X9 Services Limited

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Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

There were systems in place to report, investigate and learn from incidents. Infection control was monitored on a monthly basis as part of a service contract.

Vehicles were clean and had been regularly deep cleaned. Vehicles, and equipment on the vehicles, were regularly checked, serviced and maintained. There was a system for replenishing stock on vehicles, however some items of consumable stock were found to be out of date. We witnessed crews of all vehicles rectifying this issue immediately following our findings.

Medicines, including those in the paramedic drug bags were safely and appropriately stored and checked. However some other items in the paramedic response bags were out of date.

There were adequate human resources processes in place to support staffing. Pre-employment checks were being carried out on staff prior to them commencing work. Staff were able to develop and were supported to be able to deliver safe treatment. There were adequate governance processes and quality checking in place.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		Because this was an inspection which was focussed in its scope, rather than comprehensive, we have not rated the service on this occasion.

Emergency and urgent care services

Safe	
Effective	
Well-led	
Overall	

Information about the service

X9 Services Limited are registered to provide the regulated activities of 'transport services, triage and medical advice provided remotely' and 'treatment of disease, disorder or injury'.

The service is registered to a location address in South Woodford, Essex which was where all of the frontline, urgent and emergency ambulances and crews were based. The service also had a small depot in Southampton where there were six vehicles used for patient transport services only.

This was a focussed inspection of X9's frontline, urgent and emergency services. It took place on 29 July 2015 and was unannounced. This was in response to information we received about staffing and incident management.

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X9 Services Limited's frontline, urgent and emergency ambulance service is contracted by the London Ambulance Service.

Summary of findings

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Emergency and urgent care services

Are emergency and urgent care services safe?

Incident reporting, learning and improvement

- If an incident occurred the crew immediately contacted the ambulance service X9 were contracted by to provide the emergency service, via the Airwave radio system, who decided on the most appropriate action. The contractor's incident report form was also completed on board.
- Incidents were also reported verbally to the team leader back at X9's base, who liaised with the ambulance service they were contracted by to ensure all risks were covered. An X9 incident report form was completed when back at base. Once reported to the team leader and the incident report form had been completed, another team leader or manager investigated the incident. At this stage additional statements might be requested and vehicles were sent to check on possible damage or faults.
- The incident report form for X9 included sections for summarising and for the investigating manager to make recommendations. Also specific questions were asked on the form regarding whether welfare, counselling, occupational health or additional training had been offered to staff. Also whether equipment had been isolated, and whether estates or fleet been informed. All incident forms included the summarised manager's discussion and actions taken.
- The director and compliance manager told us that they 'tried to nurture a culture of reporting everything rather than not enough' and that most reported incidents were not of a serious nature but a full investigation was still carried out in accordance with their own due diligence process for completeness. There had been 26 reported incidents so far for the year 2015. All reported incidents were transferred on to a data base and categorised in to one of ten types, such as minor injury, serious injury or fleet related. A trends analysis could be drawn from the spreadsheet. When broken down by category, two had been categorised as serious although neither had resulted in serious injury or harm. We were given an example of an investigation of one of these, where staff support, including counselling had been provided to one crew member.
- Bi monthly operational manager group meetings (OMGs) always discussed incidents as a standing agenda item. The compliance manager took the lead to collate information regarding incidents to be reported to the group. OMG meeting minutes from the last two meetings showed that incidents and learning issues were discussed by senior managers and managers and actions were taken. Incidents were also discussed on an 'as and when' basis by leadership as issues arose, thus not awaiting an OMG meeting before leadership decisions could be made.
- The training manager was also able to describe the post incident debrief and support given by herself and team members to staff involved in difficult and/or distressing situations. This was supported by staff commenting upon a supportive culture.
- There was a monthly staff newsletter to communicate issues, including incident learning, to staff. Open forum meetings were monthly meetings for all staff to attend and served the same function. Open forum meetings and team meetings could be held at short notice and more frequently when the need arose. We were given a recent example of this, where the contractor's procedure for logging on and off of shifts had changed. Meetings were convened to show staff new processes and ensure they were aware.

Cleanliness, infection control and Hygiene

- We looked at a number of ambulances which appeared clean and free from dust, dirt and grime on their hard surfaces. We sampled the deep clean records for six vehicles for the period from January to the end of July 2015. There was clear evidence of deep cleans, with an average of 18 cleans per vehicle over the sample period.
- We saw a sluice area which had mop buckets and handles, colour coded for separate tasks, which complied with best practice. Staff told us that they disposed of used mop heads in clinical waste bags, which would be secured. We did however observe that the clinical waste bags were being disposed of in a commercial waste bin instead of the dedicated clinical waste bin. This was inappropriate and breached relevant legislation.
- Infection control on vehicles was one of seven performance indicators that were reviewed on a monthly basis with the service that contracted X9 to provide the frontline ambulance service. The

'compliance folder' itemised how the service assured itself of compliance with infection control standards. This included a named IPC lead for the service, staff training, internal database for logging monthly vehicle IPC checks, individual vehicle deep clean records, a minimum of 30 hand hygiene audits carried out per month, sharps bins audited for dates that are within three months and clinical waste contract and policy in place.

Environment and equipment

- The vehicle daily inspection (VDI) was carried out at the start of each shift by the crew of the vehicle. The team leader typed up all outcomes from the VDIs and emailed the fleet manager with faults. We saw samples of these emails which showed faults highlighted in red. We witnessed crews completing VDI sheets. Staff we spoke with were confident that any defects they reported to the fleet team would be dealt with. They told us of experiences that they had had where they were asked to use alternate vehicles where a defect was noted.
- When a fault was reported it went to the fleet manager, who also carried out a visual check of the vehicle to check for any further repair issues. Every vehicle checked was logged on to a spreadsheet, which showed that the entire fleet had been visually checked on at least a monthly basis. This was in addition to the vehicle service schedules which were set on a mileage basis of 12,000 miles services interval.
- Work done by crews was noted on a journey log sheet, which was a signed record of all calls attended together with the mileage completed. Any defects which became apparent during the shift were noted on the journey log sheet. We saw that the team leader documented faults and e-mailed them to the fleet team.
- A sample vehicle was subjected to a detailed inspection which identified two minor defects, (a number plate light and an additional brake light). Tyres all exceeded the minimum statutory tread depth. The vehicle under the bonnet (oil, water, brake fluid, windscreen washer fluid, power steering fluid) checks were all acceptable which supported the impression of a fleet where defects were addressed and vehicles regularly inspected and serviced.
- We saw a register relating to the maintenance of clinical devices, this is required to meet the recommendations of the Medicines & Healthcare products Regulatory Agency (MHRA). As a sample the devices on one specific vehicle were checked against the register. We were able to locate them, were able to identify service dates, and to see a summary of any action taken at the time of inspection to maintain, service and repair the devices.
- The same vehicle, an emergency ambulance, was reviewed in some detail. We found three oxygen outlets, an oxygen regulator (reference 117725), carry chair, trolley (reference number 003471) and scoop stretcher (reference 635167) all showing in date service stickers. The LSU suction device did not have a service due sticker, however the device reference number (78470224942) was checked against the MHRA register held by the company, this device was in date and compliant.
- The trolley cot mattress was clean and free from tears. However, there were no straps fitted to the trolley cot. Inspected vehicles were 'pre-deployment' so it was possible the straps had been removed to facilitate cleaning and had yet to be replaced.
- Consumable items were stored in a large, locked shipping container located within the garage area. Items re stored in large semi-transparent boxes located on secure shelving. This system facilitated easy visual identification of low stock levels. The stock reflected the requirements of the service and appeared well managed.
- The sampled emergency ambulance was reviewed in some detail. The consumable items held in this vehicle were checked to determine if they were in original packing, in date and fit for purpose. There was no clear system for the volume of consumable items to be held and there was some significant duplication in stock holdings. For example, I-Gel supraglottic airways were held in two locations (one full set and one part set, a third set was held in the response bag). This duplication could lead to confusion and to waste. Several items of consumable stock were found to be out of date. For instance, nasopharyngeal airways, Yanukauer suction catheter and various sizes of I-Gel. We witnessed crews of all vehicles checking for out of date consumables immediately following our findings.

Emergency and urgent care services

Medicines

- The large, locked shipping container, located within the garage area was used to store consumable items, drugs and paramedic bags.
- Consumable items were stored in large semi-transparent boxes located on secure shelving. This system facilitated easy visual identification of low stock levels. The stock reflected the requirements of the service and appeared well managed.
- Controlled drugs were stored in a secure safe. Other medicines were stored in a separate drug cabinet. The drug cabinet was located in a secure, locked, steel container.
- There was clear evidence of medication audits and of checking the contents of drug bags with two signatories. A drug register showed all of the drugs held and the volume of the holdings. This included the number issued to drug bags and the number introduced from pharmacy. All of the controlled drugs were correct, however for the others the stocks were not always correct, showing a minor over, or under stock of drug. Whilst it is clearly wrong to not have the correct number of drugs recorded, but a small margin of error is often seen in manual systems.
- There were two types of drug bags; one designed for paramedics and one for technicians. We spoke to staff who were clear that their scope of practice allowed them to use drugs within the protocols set out in the Joint Royal College Ambulance Liaison Committee (JRCALC) only. JRCALC publish a clinical manual and is used as the reference of best practice in this area.
- A paramedic drug bag was sampled. 27 drugs were carried and a sample of 12 were checked. It was found that the volumes of drug contained in the bag reflected the audit levels and the use by dates complied with the audit information; all drugs were undamaged and within the specified use by date.
- In terms of good practice, the audit sheets were attached to the drug bag but were not referenced by name (so if the audit sheet became detached it could not be reunited with its bag). The last audit had been carried out on 11 May 2015. The frequency of drugs audits may be determined by the organisation.
- The paramedic response bags weighed approximately 10kg and were stored on top of the drug cabinet at a height of approximately 1.8 metres. This presented a potential moving and handling issue and should be reviewed to minimise this risk. The contents of a sample bag was reviewed. Some items of equipment including I-Gel supraglottic airways and naso pharyngeal airways,) were out of date, this does not reflect best practice. A peak flow meter mouthpiece was scuffed, it was not possible to determine if it had been used, but it was clearly damaged. The sharps bin was full, best practice is that these are changed on a regular basis.

Assessing and responding to patient risk

- The ambulance service that X9 were contracted by, to provide their frontline service, sent information on individual jobs straight to the X9 ambulance crews. This was sent via the airwave radio system. All crews were dynamic risk assessment trained and would risk assess each job as they went along and escalate concerns and issues through the central control of the ambulance service they were contracted by to provide the service.
- If an incident or issue of risk occurred the crew escalated concerns to the ambulance service X9 were contracted by, via airwave radio system who decided on the most appropriate course of action.
- Incidents and issues were also reported verbally to the team leader back at X9's base, who liaised with the ambulance service they were contracted by to ensure all risks were covered.
- Patient care records were referred to as patient report forms (PRFs), which were collated by the team leader who ensured that there was a PRF for each journey recorded on the journey log. The team leader maintained an overview of these. PRFs were then stored in a dated envelop which is stored in a safe. Full envelopes were transferred to the ambulance service that X9 were contracted by, on a regular basis. We saw clinical performance indicators from the ambulance service X9 were contracted by, which indicated how PRF compliance could be improved upon, and we were told that this was shared with staff to support their service delivery.

Staffing

- The station manager planned the staff working rosters. They were planned to have spare staff capacity at work. Staff were rostered to work four shifts on, and four shifts off duty, which resulted in an average working week of 38.6 hours.
- In relation to planning overtime, no more than one additional shift was allocated to each member of staff.

Emergency and urgent care services

We saw a staff summary which showed that the highest volume of hours worked in a month was 61 hours which reflected this process. There was significant variation in the volume of overtime worked and the average was much lower. High volumes of overtime is a feature of ambulance service working, values such as this are within normal limits and are not generally considered to be a risk. The detail relating to working time captured would be likely to satisfy the requirements set out by the European Working Time Directive (WTD), however it was not possible to review reports which indicated that the organisation looked at this area on a regular basis. The station manager was able to tell us that staff were given compensatory rest if they were very late off of a shift and that team leaders were empowered to take this decision at the time, for example, at 5 am, two hours after the shift finished, to tell an employee to come in late. All managers spoken to were able to show they understood the requirements of the WTD and balance this with the needs of the service as well as those of staff.

- X9 were carrying out appropriate pre-employment checks. This included Disclosure and Barring Service (DBS) checks, checks on references, professional registration, qualifications and driving licenses. The single master personnel files existed for each employee and were well organised and easy to follow. Options on working time regulations compliance/opt-out were given. Offer letters and contracts of employment were issued. A random audit of five personnel files showed one reference and one signed contract of employment were missing in total.

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

Competent staff

- Through experiential learning and with the support provided by X9, we found that staff were able to develop and supported to be able to deliver safe treatment.
- A competency based assessment; a skills revalidation took place for each employee. This checked fundamental skills levels in a variety of subjects such as basic life support and manual handling. The company trainer carried this out who also went out on shifts as part of this assessment.
- 'Skill sets' were used to assist this process. We were shown the skill set for emergency medical technicians in more depth to demonstrate how the process was managed from induction. Employees' first skills re-validation was after twelve months. This process was exactly the same for other skill sets.
- Staff received individual performance reviews (IPRs) on a bi-monthly basis. This was carried out by team leaders through a set format that covered satisfaction, progress, development, agreed targets, training support and development, other matters arising that impacted on work issues, feedback. Random bi monthly checks of personnel files were done to check on attendance at IPRs.
- We spoke with employees who completed their emergency medical technician training in Ireland. The scope of practice at X9 was similar to Ireland. They described a training course which was broadly similar; of similar duration and similar competencies. One told us they had attended conversion training which complemented and developed their previous experience. They told us they had utilised their previous training fully since joining X9.
- There was clear evidence that individual learning needs were assessed and met. For instance, we were told they had received a tailored package of training and support that had included significant mentored development over a period of weeks with a further appraisal when all agreed he was competent before working with a wider range of employees.
- We spoke with nine members of staff. There was clear evidence that staff felt well supported. They received training which they felt was relevant and appropriate for their roles. Clinical advice was available to them when needed. They were aware of protocols for reporting and escalating issues and felt confident about being able to access these. Staff reported that they received appropriate training and felt confident and competent in their role.
- For instance, one told us they obtained their training in Ireland and identified that they were employed with a similar scope of practice. They had received clear training in relation to local moving and handling practice and in relation to meeting the requirements of the main front line emergency service contract. They

had also attended additional training around ECG interpretation. They felt they were developing as an emergency medical technician and would recommend X9 as an employer.

- X9 had a training and development manager who was engaged in ensuring that staff had the competence, development and support they needed. The training manager was able to confidently and competently articulate what training staff needed and also where the requirements of staff with UK (NHS or St. John's ambulance) or Eire staff differed and how to address these differing needs.
- X9 had recently leased additional space close by to enhance its training provision and the work, energy and ideas to develop an excellent training provision was evident from this investment and also from the growing amount of training equipment.
- Staff were clear about how to raise concerns with a colleague if they related to him/her and would be confident to escalate these to a team leader. Staff also felt well supported clinically and identified that the clinical support desk was available to them.
- Another told us they were confident that any defects raised in relation to vehicles would be addressed and told us they would recommend X9 to a friend and felt that they were a professional firm.
- Another emergency ambulance technician, who had worked at X9 for 5 years, told us they were comfortable to raise concerns and to escalate these if necessary. They had received training in moving and handling, meeting the needs of bariatric patients, ECG interpretation, the local protocols relating to event cover and had completed their IHCD technician training whilst an employee at X9.
- Another told us they had worked at another ambulance service prior to employment with X9 and upon employment had received refresher training that included 'first person on scene' re-qualification, moving and handling training, a driving assessment and a number of weeks of mentored support, they reported that following this he felt competent to deliver to a good standard.
- In relation to any defect he would report these to fleet, he had always felt supported when doing this and never encouraged to use a defective vehicle. He was happy to work for X9.
- Another was able to give a clear example of an occasion where they had identified a concern relating to a colleague, spoken to them and supported them in speaking to the team leader and gaining a resolution. They were also able to identify a logical step wise approach to resolving a difficult issue which included accessing the clinical advice desk.

Are emergency and urgent care services well-led?

Governance

- The 'compliance folder' itemised 30 sets of processes that assured management of compliance. This included records, qualifications, driving licenses, medicines management and training. For instance, on data protection, compliance was assured through an in date policy, patient referral forms are checked prior to filing and storage, removed from vehicles at the end of shift and stored securely. For infection prevention and control, it included an IPC lead, staff training, Internal database for logging monthly vehicle IPC checks, individual vehicle deep clean records, a minimum of 30 hand hygiene audits carried out per month, sharps bins audited for dates that are within three months and clinical waste contract and policy in place.
- We also saw evidence of audits. Medication audits and of checking the contents of drug bags with two signatories were in place. A paramedic drug bag was sampled and was found that the volumes of drugs contained in the bag reflected the audit levels and the use by dates complied with the audit information; all drugs were undamaged and within the specified use by date. Elsewhere appropriate pre-employment checks were taking place and vehicle checks took place systematically.
- There was a board meeting every quarter and an operational managers' group meeting every two months. Minutes from the last two operational managers' group meeting and the most recent board meeting showed a number of leadership and quality issues were discussed. Resultant actions from discussions were also documented; by whom and by when where appropriate. For instance, standing agenda

items for the operational managers' group meeting included compliments and complaints, fleet accident review, infection control and equipment levels. Actions were clearly stated.

- There was a system of asking staff to provide ongoing authority to check driving license status online (in the context of recent regulation change) which was exemplary and very proactive.
- There was a monthly staff newsletter and open forum meetings to communicate issues to staff. Staff open forum meetings were held monthly but also more often depending on issues that needed to be discussed. Recent subjects for discussion were convened to discuss male/female crews and pay procedures. Open forum meetings could be held at short notice. We were given an example where recently, the ambulance contractor's procedure for logging on and off had changed. Meetings were convened to show staff new processes and ensure they were aware.
- Monthly contract review meetings took place with the contractor of X9's frontline service. Three month's agendas and minutes were seen (March-May 2015). The meetings provided an operational and clinical update from both parties. Assurance monitoring for infection control and vehicle checks were reviewed as were incidents. Rota planning also formed part of these meetings. Key performance indicators as part of the contract were also reviewed. Seven were itemised and included vehicles being mobile within 45 seconds of a call, hospital turnaround time less than 30 minutes and vehicles being cleaned to high infection control standards. Statistics showed X9's performance against three other contracted ambulance services within London and showed them to be within target range.
- The ambulance contractor of X9's frontline service also carried out unannounced spot checks that usually occurred on a monthly basis. When there were issues found they were reported as a 'notice for improvement' letter. The only letter received by X9 in relation to improvement related to a missing piece of equipment on vehicles. The improvement letter and letter stating that this issue had been resolved were dated a week apart, indicating swift action to resolve the issue.

Outstanding practice and areas for improvement

Outstanding practice

- X9 had recently leased additional space close by to enhance its training provision and the work, energy and ideas to develop an excellent training provision was evident from this investment and also from the growing amount of training equipment.
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Areas for improvement

Action the hospital SHOULD take to improve

- There was no clear system for the volume of consumable items to be held, no pattern of where the items should be located and that there was some significant duplication in stock holdings.