Manchester Medical Services Limited

Manchester Medical Services

Quality Report

5e Arrow Trading estate
Corporation Road
Audenshaw, Manchester
M34 5LR
Tel: 0161 244 9995
Website: www.mmse.co.uk

Date of inspection visit: 24 October 2017
Date of publication: 19/01/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Manchester Medical Services is operated by Manchester Medical Services Ltd. Manchester Medical Services Ltd is registered to provide emergency and urgent care and patient transport services. Manchester Medical Services offers ambulance transport on an 'as required' basis and has contracts to provide pre-planned transport. Ambulance services are provided to NHS Trusts, NHS ambulance services, private hospitals and repatriation organisations. The service had not provided any emergency service since September 2017 so we inspected patient transport services only. The service had no contracts for urgent care and had no plans to deliver this going forwards.

The patient transfers include patients detained under the Mental Health Act 1983 going to or from mental health units.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 24 October 2017.

Report of inspection to 24 October 2017 2016 – Manchester Medical Services Ltd. Manchester Medical Services

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 by this service was patient transport.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

· The provider had processes and practices to assess, monitor and improve quality and safety. Staff were knowledgeable about how to report an incident and had access to incident reporting forms including whilst on ambulances. We saw evidence and examples of incident reporting and learning from incidents.

· The service had enough skilled staff to safely carry out the booked patient transfers and ensured a minimum of two staff were allocated to each patient transfer depending on risk and need. The staffing levels and skill mix of the staff met the patients' needs.

· All vehicles and the ambulance station were visibly clean and systems were in place to ensure vehicles were well maintained.

· All equipment necessary to meet the various needs of patients was available.

· There were effective recruitment and systems to support staff.

· The service employed competent staff and ensured all staff were trained appropriately to undertake their roles. Staff had a clear understanding of the Mental Health Act (1983) and were aware of their roles and responsibilities.

· Staff demonstrated exceptional pride in their role and we heard examples where they had shown care and compassion when treating patients. The provider sought to gain feedback from patients using a patient experience form.

· The service took account of the particular needs of patients and ensured flexibility, choice and continuity of care.

Summary of findings

· The leaders were clear about the vision and strategy of the organisation to make sure it provided high quality care. We saw, that the leadership of the service was open, approachable and inclusive and staff confirmed this. The management had plans to continually develop the service.

However, we also found the following issues that the service provider needs to improve:

· The provider was not fully aware of their legal requirement to notify specific information to CQC. During our inspection the registered manager acted on this.

· The provider should consider having a checklist in line with FREC (First response emergency care) to aid in checking all personal kits with equipment for medical emergencies were complete.

· The provider should consider introducing team meetings as they are an invaluable opportunity to share information and practice directly with staff.

· The provider should consider making arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		The main service provided was patient transport services. Therefore we have reported findings in the patient transport section. Urgent and emergency services were a small proportion of activity that ceased in September 2017. We do not currently have a legal duty to rate independent ambulance services. We found the following areas of good practice: • The service had enough skilled staff to safely carry out the booked patient transfers and ensured a minimum of two staff were allocated to each patient transfer depending on risk and need. The staffing levels and skill mix of the staff met the patients' needs. • All vehicles and the ambulance station was visibly clean and systems were in place to ensure vehicles were well maintained. • All equipment necessary to meet the various needs of patients was available. • There were effective recruitment and systems to support staff. • The service employed competent staff and ensured all staff were trained appropriately to undertake their roles. Staff had a clear understanding of the Mental Health Act (1983) and were aware of their role and responsibilities. • Staff demonstrated exceptional pride in their role and we heard examples where they had shown care and compassion when treating patients. The provider sought to gain feedback from patients using a patient experience form. • We saw, that the leadership of the service was open, approachable and inclusive and staff confirmed this. However, we found the following issues that the service provider needs to improve: • The provider was not fully aware of their legal requirement to notify specific information to CQC.

Summary of findings

- The provider should consider having a checklist in line with First response emergency care to ensure all personal kits were complete.
- The provider should consider introducing team meetings as they are an invaluable opportunity to share information and practice directly with staff.
- The provider should consider making arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor.

Manchester Medical Services

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Manchester Medical Services

Manchester Medical Services is operated by Manchester Medical Services Ltd. The service opened in 2011. It is an independent ambulance service in Audenshaw, Greater Manchester. The service primarily serves the communities of Greater Manchester and the East Midlands. However patients are transported across the UK as required. The service predominantly provides patient transport services to adults and children (if accompanied) and secure transport (with dedicated vehicles for this service) for patients detained under the Mental Health Act (1983). In addition the service specialise in bariatric transport, (bariatrics is the science of providing healthcare for those who have extreme obesity) with all vehicles equipped with bariatric equipment.

The service is registered to provide the following regulated activities: Transport services, triage and medical advice provided remotely Treating of disease, disorder or injury

We last inspected Manchester Medical Services in February 2014. Suitable arrangements were in place to ensure people using the service were provided with effective, safe and appropriate personalised care. The service amended its registered address and this is the first inspection under this registration.

The service has had the same registered manager in post since 2011. This person is also the Managing Director.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, one with specialist knowledge of mental health. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection (North West).

Facts and data about Manchester Medical Services

Manchester Medical Services was initially established in 2006 by the current Managing Director. The decision was made in 2016 to no longer offer event medical provision and the company now concentrates on NHS contracts. The company provides a wide range of transport to meet the needs of NHS Hospital Trusts, NHS Ambulance Services, Private Hospitals and repatriation organisations. The company employs 23 full time staff and several bank contractors, operating a fleet of 16 vehicles.

Detailed findings

During the inspection, we visited the registered location ambulance station in Greater Manchester. The service was managed from this location. Ambulances and other vehicles are securely garaged and at this location. In addition it has two ambulances located at an ambulance station in the East Midlands to enable them to cover a more rural contract. We did not visit this location during this inspection.

We spoke with eight staff including; the duty controller, the lead for safeguarding, one clinical mentor, six ambulance crew/patient transport drivers, one registered paramedic who works on the bank, and the management team. We also received eight 'tell us about your care' comment cards, which patients had completed before our inspection. We spoke with one patient and two relatives who had given us their phone numbers on the comment cards.

During our inspection we looked at 20 patient records. We looked at three of the emergency ambulances, one patient transport ambulance and four secure transport ambulances. We reviewed other documentation including policies, staff records, training records and call log sheets.

The CQC has not completed any special reviews or investigations of this service. The service has been inspected twice, and the most recent inspection took place in February 2014, which found that the service was meeting all the standards of quality and safety it was inspected against.

Activity (September 2016 to September 2017)

In the reporting period September 2016 to September 2017 there were 10,726 patient transport journeys undertaken. This figure excluded repatriations and private transfers. The majority of transfers were adults with twenty seven accompanied children transferred.

The accountable officer for controlled drugs was the registered manager.

Track record on safety

- There were no serious clinical incidents or serious injuries reported by the service.
- There were two complaints.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Patient transport services (PTS)

Are patient transport services safe?

Incidents

· The service had an accident and incident reporting policy. The policy described how accidents and incidents should be reported. Incidents were risk assessed into categories of low, medium and high in line with guidance issued by the Health and Safety Executive.

Staff could report incidents using a paper record or online. Each vehicle had a folder containing accident and incident reporting forms.

· We reviewed three incident reporting forms. We saw evidence which showed the incidents were investigated and the learning shared with staff. The health and safety manager showed us an example of a 'near miss' incident which was investigated. Following the incident hand held metal detectors had been introduced to scan patients on each of the mental health vehicles.

· The ambulance crew expected hospital staff, or the police, to conduct a search of patients, where necessary, prior to getting on the ambulance vehicle in line with their own organisational policies. As an additional measure, where patients posed significant risks to themselves or others, patients were asked to consent to a further magnetic wand search carried out by the receiving ambulance crew to detect any secreted items.

· Where patients refused a search, ambulance crew requested that the police and/or the hospital staff (following clinical advice) decided if the search should go ahead in line with the rules of the Mental Health Act Code of Practice. Where any secreted items were detected, ambulance crew requested that the police and/or the hospital staff considered removing any secreted items, in line with the rules of the Mental Health Act Code of Practice.

· Staff who worked remotely had access to online reporting forms via the dispatch system and could speak with the duty person at the control room and the services on-call manager system.

· The service had an effective system to review incidents. We saw that records in relation to the vehicles and crews were stored electronically and were linked to identified jobs. This meant that managers were able to look back to check which staff were responsible for the vehicle at the time of any incident.

· Learning from incidents that are shared with another provider were investigated using a joint incident report. The investigation is via the governance manager. Findings were then emailed to staff for learning outcomes.

· We reviewed the service's incident log and found that there was differentiation made between serious incidents, incidents, near misses, complaints and safeguarding concerns. This meant the service was able to assess and analyse incidents as well as identify themes and trends or areas for improvement.

· Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

· The service had a policy in place, which described their responsibilities under the duty of candour legislation. Staff understood the duty of candour regulations and the requirement to be open and honest and their responsibilities in reporting any notifiable incident relating to the duty of candour. Staff were expected to complete on-line training and assessment in duty of candour and 95% of staff had completed this.

Cleanliness, infection control and hygiene

· Staff followed infection control procedures in line with the infection prevention control policy. This included washing their hands and using hand sanitiser after patient contact. Hand cleaning facilities were readily available including hand wash basins at the depot and hand gel was available on the vehicles. This was monitored as part of the vehicle checks. We observed staff adhering to hand washing procedures when they returned to the depot.

· All staff wore visibly clean uniforms.

· Hand hygiene audits were completed for each staff member on a six monthly basis. In August 2017 of the five staff audited 100% were compliant with the policy and procedures.

· Staff had access to personal protective equipment such as gloves, face masks and aprons to reduce the risk of the spread of infection between staff and patients. Crews carried a spills kit on their vehicle to manage any small spillages and reduce the infection and hygiene risk to other patients.

Detailed findings from this inspection

· There was a policy for the safe disposal of clinical waste, which had been updated in June 2017, and a service level agreement was in place with a waste contractor for removal. We saw clinical waste was disposed of safely and there were appropriate arrangements in place for this to be collected, which met the requirements of the Environmental Protection Act 1990. We observed the clinical waste bins at the ambulance station to be locked and the sharps bins were secured.

· Arrangements were in place to segregate any infected laundry and store this safely prior to it being sent to their laundry provider for processing.

· Crews were required to ensure their vehicle were fit for purpose, before, during and after they had transported a patient. The service ran a fleet of 16 vehicles. We viewed seven of the vehicles: - three regular ambulances, two secure minibuses and two high security cell ambulances. All of the vehicles we viewed were clean and tidy with fixtures and fittings in good repair and easy to clean. Decontamination cleaning wipes were available on all vehicles. The crew assigned to the vehicle each day completed the day to day cleaning of vehicles. The daily records for the vehicles cleaning regime had been completed.

· A deep clean involves cleaning a vehicle to reduce the presence of certain bacteria. The service had a contract with an external company and vehicles were deep cleaned every six weeks or when required. We observed the scheduled deep cleaning of one ambulance in progress at the time of the inspection. We saw records of the last deep clean for all vehicles which detailed their last clean. The crew team leader checked each vehicle after it had been deep cleaned and this was recorded on the six weekly deep cleaning completion forms.

· The crew team leader showed us the post-deployment checklist completed after the cleaning of each vehicle.

· The crews were made aware of specific infection and hygiene risks of individual patients by the information gathered at the time of the booking. The patient's record sheets included an assessment of the patient's status in relation to infections. Crew staff confirmed they were made aware of patients who had infections so they were able to wear appropriate personal protective equipment.

· Data provided by the service showed that all staff had completed hand hygiene and infection prevention and control training. The governance manager told us staff had annual infection control and prevention training updates.

Environment and equipment

· The premises were clean and tidy with adequate space to safely store the vehicles. In addition the unit provided a suitable environment for the control centre. There was a large well equipped training room, office space, facilities for staff, cleaning and separate storage areas.

Detailed findings from this inspection

· The keys for the vehicles were stored securely. There was secure access to the station building and within that to the offices. Staff attended the office to collect the designated vehicle keys.

· Managers told us that all drivers had their driving licence and eligibility to drive vehicles checked prior to employment and on an ongoing basis by the Driver and Vehicle Licensing Agency. We saw evidence of these checks.

· Manchester Medical Services had four ambulances designed specifically for the transport of patients with mental health needs.

· Two of these vehicles were patient transport ambulances with standard minibus type seating arrangements with a screen in place to prevent patients from accessing the vehicle controls or the driver.

· The other two vehicles were secure patient transport ambulances which housed a see- through cell unit, which could transport one patient securely if they presented with significant risks including challenging behaviour or risk of absconding.

· The cell unit totally separated the patient from staff. There was no obvious ligature or self- harm points in the secure ambulances. In accordance with legal requirements on side

facing seats, there were no seatbelts in the side facing seats contained within the cell unit. The limited space within the unit, rather than seat belts, provided protection in the event of an accident.

· The mental health vehicles had CCTV within them so that all internal areas of the vehicle and any incidents were monitored and recorded. The images relayed live to the driver and any ambulance crew sitting in the front passenger seat.

· There were notices informing patients that images were recorded on CCTV.

· The provider had systems in place to ensure that all vehicles were maintained, serviced, cleaned, insured and taxed appropriately.

· Vehicles were covered by a current Ministry of Transport safety test certificates as required. Managers also ensured newer ambulance vehicles were covered by a first Ministry of Transport safety test certificates after 1 year as required in law. Records showed that drivers had the correct licence category, Category B for the weight of the vehicles driven.

· Where vehicles were off road awaiting repair, this was clearly displayed on the vehicle to prevent staff from using the vehicles.

· The records showed that vehicles had gone through a regular deep clean through a contract with an external company every six weeks. This included all fixtures and fittings internally including seats, interior lighting, grab rails, flooring and foot wells.

· Records were kept for each vehicle which included the vehicle log book, service history, insurance road tax payments and deep cleaning schedule.

Detailed findings from this inspection

· The provider kept an overarching spreadsheet for vehicle maintenance which clearly showed when vehicles were last maintained and when the Ministry of Transport safety test certificates was undertaken and next due.

· The spreadsheet was risk rated using a red, amber, green scale so that managers could see at a glance when vehicles due attention flagged up on the spreadsheet. This meant that managers were ensuring that patients were transported in vehicles that were clean and in good repair.

· The vehicle number plates indicated the vehicles were two years old, apart from one which was used if a vehicle required repair. Relevant equipment was available for both adults and children. Examples of equipment carried included a wheelchair, carry chair with stair tracks, slide sheets and stretcher. These were serviced in line with the manufacturers' guidance.

· The crew completed a daily vehicle check before they started their shift. This was to ensure any faulty equipment or vehicle faults were reported. The records showed these checks were carried out regularly. Any defects would be recorded on the post check record. This would be passed to the control room who would ensure the vehicle is booked in for repair.

Medicines

· The service had a non-prescription only medications policy relating to medicines which were not prescribed for individual patients. This indicated that a variety of medications were stocked, for example: paracetamol, aspirin, glucogel, entonox and oxygen. The policy included the transporting of patient medication and gives guidance for staff. In addition a comprehensive standard operating procedure for medicine management was in place. Staff confirmed they used this as a working document for dealing with medicines within the provider. This procedure provided a framework of processes for all aspects of medicines management including supply, administration, storage, disposal and adverse incident reporting.

· The policy clearly highlighted the indication, contraindication, side effects, cautions and dosages when staff were administering medicines.

· Medical gases were managed properly. Oxygen was carried on the ambulances. At the station and on the ambulances, oxygen cylinders were stored and secured in line with their policies and according to best practice guidance.

· The service has a policy and standard operating procedure for controlled drugs which was in date. The Home Office controlled drugs officer re-issued the providers licence in August 2017. The monthly audit for controlled drugs was up to date and showed regular audits had been carried out.

· Medicines were stored securely and appropriately in two double locked cupboards and access to them was

controlled. Only the registered manager and one other nominated staff member were able to access medicines. There was a clear process for all medicines coming in to the service which were ordered by the accountable officer.

· Controlled drugs were checked monthly by two staff members, the registered manager or his deputy and the bank paramedic, who was the accountable officer. We were told these medicines will not be replaced when they reach their expiry dates as the service currently does not require their usage as they no longer provide an urgent care service.

· Grab bags and resuscitation equipment were in place. One of the clinical mentors was developing a checklist in line with First response emergency care to ensure all staffs personal kits for medical emergencies were complete. A system was already in place ready to audit these.

· Five medicines checked were in date. The levels held in stock matched those in the controlled drugs register. This showed that medicines were being safely managed.

Records

· Crew were aware of special notes to alert them to patients with pre-existing conditions or particular safety risks. This included information about do not attempt cardio pulmonary resuscitation orders on patients notes.

· Records were held securely in the station office. Storage was in locked filing cabinets and in a secure post box at the end of each shift and through password protected computer systems.

· Staff completed paper records prior to, on the journey and afterwards and these were later scanned electronically. We looked at 20 completed patient transfer records, which included staff details, times, collection and transfer addresses, details of the patient's condition during the journey and any use of restraint. All of the forms were legible and included all the information required by the company. The information included initial referral information, risk assessments and patient details. Staff told us about the importance of handing over patient information including patient notes when they were transferred.

· Where staff provided any interventions these were also recorded for example restraint records and patient report forms included any physical health monitoring or interventions such as pain scoring, blood pressure monitoring, oxygen saturation rates and blood sugar monitoring.

· We reviewed journey records for mental health patients including patients detained under the Mental Health Act.

· Staff transferring detained patients to hospitals or between hospitals or other locations had received training to collect detention papers to take with the patients. This was so staff could continue to transfer patients legally and staff knew that they had the legal authority to convey or transfer the patient against their will.

· Ambulance staff were aware of the documents they needed to ensure that they had lawful authority to transport detained patients.

· We saw in the case of detained patients, staff received written assurances from the referring agency that transfers of detained patients were within the legal framework and that ambulance staff had the authority to transport detained patients. Records showed that staff received and copied the appropriate written authorisation. These included:

- written authorisation from the approved mental health professionals if the patient was being conveyed from the community to hospital under compulsion, written
- authorisation from the police if the patient was conveyed from the community to a health based place of safety under section 136 of the Mental Health Act,
- written authorisation on a locally devised NHS trust form if the detained patient was moving between wards in the same NHS trust,
- authorisation through the statutory transfer form (Mental Health Act form H4) if the patient was transferred to a different NHS Trust or independent hospital,
- authorisation through a completed section 17 leave form if the detained patient was being transported to another location such as a general hospital for planned treatment for physical conditions.

· There was one record where ambulance staff were called to transport a detained patient who had gone absent without leave back to hospital when they had been found. We accepted that ambulance staff acted on the verbal authorisation of hospital managers in these circumstances. This was because the ambulance staff had to work quickly

to support the return of detained patient and any delay in responding urgently may mean that patient would abscond from staff again. If the staff were employed by the detaining authority they have the power to retake and return

· Staff were aware of the importance of having the authorisation record for each patient as this gave them the legal power to transport the patient against their will, using reasonable force if necessary, and to prevent them absconding en route.

· This meant that the systems were in place to fully assure ambulance staff that they had the proper authority to convey or transport detained patients.

Safeguarding

· The service had policies for safeguarding children and for protecting vulnerable adults from abuse. The policy gave clear guidance to staff as to how to report urgent concerns. The governance manager was the safeguarding lead and the managing director was the deputy lead. The managing director had completed training in safeguarding vul nerable adults and child protection at level three and the governance manager at level four.

· Safeguarding policies included contact information for the appropriate local authority safeguarding children or adult teams. All staff we spoke with had a good understanding of safeguarding and when they would report an incident. Staff we spoke with could describe the signs of abuse, knew when to report a safeguarding incident, and knew how to do this.

· Safeguarding vulnerable adults and child protection was a part of mandatory training. All staff had completed level three training in safeguarding vulnerable adults and child protection. The company policy was that all staff should complete training annually and this was monitored by the governance manager.

· There had been two reported safeguarding incidents in the last 12 months. We saw records which showed these incidents were documented, investigated and referred to the appropriate authority. One of the safeguarding incidents dated September 2017 had been

referred to the police. Staff were not aware of the requirement to notify the CQC when there was an allegation of abuse concerning a person using their service. During our inspection the registered manager acted on this and CQC subsequently received evidence the notification had been made.

· The provider had recently changed their safeguarding policy to include guidance to staff on identifying and reporting incidents of female genital mutilation.

· The provider has a policy relating to the use of restraint and mechanical restraint. Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a patient's body, or part of the body, for the primary purpose of behavioural control.

· The provider's mechanical restraint policy identified that staff could use handcuffs as a restrictive intervention as a last resort to assist patients to be transported safely and securely. The Mental Health Act Code of Practice states ambulance staff can use their own initiative to prevent patients absconding and restrain patients.

· We looked at 12 records of mechanical restraint. Records indicated that handcuffs were used as a last resort, ambulance staff ensured they risk information from the mental health team staff and there was a clear rationale for using them, for example where patients had a forensic history, patients being transferred from seclusion or where the patient was detained under the Mental Health Act and was assessed as being very likely to try and abscond from the vehicle. This meant that handcuffs were only used as a necessity when it would be a proportionate way of managing the risk in line with the principles of the Mental Health Act Code of Practice.

· Where restraint was used, records indicated that staff clearly recorded who was involved in the restraint and their role with a clear indication of what holds they were using including which limb, how long the restraint was for and which method of restraint was used.

· Staff also recorded whether patients suffered any injuries as a result of the restraint methods used. There had been no injuries reported in the last 12 months.

· Records showed that restraint was used for a short period of time. For example, one detained patient who was an

absconsions risk and was transferring between two seclusion rooms at different hospitals was hand cuffed for four minutes to enable them to have a cigarette off the vehicle.

· The provider had recently updated their restraint record to further clarify the time spent in different types of restraint. For example, to clearly indicate the time patients spent in supportive holds and then into mechanical restraint.

· The provider's training informed staff of the dangers of prone restraint and, in line with national guidance, staff were discouraged from using this method of restraint. Records showed that prone restraint was not used.

· Managers reviewed episodes of restraint routinely to make sure that restraint was used for the shortest period and as a last resort.

Mandatory training

· The service had a comprehensive mandatory training programme. Mandatory training was delivered by a combination of e-learning and face to face training. All staff were required to complete and record their mandatory training. Examples of training included; Mental Capacity Act 2005, deprivation of liberty, medical devices, hand hygiene, infection control, disability awareness, moving and handling, equality and diversity, medicines management and information governance. Records indicated that 100% of staff were up to date with this.

· Mandatory training had also been aligned to the ambulance service. The crew transferred some patients and used their emergency "blue light" ambulance. We saw records which showed that staff had undertaken additional training, with an external provider, to drive the emergency vehicle as recommended by the institute of health and care development .The blue light training gave staff the skills to handle the vehicle safely including at high speed that may impact on safety of staff and patients.

· Staff had training to undertake vehicles safety checks. This ensured staff were competent to undertake the vehicle checks required. Staff completed the e-learning training as part of their induction process, upon beginning employment with the service. The provider had progressed the training programme for emergency care assistants so it was in line with First Response Emergency Care guidelines, a nationally recognised qualification for emergency care assistants.

· The governance manager kept a central record and training matrix. The manager was able to review records to see the training staff had completed and when training due for renewal. The governance manager told us these records were reviewed on a regular basis. We checked staff training records and all staff were up-to-date with mandatory training requirements. Five of the staff we spoke with told us they were well trained to do their job; the training was 'excellent' and the environment was one of learning and development.

· Staff, who worked as mental health crew, received training in mental health awareness, mental health legal frameworks, de-escalation, prevention and management of violence and aggression and the use of handcuffs to equip them to work with and transport patients with mental health needs including patients detained under the Mental Health Act.

Assessing and responding to patient risk

· Manchester Medical Service staff routinely requested detailed information on risks posed when transporting patients at the time of the booking. Basic risk assessment screening questions were asked at this time. We saw an example of a call that came through and the completed assessment and risk assessments which were clearly documented. The management of risks included shared information from the referring agency and the ambulance station staff that were planning to transport the patient.

· Records showed that risk assessments were completed specifically depending on the presentation of the patient. For example, ambulance staff secured additional staff escorts in a case due to identified patient risks on attending the hospital compared to the initial staff allocation following initial assessment on referral.

· We saw there was an instance where staff expressed they did not feel competent to monitor a cardiac patient on a lengthy journey. In order to minimise the risk to the patient, the manager took on board a paramedic to transport this patient.

· When transporting patients the ambulance crew told us they would use their first aid knowledge to assess if a patient's condition was deteriorating. They were expected to complete an assessment of the patient's oxygen saturation levels and heart rate and blood pressure to

monitor their condition. We saw this was mandatory on the patients' journey record. All staff were trained to carry out observations of patients in line with First Response Emergency Care guidelines.

· Records showed that in each case for mental health patients risk assessments were completed which included whether the patient was aware of the journey, current and past risks relating to physical and verbal aggression, the likelihood of the patient absconding or attempting to abscond, risks of self-harm and the current presentation of the patient.

· The risk assessment then clearly formulated how patients would be transported including the type of vehicle needed, the numbers of ambulance crew needed, whether hospital or community mental health staff were required to assist in escorting the patients and whether mechanical restraint may be required.

· The risk assessment also included any clinical requirements (including physical health issues) and the assessed mobility needs of the patient. For example in one case the records indicated that the patient was Hepatitis C positive so that staff were aware of the risks associated with infection.

· The provider's training informed staff of the dangers of using rear handcuffing due to the risks of injury. One record showed that on arrival for one episode, police were utilising the rear handcuff method on a detained patient as the patient was threatening to the police. On handover to the ambulance staff, the crew assessed the patient and changed the handcuffs in the normal manner to mitigate the risks of injury.

· Staff confirmed they always discussed any risks when they collected a patient during the handover with staff to help them identify any potential risks on the journey. Assessments included the patients' current mood or behaviour.

· Crew had access to clinical advice from an on call member of staff or they would divert to a hospital. There was an escalation process in place for the management of deteriorating patients.

Staffing

· The service employed 22 emergency care assistants and one ambulance care assistant, in addition to office and management staff. All the emergency care assistants were patient transport drivers/assistants.

· Records we reviewed contained evidence that appropriate recruitment checks were undertaken prior to employment. These included proof of identification references and with the appropriate criminal records checks through the Disclosure and Barring Service. The service had a recruitment policy that set out the standards it followed when recruiting staff.

· Staff were employed and worked solely for Manchester Medical Services. Staff who worked in the office and as a dispatcher were also trained to drive ambulances and support patients when required. The registered manager had a level three certificate in first response emergency care and worked directly with patients and crew staff as required.

· The company used an electronic system to identify patient transport jobs and the availability of staff to ensure all jobs were staffed to the correct level.

· The electronic system identified all planned work with appropriate staff for the current and following week. If a short notice booking received, the service would not accept if they could not supply two staff.

· Basic life support and Automated External Defibrillator training was completed by all new ambulance staff so they could provide the correct initial response in a medical emergency.

· Staff did not raise any concerns about access to time for rest and meal breaks. The service did not use agency staff but utilised the existing internal team who worked additional shifts on overtime or flexibly where required. Staff were called in as required to meet demand and they confirmed this appeared to work.

Response to major incidents

· There had been one reported incident where a patient had managed to self harm while in the cell vehicle. The patient had not been properly searched by hospital staff prior to being handed over to the ambulance crew and had secreted a tool to self harm. Ambulance staff intervened and the patient did not come to significant harm. As a

result of this incident, staff were briefed on the need to observe patients fully at all times and a newer cell vehicle has differently configured seating to promote better observations of patients in this vehicle.

· The provider told us that their organisation was not a part of any major incident plan. However, they were able to respond at short notice to requests for patient transport services.

· The provider assessed that current means of communication for instance mobile phones, land lines and other telecommunication was robust enough to allow partner agencies to make contact during a major incident.

Are patient transport services effective?

Evidence-based care and treatment

· The service had a comprehensive set of up to date evidence based policies and procedures in place to guide staff in their daily work. Policies were reviewed within the recorded timescale. These were accessible as a hard copy for staff to readily access and on the computer system.

· The policies and procedures referred to best practice guidance including the department of health and the Joint Royal Colleges Ambulance Liaison Committee.

· Ambulance crew members carried their pocket book which was based on guidance from the Joint Royal Colleges Ambulance Liaison Committee clinical guidelines for pre-hospital care. Carrying a pocket book was in line with company policy.

· Patients were assessed to use the service from the information included in the initial referral which included risk assessments and patient details. Staff confirmed that updates were also shared via regular contact with paramedics who shared updated practice.

Assessment and planning of care

· The patient transport service provided non-emergency transport for patients who required transferring between hospitals, transfers home or to another place of care. Staff had prior information about the patients they would be requested to transfer. Records showed that ambulance crew received a handover from approved mental health professionals or mental health staff when transporting a patient with mental health needs. This included details of the patient and any likely issues that ambulance crew may face whilst transporting the patient.

· Where necessary, approved mental health professionals or mental health staff accompanied patients on the journey to or between hospitals to ensure they were transported safely and according to their individual needs.

· If distance or rural journeys were scheduled, the journey would be pre planned with stops for toileting, refreshment food and drink. Ambulances held bottled water to provide for patients as required during a journey.

Response times and patient outcomes

· In the reporting period September 2016 to September 2017 there were 10,726 patient transport journeys undertaken. This figure excluded repatriations and private transfers.

· The provider collected and monitored the performance of staff for the jobs that were assigned to them via the information available at the control room. The screen was live so the duty controller was always aware of what issues were causing a delay.

· A report was downloaded on a monthly basis to monitor the key outcome data. This included the time the booking was logged, time allocated to the crew staff, staff response times and how long the patient was on the vehicle. The service monitored the performance of journeys for an NHS trust which was provided to them. We were informed the main reason for delays and crew staff spending a lengthy time at the pick-up point was due to patients not being ready or awaiting their medication. As a way to improve performance the service had just introduced giving the trust access to the provider's system so they could tick when the patient is ready to be collected to prevent the ambulance crews waiting time. Where booking staff recognised that they did not have the staff capacity or vehicles at the correct locations to accept a job, they would refuse it and could suggest the referrer contact the local NHS ambulance service or other providers. The governance lead told us this rarely happened.

Competent staff

Patient transport services (PTS)

· The service had an induction policy and procedure. All staff undertook an induction programme that detailed the expectations and requirements of the role, the company and policies and procedures. Their mandatory training then followed the induction.

· The governance manager told us that all staff received annual training updates, which included resuscitation, infection control, moving and handling and safeguarding.

· Driver and Vehicle Licensing Agency checks were completed prior to commencement of employment.

· Staff told us that they felt they received good and thorough training to meet patient's needs.

There was a training room with equipment available such as resuscitation equipment for staff to use. Staff told us they were able to have regular skills refreshers and practice.

· Although there were no arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor. Staff told us that if they had a concern about the standard of a crew member's driving they would inform managers. Managers told us that any poor practice would be addressed via the individual's clinical mentor. Any additional staff training or refresher training may then be identified. Staff were supported in their development by the use of a continuing professional development system where any additional training requirements or refresher training needs were identified and acted upon. A capability policy could be followed if necessary.

· Appraisals had been carried out for staff for 2015 to 2016. The service had implemented personal development plans and staff were in the process of completing them. Due to the detailed work involved in the personal development plans , the appraisals had not yet been completed in the last 12 months. The governance manager showed us al l staff had been scheduled to complete appraisals in November 2017.

Coordination with other providers and multidisciplinary working

· Since early 2015 Manchester Medical Services has been contracted by a local mental health NHS trust to provide transport of mental health patients.

· A bed manager from the local mental health trust told us that Manchester Medical Services worked well with them to coordinate the transport of mental health patients.

· We heard that the approved mental health professionals specifically request Manchester Medical Services as the crew will often stay with the approved mental health professional in the community throughout the whole Mental Health Act assessment to ensure a smooth admission.

· Bookings were made via calling the control centre and the crew staff received the information on their computer screen. A series of standard questions were asked at this stage including any special requirements. The station staff worked closely with the referring agency staff to complete the risk assessment for the patient before their transfer.

· Crew staff told us they spoke with the ward staff responsible for handing over the patient to discuss the patient's immediate needs and any changes in their condition or behaviour.

· The bed manager also told us that feedback from psychiatric liaison staff who work in general hospitals and nurses on the wards has been consistently positive, always commenting on how the transport crew are willing to wait until handover has been completed and how excellent staff were with patients.

· The bed manager went on to say that the provider were 'an excellent, professional company who treat our patients with the dignity and respect they deserve.'

Access to information

· Information was obtained from hospital staff and entered onto the patient journey forms for any special requirements.

· Crew staff had a handheld electronic device where they received information about patient journeys that were assigned from the control room. The ambulance crew could see the patient information including any specific requirements. This included any specific paperwork, for example a do not attempt cardio pulmonary resuscitation order.

· A 'live' satellite navigation system was provided for staff to track the ambulance journeys to ensure vehicles were reaching jobs as requested. Staff confirmed this was an effective system.

· Feedback from the hospital was that handovers between the ambulance and hospital staff were detailed,

professional and appropriate. Crew staff reported they had a good working relationship with the hospital staff as generally visited the same wards and departments on a regular basis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

· Staff received training in the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. This training was via eLearning. Information provided by the service showed all staff had completed training and were up to date.

· Staff we spoke with showed awareness and understanding of the Mental Capacity Act (2005), code of practice and consent processes.

· Staff training included the requirement for staff to consider any best interest considerations or decisions regarding transporting patients who lacked capacity to agree to their transfer.

Are patient transport services caring?

Compassionate care

· We did not observe any direct patient care as we did not travel with the crews during this inspection.

· Following the inspection, from telephone numbers left on the comment cards, we were able to speak with one patient and two relatives, who had been present when the service had met the needs of their relative. The patient and relatives we spoke with told us the staff

were sensitive and kind. The relatives particularly noted how staff had spoken with patients, explaining what was happening at each stage of the journey.

· We spoke with one carer who told us the crew was waiting outside at the end of the patient's appointment. The patient was agitated and stressed about the pending journey. The crew reassured the patient and kept him comfortable.

· A relative commented that staff had provided care in a dignified way while they transferred their relative who was in a wheelchair with specific needs. This was particularly important to the family who knew about the patient's anxiety.

· From discussion with staff they took the necessary time to engage with patients. They communicated in a respectful and caring way, taking into account the wishes of the patient at all times. Staff described how they maintained patients' privacy and dignity.

· The bed manager from an NHS trust told us that the provider were 'an excellent, professional company who treated patients with the dignity and respect they deserve.'

· Feedback from a bed manager of a local mental health NHS trust, who regularly requested ambulance crew to transport detained patients, was positive. They stated that ambulance staff always went above and beyond for mental health patients, with multiple incidents in the past where patients and their families have commented to the NHS trust on the ambulance staff being courteous, kind, patient and generous with time in what is often a difficult and stressful situation.

· Staff took the necessary time to engage with patients. They communicated in a respectful and caring way, taking into account the wishes of the patient at all times. Staff described how they maintained patients' privacy and dignity.

· We did not see any evidence of dissatisfaction with the service from relatives we spoke with, or other individuals who had used the service.

· Wherever possible vulnerable patients, such as those living with dementia or a disability, could have a relative or carer with them while being transported.

· All staff we spoke with were passionate about their roles and were dedicated in providing excellent care to patients.

Understanding and involvement of patients and those close to them

· Patients were involved in decisions about their care and treatment. Ambulance crews gave clear explanation of what they were going to do with patients and the reasons for it. Staff told us they checked with patients to ensure they understood and agreed.

· Patients described having confidence in the staff providing their care, and patients were involved as much as possible when planning their journey to and from the hospital.

· Staff provided clear information to patients about their journey and informed them of any delays. Information from comment cards and the three people we spoke with

showed that staff respected relatives and carers of patients and were aware of their needs. Relatives reported that information was explained in a way they could understand to enable them to support their relative.

Emotional support

· A patient informed us that staff checked on their wellbeing, in terms of discomfort, and emotional wellbeing during their journey.

· Staff understood the need to support family or other patients should a patient become unwell during a journey.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

· The main service was a patient transport services which provided non-emergency transport for patients who were unable to use public or other transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or referrals from care homes and private individuals.

· The service had two core elements, pre-planned patient transport services, and 'ad hoc' services to meet the needs of patients. Workloads were planned around this. Patients told us the service was good at responding, even on short notice bookings.

· The service works with the contracting provider to support them to meet demand by having regular telephone conversations with each NHS Trust. Manchester Medical Services can respond using four wheeled drive vehicles due to changing weather conditions as required.

· Patient transport services were commissioned by two NHS acute hospital trusts. In addition, a service level agreement was in place with an NHS ambulance trust for non-emergency and non-clinical patient transport. This covered the geographical area of East Midlands.

· On the day, bookings were responded to quickly via telephone. For the ad hoc on the day bookings, office based staff identified which drivers were available. We observed effective communication between drivers and office staff as part of service planning.

· All of the ambulances were equipped with tracking devices. The service had the ability to monitor the locations of its vehicles and to identify where they were.

· An urgent care provider told us there have been times were they needed short notice support and the service had often supported late requests.

Meeting people's individual needs

· Staff told us at the time of the booking for transport the call taker asked about the patient and their needs. The identification of patients with complex needs, such as those living with dementia, learning disabilities; physical or mental disabilities were assessed both at the job booking stage and via crew interaction with their patient.

· Staff told us that at the time of booking the question was asked if the patient required a relative or carer to support them. Staff told us this service was put in place to meet the patient's individual needs and level of risk. This ensured that an appropriate vehicle was allocated to ensure seating arrangements were suitable.

· The provider's vehicles contained bariatric equipment to transfer patients who exceeded a certain weight. Staff confirmed they were competent to use this equipment, which was generally planned in advance so staff were aware of the patient's needs.

· The governance manager told us translation services were not currently available for patients whose first language was not English however they could access an interpreter service such as language line on a pay as you go basis.

- The governance manager showed us a visual translation phrasebook which staff used to communicate with patients whose first language was not English. In addition the crew pocket books contained words and phrases written in various languages. Examples included questions about drinks, pain and medicines in nine languages.

· Six crew members had completed basic sign language training. One crew member spoke proudly about how they had communicated using sign language recently to the benefit of the patient. In addition members of the staff team were able to speak a number of languages including Urdu, Punjabi, Italian, Spanish, French and Polish.

· The provider could access an interpreter service such as language line on a pay as you go basis.

· Mental health vehicles had mirrored privacy glass, which protected the privacy and dignity of patients.

· If distance or rural journeys were scheduled, the journey would be pre planned with stops for toileting, refreshment food and drink. Ambulances held bottled water to provide for patients as required during a journey.

· Private bookings were clearly recorded. This included patient details so the type of ambulance, number of crew, any specific medical information or if oxygen was required.

Access and flow

· Patients could access their care and treatment in a timely way. The provider was able to ensure that resources are where they need to be at the time required. From taking a booking to providing the ambulance service, the provider aims to be there within the hour. This was monitored by the duty controller from the live system. Patients were advised if there was a delay.

· The service is available during the day time mainly from 9am until midnight. Long journeys or night transfers are required to be pre planned. Bookings can be made by phone or online by completing a form.

Learning from complaints and concerns

· Staff knew how to advise a patient if they wished to complain and written information of how to make a complaint was present on the ambulances.

· The service had a system for handling, managing and monitoring complaints and concerns.

The policy was updated in July 2017 and outlined the process for dealing with complaints initially by local resolution and informally. Where this did not lead to a resolution, complainants were given a letter of acknowledgement within two days of receipt followed up by a further letter within 28 working days, once an investigation had been made into the complaint.

· The service had a feedback button on its website. Patients were encouraged to leave feedback through the website and by telephone.

· The service had received two complaints from patients within the last 12 months. One patient complained about the use of restraints and the other patient complained about having to stand on an injured leg following transportation.

· In addition the service had received two complaints from an NHS trust. Complaints for NHS patients were handled in line with the NHS complaints procedure.

· One complaint related to moving and handling of a bariatric patient and the other for a delayed journey which caused the patient to miss an appointment.

· We found that all complaints had been investigated to see if anything might have improved the patient's experience. The governance manager told us the learning from complaints was discussed informally with staff and staff spoken with confirmed this. We saw on staff files examples where they had done reflective learning following a concern. Staff were aware of improvements made following a complaint's investigation.

Are patient transport services well-led?

Leadership / culture of service

· The company structure was clear and showed clear roles and responsibilities within the senior management team. Staff knew which manager would provide them with the necessary guidance and support.

· The managing director went out on transfer cases as required. This allowed him to maintain his practice. Staff spoke positively about this and told us they thought it was positive practice seeing their director out working with them. The director told us, "I run it as a family basically and would not ask the staff to do anything I would not be prepared to do myself".

· The remote workers visited the Manchester site on a regular basis and staff rotated as required to cover the East Midlands work.

· We saw records which showed that some crew had additional qualifications and had developed their leadership skills. The crew team leader had completed a management qualification, the governance manager a nurse leadership qualification and a member of the crew member a diploma in health and social care.

Vision and strategy for this this core service

· The mission and vision of the organisation was evident on the company's web site: 'Here at Manchester Medical services our main priority is to be committed to delivering 100% in all areas of our business. Our aim is to bring the

best service possible to the people of the UK'. The management team and staff spoken with told us their priority was to provide the best possible service to patients across the country.

· The registered manager told us that staff who worked away from the main base did also work out of the Manchester base on a rotational basis and were therefore involved in achieving the strategy, vision and values of the service.

· We saw staff displaying these values during the inspection.

Governance, risk management and quality measurement

· The leadership team consisted of the managing director who is the CQC registered manager, the finance director and the clinical governance lead. The two managers we spoke with were aware of their roles and responsibilities, and staff we spoke with knew who the different leads were and what they were responsible for.

· The service had introduced a clinical mentorship scheme six months prior to the inspection and trained three staff for this role. Each mentor was assigned seven staff. Staff spoke favourably about this structure and how supportive it was.

· A number of internal audits were in place including clinical practices and audits of systems and processes.

· We saw examples where the audits showed any non-compliance that action was taken to make improvements. Examples included introducing the continuous professional development system and additional training.

· The service recorded and monitored key performance indicator data for pick up and drop off times as well as the length of time a patient was restrained if necessary. All performance data was monitored online. The crew would input the journey times and this would be automatically uploaded to the system. All staff members could view a live screen whi ch would give a warning if patients had been waiting for more than an hour for a pick up or drop off.

The maximum key performance indicator time for a drop off was an hour. We saw records which showed that no drop offs exceeded 60 minutes.

· Staff told us that team meetings were not held, mainly due the challenge of getting a staff team together. They usually met individually with the managing director if needed. Staff meetings, should be held particularly if notes are available for staff that are unable to attend. These are an invaluable opportunity to share information and practice directly with staff.

· The managing director told us learning was cascaded to staff. All staff members had a work email account. The service had a bulletin which was printed and placed in the staff pigeon hole. Urgent information was also uploaded to the tablets on each vehicle and must be read before staff could go out on a job. Examples of emails cascading information and learning included a do not attempt resuscitation policy, confidentiality of patient records and the use of a wheelchair locking mechanism to ensure safety.

· Staff told us that the managing director and all the managers were supportive and approachable.

· We saw information that showed us the director had been appointed in line with the fit and proper person requirements.

· Staff told us that when they encountered difficult or upsetting situations at work they could speak in confidence with the managers and had support from colleagues.

· There was a whistleblowing policy to provide assurance to staff who wished to provide feedback about aspects of the service. We saw records which showed the crew raised concerns when a patient handover did not take place appropriately and the governance manager escalated the concern to the bed manager at the facility. The crew also raised concerns when a patient was left in an ambulance for longer than the maximum hour which was the KPI.

· Staff told us the managers were very supportive of decisions made whilst carrying out transfers. One example was where staff were not confident to manage the patient's condition. The manager provided the patient and staff with a paramedic to fully support the crew staff. Staff said the manager always had the safety and best interest of the patient at the centre of their transfers.

· Meetings were held with senior managers and commissioners of the service to ensure the provision of the service remained satisfactory.

Public and staff engagement

Patient transport services (PTS)

· The service's publicly accessible website contained information for the public in relation to what the service was able to offer.

· Staff we spoke with were positive about their engagement with the managers of the service. They told us said they felt involved in decision making around patient transport services and their roles. In addition they told us they were kept informed of any planned changes and always felt listened to.

· The provider had trialled a survey website for patient feedback. The response from the public was minimal. The website has opportunities for the public to give feedback about the service, where a number of positive comments were viewed.

· Staff were able to access information such as policies and procedures electronically and duty rotas via the services online system.

Innovation, improvement and sustainability

· The service had plans to continually develop the service. At the time of the inspection Manchester Medical Services were tendering for many NHS contracts. The manager told us how the independent ambulance market was currently very competitive and proving a very challenging time for the business. Despite this, they were determined to maintain their standards.

· The director was in discussions with several of their NHS Customers to address the competition and was looking at signing service level agreements to ensure they were a sole supplier or preferred supplier to these clients.

· Manchester Medical Services worked closely with their customers and had regular telephone or face to face meetings to discuss the ongoing commitment from their organisation to ensure the best patient and customer outcomes.

· Manchester Medical Services have worked with NHS and private customers in the movement of secure mental health patients across the UK. One customer requested a service for Ministry of Justice patients to be moved across the UK and the only acceptable form of transport was a requirement for a Home Office Approved Secure Cellular vehicle. The service designed a vehicle alongside their customer requirements that meets all the required standards for Home Office detained patients and they had implemented this service.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure The Commission are notified without delay of all incidents that affect the health, safety and welfare of people who use services. Incidents must include any abuse or allegation of abuse in relation to a service user.

Action the hospital SHOULD take to improve

- The provider should introduce team meetings as they are an invaluable opportunity to share information and practice directly with staff.
- The provider should develop a checklist in line with FREC (First response emergency care) to aid in checking all personal kits were complete.
- The provider should make arrangements for ongoing checks for driver competence, such as spot checks or 'ride outs' by a driving assessor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **How the regulation was not being met:** The provider had not reported to CQC all incidents of abuse or allegations of abuse **This was breach of regulation** Regulation 18 (2)(e)