Medical Services Ltd

Medical Services Ltd (Alperton)

Quality Report

82 Sunleigh Road
Wembley
Middlesex
HA0 4LR
Tel: 02087331283
Website: www.info@medicalservicesuk.com

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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.

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Medical services Ltd Alperton is a service that provides emergency and urgent care, including the transportation of high dependency patients and a patient transport service (PTS).

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 01 and 02 March 2017.

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 emergency and urgent care. Where our findings on emergency and urgent care – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the emergency and urgent care core service. See emergency and urgent care section for main findings.

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 within the service:

- Excellent coordination with other providers.
- Staff treating and caring for patients with compassion, dignity and respect.
- Staff expressing passion about their job and dedication to ensuring patients were provided with good care.
- Strong teamwork.
- High levels of competency and understanding of national guidelines

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

- Management of controlled drugs (CDs) and record keeping did not adhere with national guidance.
- Auditing processes, and the use of outcomes to improve the service were not routinely monitored and therefore could not be used to improve the service.
- Adequate clinical governance structures were not in place.

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

Professor Edward Baker

Deputy Chief Inspector of Hospitals London Region

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		• This service reported no serious injuries. • Staff were kept up to date on national guidelines via emails from the provider. However we saw no learning or actions taken from local audits to improve the service. • The service was caring towards patients and we found no evidence to contradict this. The service was able to meet patients individual needs for example the service had the necessary vehicles available that were suitable for bariatric patients. • However, the service did not follow their own concerns and complaints policy and failed to close two complaints out of five within their target of 25 days. • Staff we spoke to felt proud to work for this service, however there was no staff feedback surveys within the last 12 months. Therefore the was a limited opportunity for the service to capture the staff's opinions of the service.

Medical Services Ltd (Alperton)

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Medical Services Ltd (Alperton)

Medical Services Ltd Alperton opened in 2009. It is an independent ambulance service in Alperton, London. The service serves a wide range of communities across the whole of London.

The service has had a registered manager in post since March 2012, who was also the accountable officer for controlled drugs (CDs). At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in December 2016.

Medical Services limited Alperton is a third party subcontractor, subcontracted by two large ambulance providers. A third party subcontractor is defined as a firm that carries out work on behalf of larger organisation.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Monisha Parmar, other CQC inspectors, and two specialist advisors with expertise in emergency and urgent services. The inspection team were overseen by Nicola Wise, Head of Hospital Inspections.

How we carried out this inspection

During the inspection, we visited the provider's ambulance station at Alperton, West London. We spoke with 20 staff including; registered paramedics and managers. We spoke with four patients and one health care assistant.

Detailed findings

Facts and data about Medical Services Ltd (Alperton)

The service is registered to provide the following regulated activities:

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

Activity February 2016 to March 2017;

- There were 2,045 high dependency patients transported in this time period and 22 patient transport journeys.
- The number of 999 responses had not been collated by the service, however there were nine ambulances being deployed from this service on a daily basis.

The service employed eight intermediate care technicians (ICT), three emergency care assistants (ECA), one emergency medical technician (EMT), two IHCD EMT (Institute of Health Care Development), three trainee ICHD EMT and seven trainee paramedics. The service also had a set number of bank staff. Including one bank ECA, three bank IHCD EMT, one bank trainee IHCD EMT, six bank IHCD EMT, one bank paramedic, and one bank trainee IHCD EMT.

Track record on safety between February 2016 and March 2017.

- There were no never events recorded. Never events are serious incidents that are entirely preventable as guidance or safety recommendation providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were 96 clinical incidents in the same period, split into patient incidents, staff incidents, accident management, and medical devices management.
- There were no serious injuries recorded.
- There were five complaints recorded.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Clinical staff showed a strong understanding of a duty of candour.
- There were high levels of personal protective equipment in vehicles.
- Vehicles were found to be visibly clean, with clear record keeping.
- Training was in line with the Intercollegiate Document for Healthcare Staff 2014 for safeguarding.
- There were clear Disclosure and Barring Service (DBS) processes and information governance policies.
- All mandatory training was up to date.
- Appropriate medical examinations and observations were used when assessing a patient.
- There was a detailed business continuity plan.

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

- We had concerns about management of controlled drugs (CD) and record keeping.
- There was a lack of equipment checks checking for expiry dates on medical devices.

Are services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

Emergency and urgent care services

- Staff were up to date with national guidelines and showed high levels of understanding through tests applied by the provider.
- The majority of staff had received their annual appraisals.
- Clinical team leads performed clinical performance reviews for first responders. A first responder is a staff member available to be dispatched by the control centre to attend medical emergencies.
- There were clear handovers between staff employed by the service and medical staff outside the service.
- Staff received yearly refresher training in the Mental Capacity Act 2005.

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

- Opportunities for clinical progression of staff were limited.
- The service was not measuring all their key performance indicators (KPI's). They were also not routinely auditing their performance. Therefore, they could not know how effective they were.
- The service did not benchmark their achievement, ambition or goals against other similar providers in the area.

Are services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff treated patients politely, with kindness and compassion.
- Staff maintained patients' dignity at all times.
- Staff communicated effectively with patients and others.

Are services responsive?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff had access to an interpreter for patients who could not speak English.
- Staff were made aware of patients' medical status before the journey commenced giving them adequate time to prepare for the next patient.
- Staff used a satellite navigation system to access the quickest route for the journey.
- The service employed dedicated staff to prepare vehicles before and after a shift.

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

- The service had no method to capture patient satisfaction.

The service did not respond to complaints in accordance with their policy.

Are services well-led?

We do not currently have a legal duty to rate independent ambulance services.

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

- There was a risk register in place. However, this needed completing.
- Some staff were not aware of the company's values.
- Staff said they did not have job security.
- There was a lack of clinical governance in place.
- There was no regular staff satisfaction survey at the Alperton location.

However, we also found the following areas of good practice:

- Staff told us there was excellent teamwork and were proud to work for this service.
- Staff were able to turn to their managers for advice.

Emergency and urgent care services

Are emergency and urgent care services safe?

The main service provided by this ambulance service was emergency and urgent care.

Incidents

- Incidents were logged on paper forms that were kept in the ambulance. The forms were then returned to the station and placed in a secured letterbox.
- The forms were sent to the relevant contractors; where actions and resolutions were dealt with (Medical Services limited Alperton was subcontracted by two large ambulance providers). These forms were not kept on site for longer than 72 hours.
- The station manager uploaded the incidents into an electronic database. The risk manager would then forward incidents onto the appropriate department depending on whom or what was involved.
- There were fortnightly operational meetings to discuss incidents involving the service manager, the director of health and safety, risk manager, head of dispatch, head of fleet and facilities, and the incidents and complaints manager. We looked at the minutes from these meetings, which showed; the number of incidents which were discussed and comparisons made to the previous month in terms of numbers.
- Crews were made aware of incidents by newsletters or via an app on their portable electronic device. The service monitored who had read the bulletins and in turn, knew which members of staff were up to date with learning from the latest incidents.
- It was the station manager's duty to ensure that staff had read the latest incidents and the action plan created. However, staff we spoke to reported limited feedback from incidents.
- Between February 2016 and March 2017, there were 96 reported incidents. We looked at an online database showing the type of incidents reported. The most common type of incidents reported were medical devices management and medical management. The database showed that 59% incidents had not been investigated; this meant that learning from these incidents had not been achieved.
- From April 2015, all registered providers of health and social care services are required to comply with the Duty of Candour Regulation of the Health and Social Care Act 2008 (regulated Activities) Regulations 20, 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents, and offer reasonable support to that person.
- There was a detailed policy for the duty of candour and a clear reference to the duty of candour in the incident policy. This meant that the provider showed a good understanding of the Health and Social Care Act 2014, by incorporating part of the Act in their policy.
- The executive manager showed a good level of understanding of duty of candour. We gave the manager an example of a situation where a duty of candour was appropriate. We asked the manager what response would be given if a patient was harmed in an incident. The manager stated that the service would be open, transparent, and honest with the patient as well as offering an apology to the patient and owning up for when they wrong. Staff we spoke to including paramedic staff and EMTs displayed a good knowledge of a duty of candour. However, the duty of candour policy was developed in December 2016 and there had been no formal recorded incidents of a duty of candour.

Cleanliness, infection control and hygiene

- We observed the staff cleaning the ambulance seats and equipment after each patient journey.
- We saw staff followed infection control procedures including washing their hands and using hand gel after patient contact. Staff were observed to be bare below the elbows during a high dependency patient transfer.
- Personal protective equipment (PPE), such as gloves, masks, and goggles were available on the vehicles. The service also provided sleeve protection. Staff wore high visibility jackets with long sleeves. The jackets were an essential part of the uniform of staff for example when responding to a road traffic accident. The sleeve protectors would allow staff to wear their jackets, to remain visible, whilst adhering to infection prevention control guidelines.

- We saw staff wearing clean uniforms at all times. Staff took these uniforms home to wash.
- On observation, vehicles were found to be visibly clean to a high standard.
- The provider employed a group of staff to complete all deep cleaning tasks. Vehicles were deep cleaned every two weeks; a clear record was kept of which vehicles had been cleaned.
- There were good procedures for the storage of used sharps (small sharp instruments often used to penetrate the skin, for example a small needle to take blood). We saw that sharps bins were regularly emptied, were not over full, kept in a secure place and the lids were shut. There were also good procedures for clinical waste, for example we saw all ambulances were stocked with bags specifically labelled for clinical waste.
- We looked at an audit for cleanliness of the ambulance and saw that remedial action had been taken as a result. The audit used observation to gauge cleanliness, took swabs of steering wheels and seats, tested the electrical equipment, and tested the alcohol gel dispensers. Between 26 January 2016 and 11 February 2016 the audit found 51 incidences where ambulances were not satisfactory. The outcomes of the audit included an immediate deep clean, restocking, an external vehicle wash, and vehicle maintenance. However, we saw no evidence of on-going preventative actions in place or change to their practice from this audit. This showed that the provider had not responded appropriately to concerns relating to infection prevention and control. We looked at the availability of alcohol gel dispensers in the five ambulances we inspected; we found one of the ambulances had no alcohol gel available on board.

Environment and equipment

- We saw storerooms and ambulances fully equipped with equipment in sufficient quantities. We saw that specialist equipment including PPE needed for everyday jobs within the service were appropriate and available in sufficient amounts.
- The vehicles used for transportation which we observed on inspection were clean and well organised with equipment.
- The vehicles had one-way windows, which meant that passers-by could not see who was in the vehicle, when the vehicle was stationary. This protected a patient's confidentiality.
- The seats within the ambulance were retractable and foldable; this meant that seats could be removed or adjusted to make space for a wheelchair.
- The seats could also swivel, this meant that staff could turn and visually see their patients allowing easier monitoring of patients.
- The service used a power stretcher that meant less manual handling for staff and was safer for patients.
- The doors to the ambulance were fitted with alarms that would sound if the doors were not closed properly, adding an extra safety feature for the patient.
- We observed several members of staff using a Vehicle Daily Inspection (VDI) checklist at the beginning of their shift, using their personal electronic device. The checklist covered both internal and external checks. These included checking that all seat belts were functional, restraining straps (used to immobilise wheelchairs) were present, and checking light bulbs. External checks included checking the vehicle for any damage, tyres and checking oil levels.
- The VDI checklists included a free text comment box that was checked daily by the workshop manager.
- Drivers finding any issues with their vehicles whilst on a job reported these to control or to the station manager. This was communicated via email to the workshop manager. The provider had an onsite workshop for repairs to vehicles.
- If a vehicle was in an accident, the initial action was to remove the vehicle out of service. All accidents were reported to the insurance manager at the provider's central site. Vehicles were checked over in the workshop after an accident.
- The service had a department responsible for all the equipment in the ambulance such as the suction units, carry chairs, stretchers, wheel chairs and so on. These medical devices required a service, in line with the manufacturer's guidelines and in accordance with Medicines & Healthcare Products Regulatory Agency (MHRA).

- There is a requirement to ensure that all medical devices are serviced. Best practice is that this information is contained in an asset register that enables the operator to identify when the asset was purchased, its service records and when the equipment is next due for a service. The service had an asset register in the form of a database. We found irregularities in the recording of equipment maintenance checks as set out below:
- We looked at the database and saw that echocardiogram (ECG) monitors were serviced in batches. We found ECG services were out of date. The service told us that the paper work was incorrect from the manufacturer. The discrepancy in dates had not been rectified by the provider.
- All fire extinguishers were serviced; however the date displayed on the fire extinguishers was the date of the service and not the expiry date. The relevant paper work confirmed the service had been done.
- The suction units were all serviced according to the database. However, no expiry stickers had been applied to the equipment. This meant that staff could not flag up the service expiration dates of the suction units during VDI's.
- The provider used a lifting cushion to gently raise patients who had fallen onto the floor; operated by a battery pack. These battery packs had no asset tracking, testing or service details recorded. In addition, we found an ambulance that was ready to go out on service was missing a battery pack, which meant that if a patient had fallen to the floor this equipment could not have been used to aid the patient. The provider was informed of this and a battery pack for this ambulance was provided.
- The ambulance vehicles' services were conducted every 24,000 miles. The service was done in-house. Other vehicles such as those used for patient transport within the company were serviced according to the manufacturers' specifications.
- The service had a vehicle make ready operator (VMRO) team. This was made up of four VMROs at Alperton – one per shift.
- These members of staff dealt with all aspects of cleaning of the vehicle and the preparations of the vehicle. This included stocking and replenishing the vehicle as well as replacing the fuel after a shift.
- Within the ambulances, there were paramedic bags or technician bags, labelled with a unique number.
- The VMRO would check the bags for missing stock and attach a green tag indicating that all the stock within the bag was in date and readily available. The tags were signed and dated by the VMRO.
- When paramedics or EMTs would open the bag and use an item from the bag they also filled out a form (located in the bag) indicating what was used and replace the green tag with a red tag, this was also signed and dated.
- Each bag displayed a list of all the equipment within the bag and the expiration dates.

Medicines

- The station manager at Medical Services Limited Alperton was responsible for the ordering of medicines, including controlled drugs, some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. Examples include morphine. The provider held a valid Home Office controlled drug licence.
- Managers told us that all the relevant staff held a patient group directive (PGD) in order to administer medication. PGDs are documents permitting the supply of prescription only medicines to groups of patients without individual prescriptions. We were told by managers that staff proved their competence during their introduction period via in depth discussions. Copies of PGDs were available for individual staff members via an online communication software programme.
- The controlled drugs (CD) safe was locked at all times. However, we found issues with the security of controlled drugs.
- The key required to open the controlled drug safe was in a coded key box located in the reception. However, we found that 51 members of staff including non-clinical

staff had access to the code for the key box, which was accessible by computer. This meant that security for the controlled drugs was weak this could result in the potential misuse of controlled drugs.

- We spoke with management who changed the access code and ensured that only five members of staff had access to the code. During the inspection, the access to the key box was restricted to; the station manager, the clinical assurance manager, the director, and two clinical team leaders.
- The medicines and controlled drugs were in date and were kept in a secure location within the depot under surveillance by CCTV.
- The controlled drugs kept in the safe were Diazepam and Morphine Sulphate.
- The station manager filled out forms for the ordering of medicines. This would then be sent to a central location, where Medical Services Limited would place an order. The medicines were then delivered at the Alperton base.
- We looked at the form for receiving CDs. This had a section recording the sequence of receipt of the CDs.
- A witness signature was required. However in the last three months, only one form had been signed by a witness. We notified the provider that this contravened Regulation 12 of the Health and Social Care Act (2014). Under the Health and Social Care 2014, Regulation 12; safe care treatment and under NICE guidelines (National Institute for Health and Care Excellence) providers must ensure correct record keeping with controlled drugs, with appropriate witness signatures.
- Drug cabinets require written documentation for medicines that enter and exit the cabinet. This information was kept in a log book. Staff were required to enter and remove medicines in the presence of a witness, and sign the log book.
- Expired medicines were moved into an expired medicine cabinet where medicines could be disposed of correctly. A log book is also required for this medicine cabinet, which was present.
- We looked at the policy for the destruction of expired controlled drugs. Although there was a policy in place, this was not being followed.
- We looked at the control drugs log book, the number of medicines recorded tallied however we found a number of missing witness signatures. We found 21 missing signatures in the control drug book between 15/10/2016 – 31/10/2016. There were 14 missing signatures in the control drug book between 21/11/2016 – 03/12/2016.
- One signature was missing in the controlled drug destruction record under booking in on 23/01/2017. We found 104 missing signatures in the destruction record under records of destruction/collection between 28/09/2016 – 28/02/2017.
- There were no drugs present in the expired drug cabinet at the time of the inspection.
- This was in contradiction to The Misuse of Drugs Regulations 2001. We raised these issues immediately with the provider. The manager held a team meeting to rectify these issues immediately.
- No auditing of CD's processes or procedures were documented prior to the inspection. The manager stated that audits were being done before the inspection but there was no documentation for this.
- We were told by staff that if a patient travelled in the ambulance with their own medication, the patient was required to keep their medicine in a sealed green patient property bag. We were told by staff that this was recorded on a patient report form (PRF). The patients details were transferred onto the green bag via a sticker and an identical sticker would be stuck on the PRF.
- We saw the storage for medical gases were compliant with the supplier's guidelines. The service stored medical gases in a padlocked metal cage. However, we found an unsecured large oxygen cylinder. This had not been stored in line with best practice, namely to store cylinders vertically and securely to prevent them from toppling as stated by the supplier.
- We found a Nitrous oxide cylinder that was leaking and being stored alongside other cylinders. Although a sticker indicated that this cylinder was leaking, this cylinder should have been stored separately to other medical gases. (Nitrous oxide is commonly known as laughing gas and is used for pain relief).

Records

- We looked at the training database, which showed that 100% of staff had up to date training in information governance, data protection, handling patient information, record keeping and the Caldicott principles. The Caldicott principles refer to the justification of information required and how information is used and who has access to it.
- Staff used paper records for the recording of all patient details, known as a PRF. The PRF documented all clinical procedures and examinations the patient had and any medication given to the patient.
- The service did not audit the correct use of PRF forms; this meant that the service did not know if documentation was correct and accurate and could therefore not make any improvements to this area of the service.
- Patients that had a do not attempt cardiopulmonary resuscitation (DNACPR) forms or required specific medical care were highlighted by the health provider booking the transport. These patients were booked with a nurse escort and any medical intervention required was undertaken by the nurse, this was documented in the patients hospital notes by the nurse.

Safeguarding

- National guidance from the Intercollegiate Document for Healthcare Staff 2014 recommends that all ambulance staff including communication staff should be trained to level two in safeguarding. This applies to all clinical and non-clinical staff that have contact with children/young people and parent/carers. The manager told us that 100% of staff were trained to a level three in safeguarding for adults and children. Staff told us that us that there were regular cases of children and young people that required the use of this service.
- We looked at the training database for safeguarding and saw that 100% of staff were up to date in safeguarding training.
- Staff told us that the contractors provided clear instructions on what to do in relation to safeguarding. There were no reported safeguarding concerns during the reporting period.
- Staff told us they attended a one-day interactive classroom session on safeguarding. The module set out key questions that included what is safeguarding, and what is abuse. It also covered the different types of abuse, the patterns of abuse, risks of social media and the internet and factors that increase vulnerability. The classroom session also gave staff scenarios where staff members needed to identify which type of abuse had occurred. This session also covered abuse in children and young people.
- Staff we spoke with told us they also completed a yearly refresher training online.
- Staff felt confident in raising a safeguarding alert. Staff were able to talk us through the policies and procedures for reporting a safeguarding concern. We looked at the safeguarding policies, which were last reviewed on the 23rd January 2017. The policy stated that the Care Quality Commission (CQC) as well as the local authority must be informed of safeguarding concerns, which is in line with best practice. There were no safeguarding concerns reported in the reporting period of February 2016-March 2017 to the CQC.
- We were also shown the forms used for reporting safeguarding concerns that were kept in a folder in the ambulances.
- Staff we spoke with showed a clear understanding of the term safeguarding and were able to provide examples on the different types of abuse for example; sexual, financial, and physical abuse.

Mandatory training

- Training records showed that 100% of staff had completed the following mandatory training every three years. This included manual handling, safeguarding vulnerable adults, safeguarding young adults and children, equality and diversity, complaint training, conflict resolution, and dementia awareness.
- Fire safety training was repeated every two years.
- Training in control of substances hazardous to health regulation (COSHH), infection control, information governance, data protection, handling patients' information, and record keeping was repeated every year.
- Staff members had yearly refreshers on advanced life support, airway management, equipment refresher, consent, capacity, duty of care, safeguarding and facemask fitting.

- Records we saw showed that all training was complete or due to be signed off.
- Mandatory training was completed in personal time and full time staff were paid for this time. However, bank staff were not paid when training was completed in their own time.

Assessing and responding to patient risk

- When staff were called by dispatch for a job to transport a patient they were notified of the situation beforehand. This included whether or not the patient had a history of aggressive or violent behaviour.
- We observed staff performing the appropriate medical observations when assessing patients in pain.
- We witnessed staff using a pain score to determine which painkillers were most suitable for their patients, and reassessing this pain score once medication had taken effect.
- Staff we spoke to told that the National Early Warning Score (NEWS) matrix was available for each staff member to be able to appropriately access and monitor their patients. We were shown clear standard operating procedures to follow if a patient had deteriorated whilst in the care of the provider. Staff had the option to call the NHS clinical support desk in the first instance or a senior clinical adviser was available to provide clinical support over the telephone.
- We also saw clear guidance and policies set out by the two contractors of Medical Services Limited Alperton on how to respond to particular incidents. For example, patients with known Kawasaki Disease who were presenting with typical symptoms of acute coronary syndrome were conveyed to the nearest London heart attack centre.
- We spoke to managers who told us that when a nurse escort was booked to travel with a patient the care of the patient was jointly shared between the crew and the nurse. We saw that in a two person crew, one member of staff sat with the patient at the back with a nurse escort whilst the another crew member drove the ambulance. We saw that the patients care was jointly shared amongst the crew and the nurse in an appropriate manner.

Staffing

- 70% of staff had full time contracts. The service used regular bank staff to cover gaps in staffing levels. There were no external agency staff employed by the service.
- One member of staff per shift was assigned as a cover in case of staff sickness. However, during the inspection there was staff shortage due to multiple staff sickness therefore there was no staff cover available. This meant that the service did not have contingency plans in place to cover multiple staff sickness.
- All staff working with high dependency patients or responding to 999 calls worked in a two person crew. We were told by staff that due to the nature of the job they had no idea where they were going on a day to day basis.
- Staff told us they were able to take their breaks during their shifts.
- The service had contacted staff who had left the service to gain feedback on the reasons why they had left.
- Drivers' licences were checked every six months by the station manager. The manager completed driving licence validation forms with each staff member. This included checking the expiry date of the licence, driving related convictions and medical conditions that may affect safe driving. The provider also performed an online driving licence check with the licence holder present.
- The policy on DBS checks stated that every three years DBS checks must be renewed and received by the service. We found three members of staff had outstanding DBS checks.
- Staff had the option to perform overtime if they wanted to, but staff reported that they felt no pressure to do so. Drivers were not allowed to do four days overtime consecutively. Overtime was recorded automatically for staff, so staff did not need to keep their own records.
- Control staff were based at a central location away from Alperton. Drivers reported that sometimes control staff would ask a driver if they would accept a job that may run over their shift. Drivers stated that controllers with good experience would plan jobs that could be finished close to the drivers finishing time. However, drivers also

reported that sometimes the control staff would not plan ahead. This meant the last job would end late. Drivers would then need to return their ambulance to the station before finishing their shift.

- The VMRO staff we spoke with enjoyed their job and enjoyed the autonomous working. Staff worked between 7am-7pm or 7pm – 7 am. They worked four shifts in a row and then took four days off.

Response to major incidents

- The service had a business continuity plan specifically for Alperton, last revised in November 2016, and due for renewal November 2017. The aim of the plan was to ensure the safety of staff and patients through a co-ordinated response to building or site disruptions, thereby minimising the impact on the wider health economy. The plan outlined the actions and the procedures staff would take in the event of a loss of water, gas, and electricity. The plan was updated annually or as and when necessary to incorporate significant changes in detail and or lessons learned from incidents. The plan included a list of supplier contact details, which included username and passwords, payment type and a reference account number.
- Frontline staff did not have access to the business continuity plan, which meant that staff would not know the correct procedures to follow in an event of an emergency and a loss of water, gas or electricity. There was no access to the business continuity plan via their electronic portal device.
- The service was not included in any community major incident response.

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

Evidence-based care and treatment

- Staff told us they kept up to date with national guidelines such as the National Institute for Health and Clinical Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). Staff told us that they received emails from the provider to inform them of updates to regulations and new guidelines.
- Staff we spoke with knew the specific national guidelines that applied to their work. Staff were given comprehension style exercises to allow them to demonstrate an understanding of new updates in national guidelines. This meant that staff could read these updates in the national guidelines and then answer questions on the topics covered, as evidence of understanding the updates.
- The service used a survey computer programme to measure staff knowledge and understanding of guidelines. The results were reviewed by the clinical team leaders to ensure staff understood relevant guidance. Polices and updates could be reviewed in personal time. Full time staff were paid for this time, however bank staff were not.
- We saw that all staff had received training in the Mental Health Act (MHA). The training taught staff how to identify and manage patients with varying capacity. The training also looked at how staff behaviours can adapt when managing patient care and safety in regards to the MHA code of practice.
- The Health and Care Professional Council (HCPC) expect professionals to maintain continuous and up to date records of continuous professional development (CPD) and demonstrate learning activities relevant to current or future practice. The service had recently stopped funding for clinical personal development (CPD). This meant that progression for staff was limited and confined to contract requirements only.

Assessment and planning of care

- There was formal training in the Mental Capacity Act 2005 and yearly refresher in the duty of care. This meant that staff were competent in assessing patients' needs and this was observed during staff and patient interactions.
- A contractor provided clinical information on attending to patients with suspected heart attack or stroke. The information was easy to read and displayed in both a pictorial and written format.
- There was a paediatric severe sepsis clinical audit, which gave statistical information on PRF's. The audit looked at 168 paediatric PRF's where severe sepsis was a likely diagnosis and found 76% of patients had all relevant observations carried out necessary to identify

severe sepsis. Eighty- two per cent of crew's documentation suggested the presence of suspicion of an infection, 14% of crews documented suspicion of sepsis on the PRF. To demonstrate the learning from this audit tips, and reminders on how to identify and manage severe sepsis in children were noted underneath the audit results.

- Staff were able to correctly assess patients suffering from cardiac arrest. Staff had clear guidance on the care a patient would need, and would be able to plan ahead.
- Planning of the service took place twice weekly and was off site. Medical Services planned all their operations from one site using two planners.

Response times and patient outcomes

- The service did not benchmark their achievements, ambitions or goals against other providers.
- The service had seven key performance indicators (KPI's) set by one of the two providers that subcontracted the service. These KPIs included the following: All vehicles needed to be mobile within 45 seconds of a call from the dispatcher. Crews must demonstrate less than 14-minute turnaround from handover to available status. Completed PRF's must be returned to the contractor within 72 hours. Clinical documentation should be robust, rigorous and completed accurately. The service must maintain the agreed number of vehicles per shift. Monthly out of service vehicles must fall below combined 3% average, and vehicle equipment must meet the requirements noted.
- The service collected data to record their KPIs daily. We looked at the activity from the 11th February 2017 from 3pm to 1am the following morning. Out of 58 calls from the dispatcher, there were 51 times where vehicles were mobile within 45 seconds. There was one dispatch call that did not have a record for when the vehicle became mobile.
- There was no data recorded to We were told that there was strict adherence to the KPI in returning all PRF's within 72 hours however, there were no audits to measure or monitor this. There were staff shortages during inspection, due to staff sickness; this resulted in the failure to keep the agreed number of ambulances per shift stated in the KPI resulting in potential financial penalties. The service was also monitoring data beyond the KPI's such as the total time at the hospital exceeding 30 minutes. This showed that the service was aware that this could become an issue and impact on other KPI's.
- The reporting period between April 2016 and March 2017 showed that the provider met 90% of their KPI's. The provider achieved an average mobile time within 45 seconds from a call from the dispatcher 83% of the time, achieving their target KPI within the last 10 months. Hospital handover times were on average 41 seconds. The provider had an average of 2.7% of deployed vehicles out of service within the reporting period April 2016 to March 2017, which was within their 3% KPI target.

Competent staff

- Appraisals were conducted annually by the general manager and 15 out of 16 appraisals had been completed on time. However, bank staff did not receive appraisals which equated to 13 members of staff. This equates to 93.8% of appraisals being completed, which was 1.3% under their completion target of 95%.
- The service conducted clinical performance reviews that were undertaken by the clinical team leader (CTL). This was done every six months for all first response staff. Sixty-five per cent of clinical performance reviews had been completed, 10 reviews were outstanding. We saw the review was detailed and involved a whole shift of clinical observations by the CTL including: health and safety, infection control, information governance, assessing the needs of the patient, verbal and written communication, identifying conditions that need urgent intervention, demonstrating appropriate examinations on a patient, demonstrating the correct use of the medical equipment and professionalism.
- Staff who worked with high dependency patients or patient transfers did not take part in clinical performance reviews. We told by managers that these staff members were assessed during annual refresher training in the classroom once a year.
- Staff reported that they needed to do most of their training in their own time. Staff we spoke to did not mind doing this, as the training benefited them and helped keep their registration with the Health and Care Professionals Council (HCPC).

- We looked at Induction training that took place over seven days. All staff completed the following training as part of their induction; respect and dignity, lone working, falls awareness, information governance, data protection, handling patients information, record keeping, duty of care, and communication.
- The induction for first response staff (staff that respond to 999 calls) included; advanced life support theory, prevent, use of the power trolley, capacity and consent (mental health and Mental Health Capacity Act).
- We looked at training records that showed staff were well trained and competent in their role and were able to perform cannulations (a technique where by a cannula is placed inside a vein to provide venous access).
- Records showed that all the relevant Intermediate Care Technician's (7 staff members) had received blue light training or training in driving in an emergency

Coordination with other providers

- Medical Services Limited Alperton did not work with healthcare providers directly for the vast majority of their workload, as they contracted their vehicles and staff to other emergency and urgent care providers.
- We had some concerns regarding methods of auditing to improve the service. Documents such as the PRF's would be sent back to the contractors as soon as possible, leaving little to no scope for auditing.
- PRF's were stored and collected from site on either the Friday of each week or three times a week, depending on the contractor. PRFs were either collected by another provider by internal courier, or sent via a contracted courier company in a secure package and delivered to the contractors headquarters. A signature was required on handover.

Multi-disciplinary working

- Handovers between the service and medical staff outside the service were clear. Staff knew what information to give and kept information concise.
- We witnessed good interaction and handovers between staff and other paramedics from another provider, at the scene of an emergency.
- We witnessed an efficient and complete handover from the staff to a hospital emergency department doctor once a patient was transferred into the hospital's care.
- We witnessed EMT staff confirming the medical state of their patient at a ward before transporting a patient to another hospital.

Access to information

- Staff we spoke with told us they could download an App on their personal phone to view policies, procedures or clinical updates.
- When the contractor arranged a job for Medical Services Limited, the fastest route to the patent was already pre-calculated.
- Patient information was communicated to staff directly via their electronic portable device. This information included the address of where the patient was, the nearest hospital to the patient, and any other key information the crew might need to know.
- We observed staff speaking to ward nurses to ask about any additional information they may need to know before completing their journey. For example if the patient had signed a DNACPR form, or if the patient was infectious.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at the policy for consent, which was in line with Department of Health Guidance.
- The policy stated that in an emergency situation where consent cannot be obtained, for example if a patient was unconscious; staff should provide treatment that was in the patient's best interests and immediately necessary to save life or avoid significant deterioration to the patient's health. Staff we spoke with had a good understanding of consent and this policy.
- We looked at the policy for DNACPR. The policy stated that all DNACPR patients must be pre-booked as a DNACPR patient. It was the responsibility of the health care organisation caring for the patient to ensure all the necessary information was provided to the service to ensure that the correct arrangements were made and in place prior to providing transport. Staff we spoke with showed a good understanding of the DNACPR policy.

Emergency and urgent care services

- Staff had yearly training online in the Mental Capacity Act 2005. This meant that the service was equipped in dealing with patients that may need restraining or that may be violent.
- Staff received a full handover when transporting patients with mental health. Staff told us that a mental health nurse always travelled with the patient.
- If the patient appeared confused, staff said they tried to explain to the patient what was happening and offered carers or family members to accompany the patient.
- Training records showed that staff were not being trained in the use of restraint, nor was the service monitoring the use of restraint from front line contracts crew members.

Are emergency and urgent care services caring?

Compassionate care

- Throughout our inspection we observed staff demonstrating empathy and compassion towards their patients. We observed staff greeting patients on arrival in a warm and welcoming way.
- Staff addressed patients politely and in a respectful manner and treated them with kindness during the journey.
- Staff maintained dignity at all times, and ensured patients were covered with a blanket when necessary. Dignity was also maintained by closing the ambulance door.
- The drivers asked the patient what position was most comfortable when lying on the stretcher and adjusted the backrest accordingly.
- We spoke with patients who were happy with the level of care they received whilst being transported.

Understanding and involvement of patients and those close to them

- Staff always kept the patient informed of what they were about to do, for example when the driver needed to wheel the patient up the ramp at the back of the ambulance.
- We observed staff communicating with patients whilst on their journey, politely and in a professional manner. We observed staff staying with the patient at all times, whilst on a journey.
- Staff engaged well with escorts and assisted them to ensure the patients dignity and respect was well managed.
- We observed staff informing patients of speed bumps in the road and informing patients of how long their journey was without being prompted.
- We observed the staff informing the patient and their family member that they were going to use the blue light to escort them to hospital without alarming the patient.

Emotional support

- We observed the staff communicating with patients whilst on their journey, asking the patients about their wellbeing.

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

Service planning and delivery to meet the needs of local people

- Emergency and urgent care services workloads were based upon work that came in via their contractors.
- The transfer of high dependency patients and private jobs were planned. Bookings were made via the telephone. 85% of bookings were made in advanced and 15% of bookings were made on the day of transportation.
- Drivers told us the work was variable and some days were busier than others.
- Staff told us they collected patients from a range of different place and therefore it was difficult to plan services to meet local needs.
- We spoke with staff who told us that they were alerted on their portable electronic device of the patients' conditions and their current medical status. Staff were able to plan ahead using this information.

Emergency and urgent care services

Meeting people's individual needs

- Staff were made aware if a patient had communication difficulties or did not speak English via control and via their electronic portable device. This meant that staff could prepare themselves prior to the journey. Staff had access to an interpreter over the telephone.
- Staff said they would also use friends or relatives to aid with communication difficulties and use body language to communicate with patients.
- The provider was able to meet the needs of bariatric patients by having the necessary vehicles available at the Alperton location. We were told by the provider that vehicles were designed with reinforced infrastructure and widen ramps. There were also wheelchairs and stretchers available to accommodate bariatric patients. Some bariatric vehicles had fitted a hoist and were assigned to bariatric patients with this specific need. This was identified at the point of booking. Selected staff were trained in the transport of bariatric patients across the whole of Medical Services Limited and training was refreshed regularly to ensure knowledge and capability was up to date. Dispatch teams were kept informed of the staff that were able to undertake bariatric transfers.
- Bookings for private patients and high dependency patient transfers were recorded on an online form, where control staff made note of any specific requirements.
- We saw that 100% of staff were trained in the care and transportation of a patient with dementia. This was completed in the induction period and repeated in annual refresher training. Booking teams flagged up all patients with dementia, this was recorded on the booking forms. The information on the booking forms included any particular risks or needs that particular patient may have. Dispatchers were then able to inform the crews of the patient's medical condition and risks prior to transporting the patient.

Access and flow

- The service had specific KPI's to monitor the access and flow of the service. The drivers used their electronic portal device to capture transport data daily. We observed staff accepting jobs and completing jobs on this device. The data was collected and measured against the services KPI's and data showed that targets were being met.

Learning from complaints and concerns

- There was a concerns and complaints policy which was updated on 27 January 2017.
- Concerns were dealt with and closed off on an electronic database within 36 hours. There was a response period of 25 days for complaints. By day three the service needed to input the complaint in to an electronic database, receive a statement from staff and alert key members of staff if there was a clinical issue. By day 19 a letter for the complainant was approved by relevant members of staff and sent out on day 23 to meet the day 25 target.
- The letters that were sent out to the patients included contact details for the incidents and complaints manager. Patients were able to use these details to escalated complaints further if they were unhappy with the final written response. If this had occurred, the complaint would then be investigated again. A further a letter would be sent out to the patient upon completion of the second review. This letter would include further findings and provide contact details for the Parliamentary and Health Service Ombudsman.
- The service had only received one response from a patient where the initial investigation of a complaint was unsatisfactory.
- Between February 2016 and March 2017 five complaints had been logged. The complaints received were associated with professionalism.
- Three complaints were closed, and only two had been actioned. However, two out of the three complaints that were closed had not been achieved within the 25 day response period. Two complaints out of the five were left opened with no outcomes from the 25th May 2016 and the 25th August 2016. This meant that the service was not following their own concerns and complaints policies. There was learning from these complaints as the outcomes documented included providing feedback to all staff.

Emergency and urgent care services

Are emergency and urgent care services well-led?

Leadership / culture of service related to this core service

- The station manager was the overall manager of the service with clinical support from the clinical team leaders. Staff would report to the station manager. Staff reported that the CTL's were very helpful for clinical advice; and their general manager was brilliant for everything else.
- Staff told us they worked well within their team and would sometimes be on shift with the same person for an extended period of time, which they enjoyed and were able to build up good relationships with their peers.
- Staff told us there was no bullying and harassment within the service, everyone was respectful of each other and could choose who they worked with. Staff we spoke with told us that they would be comfortable to raise a concern if they felt they were being bullied in the work place.
- Staff said they were proud to work for the service.
- Staff told us that they would see their manager daily or there was always a senior member of staff available to talk with. Staff we spoke with told us that management were good at responding to emails promptly, usually on the same day or on the next day. However, staff who had no fixed station to work from reported poor communication from managers.
- Staff informed us that there were many changes of managers, which had led to a degree of uncertainty.
- Staff were unaware of who the safeguarding lead was and also who was the Chief Operations Officer (COO).

Vision and strategy for this this core service

- There was six values set out by the provider; accessible, competent, fast, efficient, helpful and reliable. Staff we spoke with were not aware of the strategy and values for this service.
- Staff we spoke with were apprehensive about their future with Medical Services Limited, and said they thought that they will most likely to be working from different bases in the future. Staff we spoke with said that job security was an issue.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- KPI data was collected daily and there was additional data that was collected to assess the performance of the service. For example, the provider monitored the number of aborted jobs per month and the percentage of bookings that were pre booked or booked on the day. However, it was not clear, how this data was used to improve the service or if the front line staff had access to this data.
- We looked at the operational meeting minutes that took place at the provider's central location. The meetings took place every fortnight and included accident management, incidents and complaints, human resources, training and fleet. However, there were no clinical governance structures in place nor were they discussed at the last three operational meetings.
- We saw a risk register specifically for Alperton with evidence of individually scored risk assessments. The register identified the risk description, the existing control measures, a risk treatment plan and a monitoring mechanism. However, the risk assessments we saw were incomplete and the review dates were entered incorrectly for eight out of the 17 risks identified. This meant that there were not clear plans in place to mitigate risks.
- The risk register failed to identify contingency plans for when more than one member of staff was off sick; this meant there would be a gap in the service when there was multiple staff sickness.
- One of the providers that subcontract Medical Services Limited Alperton audited the service in February 2017. There was several areas of concern for example there were concerns that no visitors pass had been issued to distinguish between members of the public and non-uniformed staff at the station. During the inspection, that took place one month later, members of the inspection team were not always asked of to sign in at reception, and therefore they did not always have a visitors badge. This meant that sensitive information or medical equipment was at risk. The audit set out clear actions required by the service to eliminate these concerns. However, during the inspection we noted that several of these concerns had still not been addressed.

Public and staff engagement (local and service level if this is the main core service)

- There were no routine questionnaires given to patients from this base. This meant that there was no process in place to gain continual patient feedback. Managers we spoke to told us that patient feedback leaflets were available on the vehicles however; we did not see the distribution of these leaflets to any patients at the time of the inspection. There was an option to submit feedback online via their website.
- The service reported that it was very difficult to capture the satisfaction of people using the service given that they are often in a position where they are unable to complete a survey.
- There were no staff survey completed in the last 12 months. This meant that there was no process in place to gauge staff satisfaction anonymously.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- This service was in the process of implementing a new system to improve the processes of sharing knowledge across the business. This included risk assessments, audits, corrective and preventative action plans, legal lists, non-conformities, continuous improvements, near misses, injuries and customer complaints. The service was planning to have quarterly meetings to see if risks were being assessed and implemented.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must take prompt action to ensure that controlled drugs are in line with relevant regulations and legislation. Including record management for the disposal of controlled drugs.
- The provider must establish appropriate clinical governance structures within the service.
- The provider should carry out regular audits to improve and monitor their service.

Action the hospital SHOULD take to improve

- The provider should regularise record keeping in relation to equipment checks in order to show clearly that equipment is checked and maintained regularly and according to requirements.
- The provider should review the outcomes of the audits already taken and put in appropriate and preventative actions.
- The provider should monitor patient and staff satisfaction within the service.
- The provider should review their risk register.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not comply with the proper and safe management of medicines because: • There was a lack of witness signatures on forms stating that received drugs were registered and stored securely in the control drug safe. • There was 21 missing signatures in the control drug book between 15/10/2016 – 31/10/2016 • There was 14 missing signatures in the control drug book between 21/11/2016 – 03/12/2016 • There was 1 signature missing in the drug destruction record under booking in on 23/01/2017 • There was 104 missing signatures in the destruction record under records of destruction/collection between 28/09/2016 – 28/02/2017. • The drugs cabinet key is in a coded key box and the code to this key box is assessable on a 'H' drive and accessible to 51 members of staff, which include non-clinically qualified staff.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not use systems or processes to ensure compliance with assessing, monitoring, and mitigating the risks relating to the health, safe and welfare of service users and others who may be at risk from the regulated activity because: • There was no policy for the designated key holder

This section is primarily information for the provider

Requirement notices

- No enforcement for the documentation of good record keeping for control drugs
- No auditing of medicines management