Plymouth Central Ambulance Service Limited

# Plymouth Central Ambulance Service

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected Plymouth Central Ambulance Service Limited on the 5th and 10th of May 2016. This was a focused inspection (focusing on key areas of the service) which we carried out in response to concerns received about the safe care and treatment of service users. We took action to cancel both the registered manager's and provider's registration following our inspection in May 2016. These legal proceedings have now concluded and we are able to report on the outcome of the actions we have taken. The provider and registered manager appealed against our decision to cancel their registration but withdrew their appeal following the sale of the business assets to another provider. The registration of the registered manager and the provider were cancelled on 5 December 2016.

Plymouth Central Ambulance Service provided patient transport and emergency response services. They had contracts with the NHS, local clinical commissioning group and provided services on request from organisations and individuals.

The provider operated services from a single location, an ambulance station. There were no other locations as part of this business.

CQC does not currently have the power to rate independent ambulance services.

Our key findings were as follows:

- The provider did not have processes or practices in place to assess, monitor and improve quality and safety. This included incident reports affecting the health and welfare of patients that were not always thoroughly investigated, and opportunities to raise safeguarding concerns were missed.
- There were no systems in place to document the use of oxygen, treatment given, consent decisions, mental capacity act, general observations, handover information, and medications.
- The majority of staff members did not have current mandatory training and were not supported appropriately, either by the provider's induction or through ongoing training. Staff delivering training were not up-to-date with training themselves. This included emergency driving courses and blue light training.
- Managers did not have an understanding of risk and its management relating to the business. Managers did not have the necessary knowledge or capability to lead effectively. The registered manager was out of touch with what was happening on the front line and had very little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, how they were related to the business, or the consequences of not complying with them.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Patient transport services (PTS) | | CQC does not currently have the power to rate independent ambulance services. We found that:<br>• The provider did not have processes or practices in place to assess, monitor and improve quality and safety. This included incident reports affecting the health and welfare of patients, which were not always thoroughly investigated and opportunities to raise safeguarding concerns were missed.<br>• There were no systems in place to document the use of oxygen, treatment given, consent decisions, mental capacity act, general observations, handover information, and medications. The majority of staff members did not have current mandatory training and were not supported appropriately either by the provider's induction or through ongoing training. Staff delivering training were not up-to-date with training themselves. This included emergency driving courses and blue light training.<br>• Managers did not have an understanding of risk and its management relating to the business. Managers did not have the necessary knowledge or capability to lead effectively. The registered manager was out of touch with what was happening on the front line and had very little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, how they related to the business, or the consequences of not complying with them. |

# Plymouth Central Ambulance Service

## Detailed findings

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

# Detailed findings

## Contents



## Background to Plymouth Central Ambulance Service

We carried out an unannounced focused inspection of Plymouth Central Ambulance Service based on concerns received about unsafe working practices which increased the risks to service users. This inspection was conducted on the 5th and 10th of May 2016.

A previous inspection was undertaken on 17 November 2014 following which a warning notice was issued. This was due to ineffective recruitment procedures to ensure employees had good character and were trained and competent to deliver care and treatment to people who used the service. During a follow-up inspection on 19 May 2015 the warning notice was lifted as we found recruitment procedures had improved and staff induction training was being provided. Inspectors at that time noted that although training had improved the provider needed to make improvements to the practical moving and handling training provided to staff.

## Our inspection team

The inspection team was made up of two inspection managers, one inspector, one assistant inspector and a specialist advisor with a background in governance.

## How we carried out this inspection

During this focused inspection we spoke with managers and ambulance crew members. We reviewed records, including staff files, incident forms and patient welfare forms.

CQC does not currently have the power to rate independent ambulance services. Therefore the reports will not contain any ratings.

## Facts and data about Plymouth Central Ambulance Service

Plymouth Central Ambulance Service provides patient transport and emergency response services. They have contracts with the NHS, local Clinical Commissioning Group and provide services on request from organisations and individuals.

# Patient transport services (PTS)

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

## Information about the service

Plymouth Central Ambulance Service provided patient transport services for service users between their own homes and acute hospitals, transfers between different hospitals, and the transportation of neonatal babies and their support teams to specialist paediatric hospitals. They also provided specialist transport to a small number of service users between their homes and schools. First aid services were also provided for private events. Additionally, coroners transportation services and organ transportation were also provided; however, these activities are not regulated under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service employed 14 staff and had several ambulances in use at any one time. Many of these staff were qualified ambulance technicians. This meant they were qualified to act as an ambulance care patient transport service driver but not provide medical care. There were no paramedics employed by the service. Within this staffing establishment there was one registered manager, one station manager who made up the management team and one administration staff member.

## Summary of findings

CQC does not currently have the power to rate independent ambulance services.

We found that:

- Incidents affecting the safety and welfare of patients was not always thoroughly investigated and opportunities to raise safeguarding concerns were missed.
- Any information around the use of oxygen, treatment given, consent decisions, general observations, handover information, and medications was not documented because the service did not keep adequate patient records.
- The service carried oxygen on the ambulances but did not record when they gave it to patients. This meant the use of oxygen was not monitored, audited, or traceable.
- A regular patient carried their own midazolam, which would need to be administered by a member of the crew if the patient deteriorated. Midazolam is a Schedule 3 Controlled Drug as defined by the Misuse of Drugs Act 1971 and has strict rules in place for its use. Although there was a standard operating procedure in place it was out of date.
- There was limited understanding of the Mental Capacity Act 2005 and requirements for consent. Processes and systems did not allow for concerns to be recorded and acted upon. Managers we spoke with did not understand the requirements in the legislation around mental capacity or consent. Staff did not receive training in these areas.

# Patient transport services (PTS)

- There were no mechanisms in place to provide staff with appropriate training to perform their role. Although induction training had been established when a member of staff started with the provider, there was no refresher or update training provided. Staff who delivered training were not up-to-date with training themselves and there were no assurance processes in place to ensure training was being delivered effectively. Specialist skills such as tracheostomy care and suction had not been taught to staff since 2014 when the trainer left the organisation.
- We found that staff who should have had emergency driving certification and blue light training did not have it and that some staff were driving using blue lights without training.
- Managers did not have an understanding of risk and its management relating to the business. There were no processes or systems in place for the identification of, recording, monitoring, or managing risks associated with the business. There were no systems in place to assess, monitor and improve quality and safety.
- Managers did not have the necessary knowledge, or capability to lead effectively. The registered manager was out-of-touch with what was happening on the front line and had little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, how they related to the business, or the consequences of not complying with them.

## Are patient transport services safe?

CQC does not currently have the power to rate independent ambulance services. We found that:

- Incidents that affected the health, safety and welfare of people using services were not always thoroughly investigated and actions were not taken to prevent recurrences.
- There was insufficient attention to safeguarding children and adults. Staff did not recognise or respond appropriately to potential abuse. There were multiple incidents where safeguarding alerts should have been completed but were not. Where action had been taken by the provider, the appropriate safeguarding organisations were not always informed.
- Although staff had received induction training, updates were not given. This meant the majority of staff training was out-of-date.
- The provider did not use patient care records so did not have anywhere to record the use of oxygen, treatment given, consent decisions, general observations, handover information or medications.
- There were no policies or procedures in place for the storage, handling, administration and monitoring of medicines. All ambulances were stocked with oxygen cylinders. However, there were no policies or processes in place and no evidence staff had received up-to-date training in its use. This meant there was a risk patients may have received oxygen incorrectly. There was one patient who was at risk of deterioration and would require the ambulance crew to administer Midazolam. This medicine is a prescription only controlled drug. The provider had not ensured staff were up-to-date with training to give this medicine and was not named within the care plan.
- There was no risk assessment process to ensure staff were adequately trained to attend the work that was booked. The provider had a contract with the local acute trust and this required all staff to hold an emergency driving qualification. However, this was not always the case. Rotas showed multiple days where there was not a trained blue light driver allocated to this contract. Drivers had been using blue lights when not trained to do so.

- Although cleaning processes had improved, through the use of a cleaning checklist, we found there were dog hairs and a dog lead in the back of one of the ambulances.

**Incidents**

- Incidents were not adequately investigated and learning was not shared with all staff. We looked at a large number of incident forms and found none had been adequately investigated.
- In one example, an incident form had been completed following a patient leaving the ambulance on a dual carriageway while being transported under the Mental Health Act 1983.The patient had already left the ambulance on several occasions prior to getting out on the dual carriageway. The staff reported being unable to do anything other than try to persuade the patient back on board and call the police on each occasion. This was because they were not permitted or trained to restrain patients. There was no evidence of an investigation being completed or of any learning opportunities and resulting actions being identified and communicated to staff. We asked the station manager what investigations had been completed and what learning actions had been put in place but they were unable to identify any.
- A further example involved a patient who kept undoing their seatbelt and standing up while being transported. The patient stood up multiple times in the moving ambulance so the ambulance had to be stopped until the patient agreed to return to their seat. There was no record of an investigation, or actions being taken to prevent a recurrence. When asked, the station manager told us he had reported the issue back to the social worker but no further actions had been taken. Again, the station manager was unable to identify any internal investigation or learning actions.
- **Mandatory training**
- Staff were not provided with ongoing mandatory training, or any additional training required to develop or maintain the skills required to provide safe care.
- Although all staff had received induction training, which included infection control, manual handling and first aid, the majority of staff had not received any updates. Certification for all three of these training schemes required yearly updates.
- We reviewed 11 staff files out of the 15 staff employed by the provider. Only four of these staff had current training for infection control, first aid and manual handling. This was because they had started within the last year. The remaining staff had not received any recent training in these areas. One staff member's first aid and manual handling training had expired in January 2013 and their infection control training had expired in February 2014. Another staff member's first aid training had expired in September 2014, and their manual handling and infection control training had expired in August 2014. A third staff member's infection control training had expired in February 2015 and their first aid and manual handling training had expired in November 2013.
- Manual handling training was completed online. There were no practical elements to the training or assessment. We saw several accident forms where there had been injury to staff due to poor manual handling processes. One accident form stated "as my crew mate operated an electric w/c [wheelchair] with patient in it up the ramp the w/c right wheel fell off the ramp. I lifted the chair with force back onto the ramp this was extremely heavy". Another form reported "I was carrying patient down some steps and my back went as I carried him down the last step". A third accident form stated the staff member "took all the strain" when moving a bariatric patient. In another form the staff member reported they had "experienced a sharp pain" when "assisting a lady using a stand and turn table to transfer a patient". Despite these incident reports, no action had been taken to improve or update manual handling training to protect staff and people using the service.
- The station manager told inspectors they had thrown a lot of training equipment out "because we do so little training here".
- The registered manager told inspectors he could not see any benefit to providing refresher training. He told inspectors this was a waste of money in his view.
- One member of staff told us there was reluctance from the registered manager to spend money on training. Another member of staff said "we are being put in quite a vulnerable position".

- Some ambulances were equipped with defibrillators. Staff had not received training in their use.The registered manager told inspectors that everyone can use a defibrillator without training so it was not necessary.
- **Safeguarding**
- Processes, training and policies did not keep vulnerable people safe. The service transported children, patients with learning disabilities and patients living with dementia, as well as persons otherwise vulnerable due to their age, mobility or illness. There were no systems or processes established or operated effectively to prevent abuse of service users, or to recognise and report concerns. There was no oversight or scrutiny of safeguarding.
- When inspectors asked the registered manager about safeguarding, he did not know what this meant. Inspectors explained what safeguarding meant and asked what would happen if a safeguarding concern was raised. The registered manager responded that the station manager would inform the person, company, or hospital who booked the transport. No further action would be taken. We asked about notifications to CQC and the local authority and the registered manager did not know these were required. He told inspectors the station manager would complete any required notifications, but the station manager told us the registered manager would do this.
- Staff were not provided with any safeguarding training, either as part of their induction or as part of an ongoing training programme.
- As part of a contract with the local acute hospital for the transfer of Neonatal Intensive Care Unit babies the business had to comply with the trusts safeguarding policy. The business did not have a copy of the policy and the station manager was not aware of the requirement when challenged.
- We saw free-hand notes on a small number of welfare forms that indicated safeguarding concerns; however, the safeguarding concern yes/no box was then ticked 'no'. No action had been taken by the provider to investigate or escalate these safeguarding issues. In one example, an incident form described the poor condition of a patient's property and highlighted that social services needed to be aware. The corresponding patient welfare form stated there were no safeguarding concerns. The provider was unable to provide any evidence that these concerns had been reported appropriately to the local authority safeguarding service, and CQC had not been notified of these safeguarding concerns.
- Although there was a safeguarding policy, this was a generic policy obtained from the Federation of Small Businesses and lacked details relevant to the service. We spoke with one crew member who said he had not seen the policy. We also spoke with one of the supervisors who could not confirm if they had seen the policy or not.
- The incident reporting process did not give assurances that safeguarding would be appropriately investigated or escalated, if reported. Patient welfare forms were completed for each patient. If a member of staff identified an issue they were required to then attach a separate incident form. The general process for investigation and learning was lacking, as detailed in the incidents section. There was no specific investigation or learning process for safeguarding.
- There were no procedures for staff to follow in the event of them having a safeguarding concern, and no guidance documents to support staff in identifying a safeguarding concern. Staff were not kept up to date about changes to national and local safeguarding arrangements.
- Staff were unable to restrain the patient because there was a no restraint policy. This policy was deficient in that it did not allow for any form of restraint to protect a patient from avoidable harm, for example holding a patient back from walking on a dual carriageway.
- **Cleanliness, infection control and hygiene**
- Since the last inspection standards of cleanliness and hygiene in respect of the ambulances had improved. However, other parts of the service were not clean, tidy or well-organised.
- Ambulance crews showed us daily cleaning sheets evidencing when vehicles and equipment were last cleaned and when cleaning was next due. We were told that no ambulances left the station without the correct cleaning on the inside and outside of the vehicle being completed. During the inspection we observed ambulances being cleaned. The implementation of the

cleaning sheet was monitored by the station manager. On a weekly basis they would perform a cleaning test on an ambulance to ensure it had been cleaned appropriately.

- All but one ambulance we looked in was physically clean. However, in the back of one ambulance we found a dog lead and dog hairs, as well as broken boxes of gloves. The station manager and the registered manager said this ambulance was rarely used and that one of the supervisors used the vehicle for personal use. We were told by the station manager that if the ambulance was to be used it would be cleaned before use.
- It was not clear from conversations with the station manager how dirty linen was managed. We were told dirty linen was left at the hospital and replaced from the hospital stock. Staff were unable to explain if this was a formal agreement.
- Managers were not able to explain how they managed clinical waste. We were told they used the hospital bins. Bins for segregating clinical and non-clinical waste were not apparent at the ambulance station.
- Some equipment stored in the ambulance station, such as wheelchairs and stretchers, was not visibly clean and there was nothing to identify when it had last been cleaned. There was no segregation of clean and dirty equipment and the station was cluttered and dirty. This increased the risk of infections spreading.
- There was no appropriate storage for uniforms. There were a number of clean staff uniforms (trousers and shirts) being stored on a dirty floor without any wrapping, which staff collected for use daily. This increased the risk of infections spreading.
- There were no infection control or decontamination policies and managers were unable to describe the process for ensuring all equipment was cleaned prior to use.
- **Medicines**
- Policies and procedures were not in place to ensure that medicines were used safely. There were no policies or procedures in place relating to the management of medicines, including oxygen.
- The ambulances carried oxygen and additional stores were kept at the ambulance station. The registered manager told us staff were administering oxygen where already prescribed, but recording of this was not formalised because there were no patient care records. The staff we spoke with confirmed this was the case. Staff did not have any guidance or procedures to follow with regard to the administration of oxygen, which meant patients were at risk from either receiving oxygen at a higher flow rate than required, or not receiving oxygen when required. The lack of recording meant the use of oxygen was not monitored, audited or traceable in the event of a complaint or incident occurring. The ordering, monitoring, replenishment, replacement and storage of medical gases were not covered within any written policy or procedure.
- Full/ unused oxygen cylinders were kept in locked cabinets at the back of the ambulance station. However, ones which were no longer used (so below their recommended use levels of oxygen) were stored in the ambulance station storage area and were not locked away.
- One of the regular patients transported by the service was at risk of deterioration that would require midazolam to be administered. The service did not carry its own stock of this medicine, so would need to administer the patient's own medicine in the event of them deteriorating. The provider had not ensured staff were up-to-date with training to give this medicine and was not named within the care plan.
- **Records**
- Records relating to the care and treatment of each person using the service were not being used. There were no care records in place, just a very simple welfare form completed after the journey. Staff were administering oxygen but had nowhere to record this. There was nowhere to record any treatment given, if needed. Matters such as consent, general observations, handover and medicines were not being recorded.
- Completed welfare forms were not held securely. Completed forms were stored in boxes on the office floor. They were not organised or filed for easy access in the event of an investigation being required, and their storage did not ensure patient confidentiality was maintained.

# Patient transport services (PTS)

- **Assessing and responding to patient risk**
- There were no processes in place to assess, manage and reduce risks to patients.
- The registered manager was asked how confident he was that their processes for managing risk were meeting the needs of the service and he replied "very confident". When asked how risk assessments were completed he stated "we just go out and do an assessment – every house and situation is different". There was no evidence of any risk assessments being completed, for example in relation to emergency driving.
- Emergency driving is known to carry a high element of risk, even if travelling within the speed limit. When asked about staff driving with blue lights without having received training, the registered manager told us this was not an issue because it was not a requirement in road traffic law as long as the driver stayed within the speed limit. There was no understanding or appreciation of the potential risks to other persons, including service users, staff, other road users and pedestrians. The organisation did have a blue lights driving policy, which was reviewed in February 2016; however, it did not reflect the most up-to-date legislation, including the Road Vehicles Lighting Regulations 1989 and the Road Safety Act 2006.
- There was limited information collected by the service to determine risks and to assess the skills required for any job. The provider relied on the person booking the transport to have ensured it was appropriate for the service to undertake the work. The provider did not have any processes in place to ask the callers questions that would ensure the patient was safe to be transported by their service.
- **Staffing**
- There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's care and treatment needs.
- The requirements of the neonatal intensive care unit (NICU) transfer contract with the local acute hospital trust required all staff working under this contract to hold an "emergency driving qualification or equivalent national standard (advanced driving skills to be used under blue light and normal traffic conditions when responding to emergency and routine calls)". This was not always the case. Only four members of staff on the NICU rota had completed an advanced driving course, but these staff were not always deployed on NICU transfers. We were told by one member of staff they had used their blue lights despite not being trained because they had been instructed to do so. We looked at five weeks' rotas for NICU and found that on 13 days no one with emergency driver training was rostered. This placed patients and staff at risk in the event of an untrained member of staff being required to use emergency driving techniques without training.
- There was not a systematic approach to determine the number of staff or the range of skills required in order to meet the needs of people using the service and keep them safe at all times.

## Are patient transport services effective?

CQC does not currently have the power to rate independent ambulance services. We found that:

- There were no mechanisms in place to provide assurance around the competency of drivers.
- Although there was an initial induction programme it did not ensure that staff were sufficiently prepared for their role. Learning and development needs were not reviewed and there was no ongoing training programme.
- Although two in-house trainers had been appointed there were no processes in place to gain assurance as to their competence to teach others. There were no defined expected standards or additional training provided to these individuals to give them the skills to teach effectively.
- Some patients required additional skills to ensure safe transfer, such as the use of Vagus Nerve Stimulation application and suction. There had been no training in these techniques since 2014.
- Service managers did not understand the relevant consent and decision making requirements and legislation around the Mental Capacity Act 2005 and the Children's Act 1989 and 2004. There were no processes in place to gain informed consent and there was no consideration in working practices for the Mental Capacity Act.

# Patient transport services (PTS)

- **Competent staff**
- Training, learning and development needs were not reviewed. Staff were not assessed for competence beyond initial training. Mandatory training, including first aid and manual handling, was only completed on commencing employment; there was no ongoing training programme.
- The registered manager told us that competency assessments were completed by both of the supervisors for driving and manual handling. This was reportedly being delivered through informal observational shifts. However, there were no expected standards defined and no additional training had been provided to the supervisors to enable them to assess others' competence. The registered manager could not assure inspectors that the supervisors were assessing to the same standard. There was no formal process to ensure all staff received an assessment; instead, it relied on a supervisor filling a staffing vacancy and working unplanned with a staff member. Inspectors spoke with one of the two supervisors who said he did not carry out any staff assessments because the other supervisor did it all.
- The registered manager told us he had delegated responsibility for all training to the station manager. The registered manager told inspectors he believed all training should be provided on the job, and handed down from more experienced practitioners to new staff. He saw this as the most effective method of training and stated that he had only initiated training for manual handling because CQC said he had to.
- Some patients required additional skills to ensure safe transfer. This training included the use of tracheal insertion and removal, the use of Vagus Nerve Stimulation, oral and tracheal suction and administration of midazolam. Historically this training was provided by a paramedic. However, no staff had been trained in these clinical skills since 2014 when that staff member left.

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

- Managers did not understand the relevant consent and decision-making requirements of legislation and guidance. This included the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. The provider did not have any policies or procedures that referred to obtaining consent from service users, or considerations which should be made with regard to the Mental Capacity Act 2005. Inspectors asked the station manager for a consent policy but there was none in place. The records relating to patients that were used did not have anywhere to record consent.
- Staff had not received any training and were not provided with any guidance in this area.

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

CQC does not currently have the power to rate independent ambulance services. We found that:

- Although patients received feedback forms to allow them to comment on the service received we were shown examples where negative feedback was made with no action taken. These feedback forms had a mechanism for requesting a 'call back'. However, we were told that these were ignored.

**Learning from complaints and concerns**

- Although patient-centred feedback forms were being sent out to patients, there were examples where action was needed but had not been taken. On a small number of forms the service user had requested a call back from a member of staff to discuss their comments further, but we saw no evidence of this having been completed. One member told inspectors that the ticks were ignored.
- There was no evidence that complaints were used to improve the service, and learning opportunities were not identified and shared with all staff.

## Are patient transport services well-led?

CQC does not currently have the power to rate independent ambulance services. We found that:

- There were no processes or systems in place for the identification, recording, monitoring and management of risks associated with the business. There were no systems in place to assess, monitor and improve quality and safety.

- Leaders did not have the necessary knowledge or capability to lead effectively. The registered manager was out of touch with what was happening on the front line and had little understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, what the business was registered to do, or what his responsibilities were to ensure compliance. There was no understanding from managers about risk and they could not identify any risks associated with the business other than keeping the ambulances on the road safely.

**Governance, risk management and quality measurement**

- There were no systems or processes in place for the registered manager to monitor their service against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider did not undertake regular audits of the service, nor they did they use any other method to assess, monitor or improve the quality and safety of the service.
- When the registered manager was asked about quality the only indicator he could refer to was the timeliness of ambulances arriving at appointments. He went on to say that if there was a problem with quality he would be getting lots of complaints, but as he did not get many complaints he was assured of the quality of the service.
- Incident forms were very basic. The station manager told us that few incident reports had been acted upon. Of the forms which had been reviewed by the station manager when received, there was no evidence of learning or changes in practice and when asked, the station manager could not describe any. Incidents were not reviewed on a regular basis and there was no system to review trends.
- The provider did not have systems or processes in place to enable them to identify and assess risks to the health, safety, or welfare of people who use the service. There was no way for risks to be reported, recorded and monitored. A risk register or similar model was not being used.
- The management team did not understand what was meant by a risk within the service. The registered manager and station manager were asked to explain what they understood by the term risk as it applied to their service, and both replied that this was to do with keeping the ambulances on the road and in a state of good repair. There were was no consideration given to any other kind of risk within the service.
- When asked how confident he was about the safety of the service, the registered manager responded “we are well insured”.
- There were no formal assurance processes in place. When asked about assurance processes the registered manager said he spoke with the station manager regularly to ask if there were any issues. He said he trusted the station manager and he knew the service was running well because that was what he was being told. Inspectors asked if the registered manager had ever read through the regulations to review the service’s compliance and he advised he had not, but that the station manager probably had. There was no evidence of this taking place, and no evidence this had been discussed by the managers.
- Neither the registered manager nor station manager had good oversight of the quality of the business. The station manager and the registered manager were only able to provide examples about equipment availability, the ambulance GPS tracking system and getting ambulances to their destinations on time. There was no understanding or appreciation of wider quality or assurance issues.
- **Leadership of service**
- The registered manager did not have the appropriate skills, qualifications, knowledge or experience to demonstrate the competency required to manage the regulated activities.
- A registered manager should have a solid understanding of the Health and Social Care Act, however when asked about his understanding, the registered manager did not know what the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were. He also did not know how the regulations applied to the service. He stated that if inspectors told him what was wrong, he would put it right, like he had done in the past. When asked specifically about the regulations, he told inspectors they set out “driving, manual handling,

pensions, time targets and first aid". In another conversation when asked what the regulations were we were told by registered manager that it was to do with working time directives.

- A registered manager should have a good understanding of the regulated activates they are registered to provide. Inspectors asked the registered manager what the regulated activities were that he was registered to provide. He was only able to answer "patient transport and first aid". This showed a lack of knowledge of the regulated activities for which he was responsible for managing as the registered manager.
- Inspectors asked the registered manager how he actively managed the regulated activities. He said he "relied on [the station manager]" for everything and had informal conversations with him to ask if anything was wrong. He said the station manager was "more in touch than I am". He also said the station manager assured him that the business was compliant with the regulations; however, there was no evidence of this assurance and the registered manager spoke only of informal discussion. The registered manager did not review whether the business was compliant with the Regulations. He said that if he was unsure of anything he would discuss with the station manager and ask him to look through "the CQC book" and discuss if there were any issues. There was no evidence of such discussions or exercises taking place.
- Inspectors asked the registered manager what qualifications he had to manage the regulated activities. He said that he was an emergency medical technician and last had training 18 months ago from a Paramedic. He was not able to provide evidence of this qualification at that time. He told inspectors the last time he had worked on the ambulances was about "a year and a bit ago". He was not regularly active within the business, only spending about one hour twice a week on site, and relied on the station manager to run the business. This was informally arranged and the registered manager did not oversee this.
- The registered manager was unable to answer a number of questions relating to his responsibilities as a registered manager and referred us to the station manager. The station manager was not a registered person. Inspectors asked the registered manager what it meant to be a registered manager and his reply was "I'm responsible at the end of the day. Whatever goes wrong is my fault". This was the entirety of his response and showed he had no depth of understanding of the responsibilities of this role.
- The registered manager did not know there were certain events he would be required to notify CQC of, and told us this would be the station managers' responsibility. When we asked the registered manager what would be reportable he said "I suppose the cop-out answer would be a patient safety incident". When given the example of a safeguarding incident, the registered manager did not know that he would have to notify the Commission.
- The registered manager was unsure what the consequences could be if the service was found not to compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When asked he initially stated his registration could be cancelled, and after inspectors probed some more he could only add that CQC would write a public report. He was unaware that he could be prosecuted as the registered manager for breaches in certain regulations.