registered manager told us medicines were not carried on the PTS ambulances. The only medicines carried were those of the patient being transported.
- We did not see any evidence of a policy or procedure being in place in respect of transportation of a patient with their own medicines.
- The medical gases were stored securely and were in date.
- The ambulance did not carry any medicines.

Are patient transport services effective?
(for example, treatment is effective)

Requires improvement

We rated effective as **requires improvement** because;

- The service did not have an induction procedure or course for new staff. The registered manager told us the induction procedure consisted of new staff being provided with access to an app on their mobile phones which had a link to the staff handbook and links to the providers policies and procedures.
- There was no evidence the service completed a training needs assessment for new staff.
- The service recorded the number of transfers but did not record response times or patient outcomes.
- The provider did not have a system to check if new staff or existing staff had read and understood the contents of the staff handbook or had accessed the policies and procedures understood and adhered to them.
- What was stated in the recruitment policy dated November 2015 regarding induction training was not being followed.
- PTS was not included in the driving on company business policy.

However, we did the following good practice;

- During this inspection we saw evidence the registered manager had commenced conducting staff appraisals.
- All staff had completed training updates in basic life support and the use of automated electronic defibrillators.
- We saw evidence of a policy document titled "Dealing with patients having mental health illnesses" which was in date, had a review date and version control.

Evidence-based care and treatment

- The service used JRCALC guidance and the registered manager was available for clinical support and advice. However, there was no evidence that people's care and

treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, legislation or technologies. There was no way to monitor there was consistency of practice.

- There was no way to identify if patient outcomes were positive or negative in relation to the care, training, treatment or type of transport provided.

Nutrition and hydration

- The service adhered to JRCALC for guidance in the management and treatment of symptomatic dehydration or kidney failure or injury.
- The service did not provide food or water for patients.

Response times / Patient outcomes

- The service did not monitor response times so that they could facilitate good outcomes for patients, therefore, they had no findings to make improvements.
- The service did not monitor the effectiveness of care and treatment; therefore, they could not use findings to make improvements and achieve good outcomes for patients.
- There was no monitoring of the outcomes of care and treatment.
- There was no way to identify if patient outcomes were positive or negative in relation to the care, training, treatment or type of transport provided.
- The provider did not produce any evidence to show they monitored response times. The registered manager told us they reviewed all patient records and would address any issues identified in relation to response times. It was not clear what was a response time issue requiring review and what was discussed or identified. There was no evidence of any issues being reviewed and the outcomes recorded.
- During the inspection the registered manager told us the service recorded the number of transfers but did not record response times or patient outcomes, however, the provider did not produce any evidence which demonstrated assurance the service was provided in a timely way and patients obtained the best outcomes.
- The service did not record information about the outcomes of people's care and treatment. There was no method of comparing outcomes for people in this service compared with other similar services and how they had changed over time.
- The service did not participate in any quality improvement initiatives either internally at service level, locally or nationally.

Competent staff

- During inspection we reviewed the recruitment policy which was in date. This policy defined the company policy and procedures for employing staff or volunteers to ensure the company made safe and successful recruitment decisions.
- A section of the document was headed “Induction Training” which outlined that induction was an essential element of the recruitment and it was a good time to complete a training needs assessment if this had not been done all ready.
- During this inspection there was no evidence the service had an induction course for new staff. The registered manager told us the induction procedure consisted of new staff being provided with access to an app on their mobile phones which had a link to the staff handbook and links to the services` policies and procedures.
- There was no evidence the service completed a training needs assessment for new staff.
- There was no evidence the provider had a system in place to check if new staff had read and understood the contents of the staff handbook or had accessed the policies and procedures read, understood and adhered to them.
- In addition, there was no system in place to check if existing staff had read and understood or had accessed any new, revised or additional policies and procedures.
- During inspection we reviewed 12 staff files. The 12 files reviewed; all had enhanced Disclosure and Barring Service (DBS) checks, five had proof of identity, nine had evidence of qualifications relevant to role; driving license checks; three had a health questionnaire; one had two references, although this did not include the

reason the employment had ended, 11 had no employment history; two had details of full employment history. There was evidence in the files we reviewed not all staff had completed an application form.

- There was no evidence of staff appraisals in the 12 staff files we reviewed.
- There was evidence of driving license checks in the files.
- There was no evidence of fire safety training noted in the files we reviewed.
- There was evidence of safeguarding training, but it was not always clear if the training was within statutory or mandatory training or online training.
- The service used a central spreadsheet to monitor DBS, qualifications, training and driving license checks.
- We saw evidence staff were responsible for providing up to date DBS checks and updated driving licence checks if they received driving penalty points. The spreadsheet showed use of a RAG system to identify significant dates when updates were required.
- During inspection we reviewed the company handbook which was provided for new staff. The handbook included the service's mission statement, the start of employment checks, absence reporting and management, health and safety, service expectations, important policies and procedures, discipline and grievance, changes in terms and conditions, changes in personal details or circumstances and leaving the service.
- At the last inspection we reviewed the staff conduct policy document which defined the company policy on how staff were expected to conduct themselves when performing duties for the company. The policy was out of date being due for review November 2017. During this inspection we found the policy was in date.
- Following the inspection in December 2017 the service was given a 'should do' action to improve the service, to ensure staff received annual appraisals and recorded these. During the inspection conducted in January 2019 the provider did not produce any evidence they had a staff appraisal system.
- During this inspection we saw evidence the registered manager had commenced conducting staff appraisals. We reviewed four staff appraisals, none appeared to have supporting evidence regarding statements made and there were no objectives set either personal or organisational. There were personal development objectives, but these were not linked to the company strategy, objectives or vision.
- During this inspection we spoke with managers who told us they had not had an appraisal nor had any of the PTS staff.
- During the inspection we saw all staff had completed training updates in basic life support and the use of automated electronic defibrillators.
- The registered manager told us additional training was available for staff on request and would be part funded by the service if considered appropriate. We did not see any evidence of which additional training had been made available or had been completed by staff.
- There was no evidence managers or supervisors from the service assessed the competence of staff delivering patient care. The PTS team leader told us they did accompany PTS staff on transports to observe them but did not record their observations. The team leader had not been given any guidance as to how many observations to conduct over what time periods or which areas to observe.
- The provider did not produce any evidence of a system to identify poor or variable staff performance and how this would be managed for staff to improve.
- During inspection we reviewed the driving on company business policy which was in date. The policy outlined the appropriate measures, controls and checks for all members of staff and contractors to adhere too before driving on behalf of the provider. There were 18 areas highlighted.
- The policy applied to the driving of a vehicle on company business, including to and from events, but excluded travelling to and from work. There was no mention of driving PTS vehicles in the policy.
- The policy did not outline how the service would check or audit the 18 areas highlighted in the policy to ensure staff compliance. There was no evidence of a system as to how the service would check if staff had read and understood the policy.

Multi-disciplinary working

- During inspection the registered manager was unable to produce any PTS patient records to enable the handover process and documentation to be reviewed.

Health promotion

- The service did not take part in any health promotion activity with service users.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Following the inspection in December 2017 the service was given a 'should do' action to improve the service; to develop clear guidance for staff on the transfer of children not accompanied by a responsible adult.
- During the last inspection in January 2019 the provider did not produce any evidence the service had developed the guidance. When we spoke with the registered manager they confirmed the guidance had not been developed.
- During this inspection we saw evidence a paragraph titled "Unaccompanied children" had been added to the 'consent in children' policy document which was in date. The content provided staff with information as to what to do when treating or transporting an unaccompanied child.
- The policy detailed paediatric consent, transfers and unaccompanied children. The policy covered the basic principles of consent and actions in the best interests of the child to ensure they were accompanied unless this was not possible to avoid delaying care or transport.
- Following the last inspection, the service was provided with feedback in relation to issues of concern in relation to dealing with patients with mental ill health. The service responded by devising a policy. This policy was reviewed. It did not provide members of staff with enough information to deal with patients suffering mental ill health.
- During this inspection we saw evidence of a policy document titled "Dealing with patients having mental health illnesses" which was in date, had a review date, was version controlled and did provide members of staff with enough information to deal with patients suffering mental ill health.
- Staff we spoke with describe what to do when dealing with patients suffering mental ill health.
- Staff were trained in relation to consent, mental capacity act and deprivation of liberty safeguards using an online training package. There was not a clear training policy identifying which training needed to be delivered, what training consisted of and if it was appropriate for E-learning. The frequency of the training and when refreshers were required was not outlined.
- There was no evidence the service monitored and reviewed the seeking of consent to meet legal requirements and to ensure staff followed relevant national guidance.
- Staff were aware of and understood what best interest decisions and deprivation of liberty standards were. We were told such this information was made available to staff son the patient booking forms.

Are patient transport services caring?

Not sufficient evidence to rate

We inspected but did not rate Caring.

Compassionate care

- During inspection of the PTS service there were no patient transports we were therefore unable to carry out any patient observations.
- The service did not have any patient feedback information in respect of PTS to refer to which may have evidenced compassionate care. The only feedback we could review related to events.

Emotional support

- During inspection of the PTS service there were no patient transports carried out we were therefore unable to carry out any patient observations. Emotional support could not be evidenced.

Understanding and involvement of patients and those close to them

- The PTS team leader told us staff were provided with patient details by the NHS hospital tracker who allocated patient transports. During inspection no patient transports were allocated to the PTS ambulance, therefore, no patient observations were carried out. This

meant we were not able to inspect this aspect. PTS staff told us they were made aware, through the patient booking system as to the type of patient they were transporting and would look after them accordingly.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated responsive as **requires improvement** because;

- Services were not delivered in a way that focused on people's holistic needs.
- Services were planned and delivered without consideration of people's needs and preferences.
- There were shortfalls in how the needs and preferences of different people were taken into account, for example on the grounds of protected characteristics under the Equality Act.
- Information is not always accessible to all people.
- There were obvious logistical issues because of the remote working of the PTS and the fact there was no local base for the storage of consumable items or replacement equipment.
- There was no patient information collected in addition to what was on the patient booking from which was provide by the NHS trust requesting the PTS service.
- The provider did not produce any evidence to demonstrate they monitored performance in relation to timeliness and quality.
- The company logo used on feedback forms was Oak Valley fire, medical and training services. There was no mention of the company being an ambulance service.
- The complaints procedure document was not dated or signed and there was no review date. The document did have company logo displayed. The version control on the footer was dated 2 May 2017 which meant the document was out of date.
- The EUC service planning was reactive, not responsive.
- There was no evidence the provider had a considered approach for tendering for the event work and associated EUC service undertaken.

However, we found the following areas of good practice;

- There was evidence of a multilingual phrase books available for patient's onboard the ambulances we inspected.
- Both PTS ambulances inspected had a supply of patient information and feedback forms, which briefly detailed how to make a complaint and provide feedback regarding the service received.

Service delivery to meet the needs of local people

- The service did not have a formal contract in place which detailed what provision of service was expected to meet the patient's needs. It was therefore not possible to evidence if the service delivery was meeting the needs of local people.
- The service provided a 'general' stable patient transfer resource on an "as required "basis to meet the needs of the patients, including end of life patients being transported to and from hospital and between hospital sites.
- Due to the distance from the providers operating base and the fact there was no local base, there were obvious logistical issues in relation to resupplying ambulances.
- Consumable items, medicines and replacement equipment all had to come from the providers base in Skipton. The travelling distance involved could potentially result in delays and adversely affect the service delivery to meet the needs of local people.
- There was no evidence the storage of supplies of consumable items at the house rented by the provider would be enough to prevent service delivery being affected if the PTS ambulances required resupplying.

Meeting people's individual needs

- The service did not take account of patients' individual needs and preferences. The service did not make reasonable adjustments to help patients access services.
- During the inspection multilingual phrase books were available for patient's onboard the ambulances we inspected.

Inadequate

Patient transport services

- There was no evidence the service understood the needs of people, including individual preferences, culture or faith because there was no patient information collected in addition to what was on the patient booking from which was provide by the NHS trust requesting the PTS service.
- The service did not meet the Accessible Information Standard. This has been in legislation since 2016. All organisations that provide NHS care must provide people with a disability or sensory loss information in a way they can understand.
- There was no evidence the service understood the needs of patients with learning disability, mental health illness, dementia, bariatric patients, hard of hearing or deaf, partially sighted or blind.
- There was no evidence of how the needs of such patients influenced the care they received because there was no patient information collected in addition to what was on the patient booking which was provided by the NHS trust requesting the PTS.
- During inspection the registered manager was unable to produce any PTS patient records to enable them to be reviewed to evidence if people`s individual needs had been met.

Access and flow

- The registered manager told us the PTS crew reported to the patient tracker at the NHS trust where PTS were provided. The service provided two PTS ambulances and staff which covered between 8am until 8pm.
- The patient tracker worked for the NHS trust where PTS was provided. They identified the suitable PTS ambulance to transport patients dependent upon their needs.
- The staff told they had no control over the access and flow of patients. However, we noted they did have responsibilities to ensure their service was timely and met the needs of patients.
- The tracker allocated the crew the transport information either to transport discharged patients back to their place of residence or an internal transfer of patients to a different hospital in the trust or an external transfer to another hospital. Once the patient transport was completed the crew would return to the hospital for the next patient transport.
- The provider did not produce any evidence to demonstrate they monitored performance in relation to timeliness and quality.
- The PTS team leader told us there were no key performance indicators in place to measure the time taken to complete patient transfers or record patient outcomes.

Learning from complaints and concerns

- The service had received one complaint in the reporting period which had been investigated by the NHS trust where the PTS was provided. The complaint was not upheld.
- Both PTS ambulances we inspected had a supply of patient information and feedback forms, which briefly detailed how to make a complaint and provide feedback regarding the service received.
- Although there was a supply of patient information/ leaflets available on the PTS vehicle, including details on how to feedback or complain. The company logo used on the forms could potentially be misleading for patients. The logo was Oak Valley fire, medical and training services. There was no mention of the company being an ambulance service.
- During inspection we reviewed the complaints procedure document. The document outlined the services complaints procedures. The document was not dated and there was no review date. The document did have the company logo displayed. The version control on the footer was dated 2 May 2017. The document was not signed.
- There was no evidence of a system being in place to check if staff had read, understood and were complying with the complaints policy.

Are patient transport services well-led?

Inadequate

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

Inadequate

Patient transport services

- Leaders did not fully understand or managed the priorities and issues the service faced.
- We did not see evidence or gained assurance the safeguarding lead understood the role, the responsibilities, or the safeguarding reporting/ notification procedures.
- We did not see any evidence the leaders understood the challenges to provide good quality care.
- The document which contained the executive summary, company vision, company mission statement, strengths, weaknesses, opportunities and threats and goals had no title, no creation date, or author. There was nothing to identify it as belong to the provider.
- The vision and strategy were not focused on sustainability of services or aligned to local plans within the wider health economy.
- The service did not have key drivers or performance indicators because it was not a commissioned service, nor did it have a contract with the independent ambulance company it worked alongside.
- Leaders did not operate effective governance processes, throughout the service and with partner organisations.
- There was evidence of management meetings being held, however, those attending were never the same, there was no a set agenda, there were no links to the actions from the previous meeting, no discussion of risks and there were no separate agenda items for the services provided.
- There was no evidence of a holistic understanding of performance with safety, quality, activity and financial information considered.
- There was evidence the service had developed some critical success factors to measure internal performance, however, there were no key performance indicators to enable the service to collect, review and use to improve patient care.
- There was no evidence the service routinely collected, reviewed and acted upon patient feedback to improve the service.
- The service did not hold staff meetings, carry out staff surveys or routinely collected, reviewed and acted upon staff feedback to improve the service.
- We did not see any evidence of any contingency plans in the event of a cyber-attack, failure of the mobile phone app, loss of mobile phone or internet signal to enable staff to still access key providers policies and guidance.
- We did not find any evidence the services provided were sustainable because of limited finances and reliance on seasonal event work booked in the summer months to generate income to plan the replacement program for equipment.
- The was no evidence of financial contingency plans linked to an equipment replacement plan should the service not secure the events contracts and accompanying income.

However, we saw the following good practice;

- Staff we spoke with told us the local managers were visible.
- The PTS staff we spoke with told us the company was a good service to work for and the managers were approachable.
- During inspection we saw evidence staff had to provide their driving licence details which were checked using the government internet licence check system.

Leadership of service

- Leaders did not fully understand or managed the priorities and issues the service faced.
- Staff described the leaders as visible and approachable.
- There was no evidence leaders had supported staff to develop their skills and take on more senior roles.
- The service was led by a director who was the registered manager. They were a registered paramedic. They took the leadership role in relation to clinical care. They were supported by the equipment and supplies lead was also the safeguarding lead, a deputy manager and an administrative assistant who was free-lance and worked four hours on Monday and Friday and three and a half hours Tuesday, Wednesday and Thursday.
- The registered manager told us the service used two paramedics who worked on a “as required” basis at events. They were described as assistant managers who took leadership roles in the event medical plan command structure.

- During inspection we spoke with the equipment and supplies lead was also the safeguarding lead. We did not see evidence or gained reassurance they understood the role of safeguarding lead, the responsibilities it carried or the safeguarding reporting/notification procedures.
- We did not see any evidence the leaders understood the challenges to provide good quality care. The service was totally reactive and the main driver to submit invoices on time to generate income.
- PTS operational staff we spoke with told us they saw the occasionally saw mangers. They told us they saw the team leader more frequently as they were based at the NHS trust where PTS was provided.

Vision and strategy for this service

- The service had a vision for what it wanted to achieve but did not have a strategy to turn it into action. The vision and strategy were not focused on sustainability of services or aligned to local plans within the wider health economy. Leaders and staff did not understand or knew how to apply them and monitor progress.
- The service had a mission statement which was, "We provide high quality Ambulance and Medical services, along with Fire Safety Services to customers in the events, film and health and safety industries, all around the UK. Taking great care and pride in our work with the highest priority on transporting patients with safety, comfort and care".
- The mission statement was not displayed anywhere in the services operating base nor did it appear on the services internet page.
- During inspection we reviewed a document with no title. It had an executive summary, company vision, company mission statement, strengths, weaknesses, opportunities and threats and goals. The document had no title, no creation date, nothing to identify it as belong to the provider and no author.
- The goals consisted of; long term goals. key performance indicators (KPI`s), target customers, industry analysis, competitive analysis & advantage, marketing plan, team, operations plan and financial projections. There was no action plan accompanying the goals with owners, dates for completion, targets, milestones or where progress would be monitored.
- There was no evidence the service had a system to check staff had read and understood the providers mission statement or the goals.
- The PTS staff we spoke with did not know what the service mission statement and vision were. The key drivers for providing PTS consisted of reacting to requests from the hospital tracker team.
- The service did not have key drivers because it was not a commissioned service, nor did it have a contract with the independent ambulance company it worked alongside.

Culture within the service

- The registered manager described the culture as open and encouraging.
- Due to the nature of the PTS and emergency and urgent care service provided operational staff we spoke with confirmed this. The PTS staff we spoke with told us the company was a good service to work for and the managers were approachable.
- However, we did not find the culture to be patient focussed or quality focussed. There was no accountability of staff in relation to delivering performance or high-quality patient care.
- The was no evidence the service had a culture of performance management which was patient and quality focussed.

Governance

- Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities, however they did not have any opportunities to meet, discuss and learn from the performance of the service.
- During the last inspection there was no evidence the service held regular governance meetings which had a set agenda, with minutes and actions.
- At this inspection we saw evidence of management meetings having been held, however, those attending were never the same, there was no a set agenda, there

were no links to the actions from the previous meeting, discussion of risks and there were no separate agenda items for the services provided. The agenda appeared to consist of what was current at the time of the meeting.

- During inspection we saw evidence staff had provided their driving licence details which were checked using the Government internet licence check system.
- PTS staff we spoke with were clear about their roles, however, there was not an effective governance framework to support delivery of good quality care.
- There was no evidence of a holistic understanding of performance with safety, quality, activity and financial information considered.
- When we spoke with the registered manager they told us the service had not formally monitored their performance, but since the last inspection in January 2019 they had employed the services of an external consultation company to assist them in devising suitable audits and monitoring of staff performance including clinical auditing which would be added to the key performance indicators.
- The registered manager could not tell us when this work would be completed.
- In addition, during inspection, we did not see any evidence of a robust audit system being in place to monitor staff performance.
- During inspection the registered manager told us the service was in the process of uploading all their policies on to a mobile phone app.
- The registered manager could not tell us when this work would be completed.
- We were told the app would provide management information as how many hits there been on the app, but not which member of staff had accessed the app or which policies, or procedures held on it.
- There was no system to check which staff had read the policies, procedures, protocols or guidance and had adhered to them.
- The NHS trust where the PTS was supplied was a considerable distance from the providers operating base. We did no see evidence of effective governance linking the service to the providers management team. Minimal performance information was collected which could be reviewed to improve the PTS.
- There was no evidence of a systematic programme of clinical and internal audit which was used to monitor quality and systems to identify where improvement actions should be taken.
- During inspection we saw evidence all staff had provided their driving licence details which were checked using the Government internet licence check system.

Management of risk, issues and performance

- Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues. They did not identify actions or monitor risk to reduce their impact. There were no plans to cope with unexpected events. Staff did not contribute to decision-making to help avoid financial pressures compromising the quality of care.
- Following the inspection in December 2017 the service was given a must do action to improve the service which was, to develop a system for identifying, mitigating and controlling risks appropriately.
- During the inspection held in January 2019 there was no evidence the service had a risk register and there was not a system for identifying, mitigating and controlling risks appropriately. The registered manager we spoke with confirmed the service did not have a risk register.
- At this inspection we saw evidence the service had a risk register with 47 current risks identified. The risks were rated by number and severity. There were risk owners, mitigation and dates for finalisation.
- However, there was no evidence where and when the risk register was discussed and updated with progress against the identified actions.
- Following the last inspection in December 2017 the service was given a should do action to improve the service which was, to develop some clinical quality indicators related to the safety of the service and monitor performance against these.
- During the inspection held in January 2019 there was no evidence the service had developed clinical quality

indicators related to the safety of the service and monitored performance against these. The registered manager we spoke with confirmed this. The service did not monitor performance.

- At this inspection we saw evidence the service had developed some critical success factors to measure internal performance, however, there were no key performance indicators that would enable the service to collect, review and use to improve patient care.

Information Management

- The service did not collect reliable data and analyse it. Staff could find 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. Data or notifications were not consistently submitted to external organisations as required.
- The service did not have holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances.
- We did not see any evidence of any contingency plans in the event of a cyber-attack, failure of the mobile phone app, loss of mobile phone or internet signal which would enable staff to still access key policies, procedures, guidance documents and submit documents such as safeguarding referrals and patient records.
- Staff received a notification on their mobile phones from the hospital tracker team to ensure the patient was transported safely and to highlight any individual needs. This presented a risk of confidential patient information being shared or viewed.

Public and staff 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 the inspection we saw evidence the provider had a patient feedback sheet providing an email address and telephone number should a patient wish to respond.
- The patient feedback form did not make it clear the feedback was in relation to the ambulance service. The first question was; "Where did you receive your treatment from us today?". On the forms we reviewed patients had responded by referring to the trust where they had been treated.
- The company logo used on the forms could potentially be misleading for patients. The logo was Oak Valley fire, medical and training services. There was no mention of the company being an ambulance service.
- During inspection, we reviewed a selection of feedback forms and comments / compliments from patients and clients from events. These included two patient feedback forms relating to the patient transport service, with positive comments and three letters / compliments and one patient feedback form from patients at events, with positive comments.
- There was no evidence the service routinely collected, reviewed and acted upon patient feedback to improve the service.
- The service did not hold staff meetings and had therefore could not routinely collect, review or act upon staff feedback to improve the service.
- We spoke with the registered manager who confirmed the service had not carried out any staff surveys.

Innovation, improvement and sustainability

- Staff could not commit to continually learning and improving services because the provider did not collect relevant performance information. Staff 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.
- We did not find any evidence the services provided were sustainable. There were no contracts in place for the emergency and urgent care service as the service was totally event based and reliant upon winning contracts for events competing against other providers.
- There was no contract in place for PTS. The service worked on behalf of another independent ambulance provider on an "as required basis".

Inadequate

Patient transport services

- We did not find any evidence of business improvements because the service did not collect key performance indicators, carry out audits or had contracts with service level agreements attached to identify if these had been met or where improvements could be made.
- In relation to replacing equipment to make the business sustainable the registered manager told us the company was relatively small with a limited financial resource.
- They confirmed they did not have any NHS commissioned service income, so they were reliant on seasonal event work booked in through the summer to generate income to support the replacement program for equipment.
- The was no evidence of any other financial contingency plans linked to an equipment replacement plan should the service not secure the events contracts and accompanying income.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must store medicines with their patient information leaflets as per pharmacy guidance and in accordance with manufactures guidance.
- The provider must ensure the medicine pouches contain enough hydrocortisone to meet the minimum quantity required of 200mg of administration for acute anaphylaxis.
- The provider must record the amount of diazepam used by the service, it must be kept secure and the stock levels recorded.
- The provider must ensure the controlled drugs register conforms to NICE guidance for controlled drugs documentation.
- The provider must have a system to record when medicines stored in bags had expired
- The provider must ensure staff act in accordance with the safe management of controlled medicines.
- The provider must use medical gases issued to them and not obtained by other means.
- The provider must demonstrate and confirm the safeguarding lead has a full understanding of the role, responsibilities and reporting procedures.
- The provider must have a system in place to ensure the deep cleaning of vehicles was effective against bacteria, viruses and fungi infection risks.
- The provider must ensure the packaging of all medical devices are free from rips or tears.
- The provider must have an induction procedure for new staff.
- The provider must have contingency plans to enable staff to access policies, procedures or guidance should the providers mobile phone app fail.
- The provider must ensure robust checks are in place to ensure vehicle check lists are completed daily or at the start of each shift, and any equipment issues are highlighted to the supervisors, so they could be addressed.
- The provider must have a system to formally monitor, audit and recorded adherence to infection control policies and procedures.
- The provider must have an operating procedure or protocol to provide guidance for staff in relation to the management of deteriorating patients detailing the frequency of observation recordings and the relevant action dependant of the NEWS2 score/ thresholds.
- The provider must ensure all staff files include references and full employment history and ensure the recruitment policy for staff requiring two references is followed.
- The provider must have a system to check if new staff or existing staff had read and understood the contents of the staff handbook, had accessed the policies and procedures understood and adhered to them.
- The provider must have a system in place to overcome the logistical problems because of the remote working of the PTS and the fact there was no local base.
- The provider must ensure management meetings are attend by the same managers, there is a set agenda, there are links to the actions from the previous meetings, risk is discussed, and each service is discussed.
- The provider must develop key performance indicators to collect, review and use to improve patient care.
- The provider must ensure all the ambulances have a designated general waste or clinical waste bin.
- The provider must standardise the contents of the paramedic bags.

Outstanding practice and areas for improvement

- The provider must have a system to check staff had read, understood and adhered to company policies.
- The provider must ensure safeguarding reporting is made direct to the safeguarding team at the local council not a third party such as an accident and emergency department of the hospital receiving the patient.
- The safeguarding lead must understand their role, and safeguarding reporting processes.
- The provider must use a safeguarding form which identifies the form as being submitted by Unit 1 staff.

Action the provider SHOULD take to improve

- The provider should devise the risk assessments in relation to the storage of medical gases identifying each associated risk and how the risk will be mitigated.
- The provider should ensure each ambulance is fully stocked with consumable items.
- The provider should include a detailed method of recording patient information relating to the transfer of patients to improve patient care.
- The provider should review and centrally store ambulance response times.
- The provider should carry out a training needs analysis of staff to identify training requirements and taken appropriate action.
- The provider should have a system to assess the competence of staff delivering patient care and a system to identify poor or variable staff performance.
- The provider should record patient handover information not just a signature from the receiving service.
- The provider should record information about the outcomes of people's care and treatment.
- The provider should ensure the vehicle cleaning protocol document is dated, signed and identified as being the services` protocol.
- The provider should record the number of patient transfers including response times and patient outcomes.
- The provider should ensure the contents of recruitment policy regarding induction training is followed.
- The provider should ensure PTS is included in the driving on company business policy.
- The provider should collect patient information in addition to what was on the patient booking.
- The provider should monitor performance in relation to timeliness and quality.
- The provider should be identifiable as an ambulance service on feedback forms.
- The provider should ensure the complaints procedure document is dated, signed and has a review date.
- The provider should ensure leaders understood the challenges to provide good quality care.
- The provider should ensure the document which contained the executive summary has a title, a creation date, and it is identified as belong to the provider.
- The provider should routinely collect, review and act upon patient feedback to improve the service.
- The provider should hold staff meetings, carry out staff surveys and act upon staff feedback to improve the service.
- The provider should have financial contingency plans linked to an equipment replacement plan should the service not secure the events contracts and accompanying income.
- The provider should record the hours staff worked to comply with the European working time directives.
- The provider should meet the Accessible Information Standard by providing people with a disability or sensory loss information in a way they can understand.
- The provider should monitor performance in relation to timeliness and quality.

Outstanding practice and areas for improvement

- The provider should review how staff receive notifications on their mobile phones from the hospital as the current practice presents a risk of confidential patient information being shared or viewed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 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 service did not have a specific risk assessment for the storage of medical gases. One of the Entonox cylinders had a named patient sticker on it implying it had been issued to the patient not the service. The service did not have a deteriorating patient policy document detailing the frequency of observation recordings and the relevant action dependant of the NEWS2 score/thresholds. **(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;** The staff files contained enhanced DBS checks and driving licence checks but few included references or full employment history. The recruitment policy for staff requiring two references was not followed. There was no staff induction procedure or training needs analysis done.

This section is primarily information for the provider

Requirement notices

(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;

It was identified one of the PTS ambulances had not had any defibrillator pads for 2 days. The service submitted an incident form and recorded a near miss.

One of the medicine pouches contained one hydrocortisone vial. This did not meet the minimum quantity required of 200mg for administration for acute anaphylaxis.

h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including

those that are health care associated;

There was no evidence the provider formally monitored and recorded adherence to infection control policies and procedures. During this inspection we found the service did not carry out any IPC audits. The service did not have a system in place to ensure the deep cleaning was effective against bacteria, viruses and fungi infection risks during cleaning. The registered manager confirmed there were no audits in place.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 CQC (Registration) Regulations 2009 Financial position **Regulation 13 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

Requirement notices

upon becoming aware of, any allegation or evidence of such abuse.

The safeguarding lead who had recently attended a safeguarding level four course appeared not to understand their role, the responsibilities or reporting processes.

The safeguarding reporting procedure was not direct to the local authority safeguarding teams.

The service used the NHS safeguarding form if the staff were to make a referral. There was nowhere on the form to identify it as being submitted by Unit 1 staff.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good governance.** **(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);** **(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;** **(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 provider did not routinely collect patient feedback. The provider used PRF`s for EUC patients but for PTS they used the patient information supplied by the trust requesting the PTS. Any risk assessments were those supplied by the trust.

This section is primarily information for the provider

Requirement notices

No performance information was analysed and reviewed to understand its significance and improve patient care. There was no monitoring of progress against plans to improve the quality and safety of services because each service was reactive.

There were no systems and processes that enabled the provider to identify and assess risks to the health, safety and/or welfare of people who used the service.

17(2)(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;

There were no records relating to the management of regulated activities including planning and delivery of care and treatment.

The providers governance arrangements were inconsistent. There was not a set agenda to cover key issues such as patient safety, risk and service planning.

The providers policies and procedures were in transition being moved to a computer based mobile phone application. There were no contingency plans if the application failed. There was evidence of vehicle servicing and maintenance but no details as to what parts had been replaced or what the service consisted of.

17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

There was no evidence the audit and governance systems were effective.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 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— (**g) the proper and safe management of medicines;** The medicines management policy was not being followed by staff. The registered manager was unclear about patient group direction medicines in line with legislation and guidance which included controlled medicines. Medicines were not kept with their patient information leaflets as per pharmacy guidance. Medicines were not stored in accordance with manufacturers guidance regarding exposure to sunlight and being stored within a minimum and maximum temperature range. The controlled drugs register did not conform to NICE guidance for controlled drugs documentation. The diazepam was not kept secured or the stock levels recorded. This is not a requirement for a schedule four medicine, but it is recommended to be best practice to monitor the movement of controlled medicines which may be abused or used for unlawful purposes. One of the medicine pouches inspected did not contain enough hydrocortisone to meet the minimum quantity required 200mg of administration for acute anaphylaxis. It was not clear if the glucagon on one the vehicles inspected had expired due to a missing revised expiry date and due to it being a fridge item being stored out of a fridge.

This section is primarily information for the provider

Enforcement actions

There were no set minimum quantities for each medicine to be placed in the bag and there was no system in place, for example, an expiry date on the outside of the bag, for staff to know when the bag expired.

There were inaccuracies in how the batch numbers and expiry dates for medicines were recorded. Although some expiry dates were recorded, there was no overarching system to highlight to staff when the medicines bag expired.

There was evidence of morphine sulphate withdrawal not being witnessed.

The service stocked tranexamic acid, which is not covered under Schedule 17 or 19 of the Human Medicines regulations 2012. There was no patient group direction (PGD) in place to allow non- prescribing healthcare professionals to administer this medication in line with JRCALC guidelines, without the PGD in place, the service cannot legally obtain, store or administer this medication.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19: Fit and proper persons employed.** **19(1)(a) be of good character.** The good character of staff could not be established because previous employment checks were not carried out. The recruitment policy for staff requiring two references was not followed. **19(1)(b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them.** The provider did not carry out a training needs analysis for staff. There was no evidence of a programme of personal professional development. There was no evidence of supervisors carrying out operational competency assessments. There was no induction procedure for new staff.