Medical Services Ltd

Medical Services Ltd (Shropshire)

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.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

Medical Services Limited (Shropshire) is operated by Medical Services Limited (MSL). The service provides high dependency patient care and a patient transport service, together with a call centre and control room. The service has been registered to provide transport services, triage and medical advice provided remotely since 12 January 2015.

From its location in Atcham, the provider employed 144 staff and operated 59 ambulances. From January to December 2016, the provider carried out 124,688 patient transport journeys and 3,523 high dependency transfers. It provided transport services for adults and children.

Since 2013 the Denmark-based based Falck Group had been the largest shareholder in MSL, and in July 2015 MSL became a subsidiary of the Falck Group. As a result, the provider was going through a change process as the new parent company's policies were rolled out across its UK bases.

We inspected this provider using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 January 2017, along with an unannounced visit to the provider on 31 January 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.

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:

- Staff demonstrated a positive culture of incident reporting.
- Staff demonstrated compliance with infection prevention and control guidelines.
- Management of vehicle and equipment servicing was structured and controlled.
- Appraisal rates were high.
- Patient feedback about standards of care was consistently positive.
- Staff demonstrated obvious regard to patients' dignity and comfort.
- Call-answering performance in the control room exceeded the parent company's national targets.
- Local managers were visible and approachable.

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

- Staff told us they rarely received feedback on incidents they reported.
- Staff told us they did not have protected time to clean their ambulances at the start of their shift.
- There was no policy to ensure staff did not report for duty until at least 48 hours after their last episode of diarrhoea or vomiting, potentially putting patients at risk of infection.
- The provider was failing to achieve its key performance indicators for transport of patients undergoing dialysis or treatment for cancer.

Summary of findings

- National managers were not visible.
- Clinical waste bags awaiting collection for disposal were not always labelled in accordance with Department of Health standards.
- Staff were not provided with adequate changing facilities, or lockers to store spare items of uniform.
- The rest area for high dependency unit staff was not located in an appropriate area, and could not be maintained at a comfortable temperature during colder weather.
- Staff felt senior managers did not demonstrate the parent company's values: 'fast, efficient, helpful competent, reliable and accessible'.
- Staff felt the parent company had imposed significant changes to their working conditions, particularly around shift patterns, without effective consultation. Ambulance staff told us they had very little communication from their managers and did not feel engaged with or included in the provider's plans.
- The provider was performing poorly against its key performance indicator for providing transport for patients undergoing dialysis or receiving treatment for cancer.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		The main service provided from this location was patient transport services and high-dependency transport, provided for patients in the county of Shropshire, and Telford and Wrekin clinical commissioning group areas. Services were also provided for patients of a charity-funded hospice in Telford. We found a good culture of incident reporting among staff, who also followed infection prevention and control guidance. However, we were not reassured the provider's sickness policy always protected patients and staff from the risk of infection. We saw effective use of information technology to monitor vehicle and equipment maintenance, and the quality of patients' journeys. Feedback from patients about the quality of their care was universally positive. The local control room answered telephone calls quicker than the length of time specified in national company targets, however staff told us they experienced problems getting through to the national control room out of hours. The provider was performing poorly against key performance indicators for transporting patients undergoing dialysis or treatment for cancer. Local managers were visible and approachable, however senior, national managers were not visible at the location. Feedback on the provider's management of change during a recent transition to a new parent company was mixed.

Medical Services Ltd (Shropshire)

Detailed findings

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Detailed findings

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Background to Medical Services Ltd (Shropshire)

Medical Services Limited (Shropshire) is operated by Medical Services Limited, part of the Falck group of companies. The provider is one of nine independent ambulance service locations operated by Medical Services Limited and is based in Atcham, Shrewsbury, Shropshire. The provider employs 144 staff at its base in Atcham, Shrewsbury and primarily serves the communities of Shropshire, and Telford and Wrekin.

The provider employed 144 staff at and ran 59 ambulances from its Atcham location. From January to December 2016, the provider carried out 124,688 patient transport journeys and 3,523 high dependency transfers. It provided transport services for adults and children, from birth up to 18 years of age. Children accounted for 1% of the provider's patient transport service journeys, and 4% of its high-dependency activity.

Since 2013 the Denmark-based based Falck Group had been the largest shareholder in MSL, and in July 2015 MSL became a subsidiary of the Falck Group. As a result, the provider was going through a change process as the new parent company's policies were rolled out across its UK bases.

The provider has been registered to provide transport services, triage and medical advice provided remotely since 12 January 2015. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in December 2016.

Our inspection team

The team that inspected the provider comprised a CQC lead inspector with expertise in ambulance services, one other CQC inspector, and a CQC assistant inspector. The inspection was overseen by Debbie Widdowson, CQC Inspection Manager.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service provides a non-emergency patient transport service (PTS) on behalf of two clinical commissioning groups covering the county of Shropshire, and Telford and Wrekin, and for a specialist NHS hospital and a charity-funded hospice in Shropshire. It also provides a high-dependency transfer service for an NHS acute trust. A control room located at the provider's base in Atcham receives journey bookings from patients and healthcare providers, and co-ordinates PTS and high-dependency vehicle movements.

The provider is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection, we visited the provider's base at Atcham. We spoke with 50 staff including; patient transport drivers, call handlers, despatchers, intermediate care technicians, mechanics, vehicle make ready operatives and managers. We spoke with 10 patients and three relatives.

There were no special reviews or investigations of the provider ongoing by the CQC at any time during the 12 months before this inspection. This was the provider's first inspection since registration with CQC, which found that the provider was meeting all standards of quality and safety against which it was inspected.

Activity

- From January to December 2016, the provider carried out 124,688 non-emergency patient journeys, and 3,523 high dependency transfers.

Eighty-eight patient transport drivers, 36 intermediate care technicians, 5 control room staff and 15 other staff worked at the provider, which also had a bank of volunteer hospital car drivers.

Track record on safety, from June to December 2016:

- One serious injury, resulting in the death of a service user
- 107 complaints

Patient transport services (PTS)

Summary of findings

We always ask the following five questions of each service:

Are services safe?

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

We found the following areas of good practice:

- Staff demonstrated a positive culture of incident reporting.
- Staff complied with 'arms bare below the elbow' guidelines and demonstrated good compliance with the hand hygiene policy.
- The provider's fleet management system provided reliable and effective monitoring of vehicle servicing and MoT test dates, and equipment servicing.
- Medical gases were stored safely, in line with best practice guidelines.

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

- There was no policy in place to ensure staff did not attend work within 48 hours of suffering diarrhoea or vomiting, potentially exposing patients to the risk of infection.
- Clinical waste bags awaiting collection for disposal were not always labelled in accordance with Department of Health standards.
- Rest facilities for high-dependency ambulance crews were not segregated from the vehicle garage, which meant staff often chose not to use it as it was exposed to diesel fumes.

Are services effective?

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

We found the following areas of good practice:

- Ambulance staff demonstrated a good understanding of patient consent and mental capacity.
- All staff who required one had received an up to date appraisal.
- The provider used telematics to monitor driving standards and give immediate feedback to drivers at the end of each journey, promoting smooth driving and patient comfort.

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

- The provider was performing poorly against its key performance indicator for providing transport for patients undergoing dialysis or receiving treatment for cancer.

Are services caring?

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

We found the following areas of good practice:

- Feedback from patients about the way ambulance staff had cared for them was consistently positive.
- We saw ambulance crews displaying obvious regard for patients' dignity and comfort.

Are services responsive?

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

We found the following areas of good practice:

- The service's control room performed exceptionally well against its target of answering all incoming calls within 45 seconds.
- The service provided specialist ambulances to provide transport for bariatric patients.

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

- Staff told us they frequently experienced problems contacting the national control room in London during hours when the local control room was closed.

Are services well-led?

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

We found the following areas of good practice:

Patient transport services (PTS)

- Staff told us local managers were visible and approachable.
- We saw evidence of a comprehensive risk register that was regularly reviewed and updated, with actions to mitigate or reduce risks.

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

- Staff told us senior, national managers were rarely seen.
- Staff felt the parent company's values - 'fast, efficient, helpful, competent, reliable and accessible' - did not apply to senior managers
- Many staff felt the new parent company had imposed changes with little or no effective consultation

Are patient transport services safe?

Incidents

- We were given a copy of the provider's incident reporting and management policy, which included its serious incident procedure. The policy detailed the process for reporting, investigating and sharing learning from incidents. It also included a comprehensive section on the background on and obligations under duty of candour. The Duty of Candour regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires health service providers to act in an open and transparent way with people when things go wrong.
- The provider had recorded one serious incident, triggering duty of candour, from January to December 2016. The incident resulted in the death of a service user when the ambulance they were travelling in was involved in a collision with another vehicle. At the time of our inspection, this incident was still open and the provider was reviewing progress against the action plan it had written following the event. Senior managers had ongoing meetings with the Clinical Commissioning Group for the area where it had occurred to keep them informed. We were given a copy of the action plan resulting from this incident. The plan listed eight issues to be addressed to prevent the incident re-occurring, seven of which had been completed and one that was ongoing. Staff we spoke with were aware of this incident and confirmed procedures had been changed or reinforced since it happened, in accordance with the action plan.
- Staff had paper incident report forms (IRFs) on each ambulance. Managers and staff told us incidents were reported verbally to the control room, and backed up with a paper form. Staff either handed completed IRFs to a manager on their return to base, or, if no manager was available, left them in a secure letterbox located inside the premises.
- All the control room staff we spoke with knew how to record incidents verbally reported by ambulance crews, and told us they had done so on numerous occasions.
- Managers logged incident report forms on an electronic system, after reviewing them for discrepancies and

immediate actions. Investigations were co-ordinated by the parent company's health, safety and quality department based in London. Control room staff also logged incidents on the electronic system, when ambulance crews reported them verbally.

- Every incident reports submitted was sent to the site manager, human resources manager, regional manager and patient transport services' director.
- At the time of our inspection, the provider was rolling out a new mobile IT system which included a facility for staff to complete incident reports electronically, while away from their base. The rollout was scheduled to be completed by summer 2017.
- From January to November 2016, staff at Shrewsbury reported 816 incidents. Incident types included equipment issues, communication problems, patients becoming ill before, during or after transport, and 12 'running calls'. Running calls are situations where MSL staff have come across incidents such as road traffic collisions or people injured in the street, while going about their own transport work, and have stopped to render assistance. Each incident had actions taken recorded against it as a record of its outcome. The provider's incident register did not include a grading of their severity.
- We saw feedback from incidents displayed on notice boards in the high dependency unit (HDU) vehicle garage.
- Ambulance staff told us they were encouraged to report incidents, but never received individual feedback when they did. Senior managers, including one who was new in post told us they were aware the incident reporting and feedback system needed to be improved. The newly-appointed manager told us they were aware their process for sharing incident feedback needed to be improved and this was one of the first projects they were working on.
- Control room staff told us they received feedback on incidents they raised, by email.
- A senior manager based at the provider's head office described their Shrewsbury station as a "high-reporting location", indicating a positive culture of incident reporting among staff.
- The parent company held serious incident review meetings monthly, apart from months in which their quarterly governance meetings took place. Serious incidents were also a standing agenda item for the quarterly meetings. During review meetings, managers discussed leaning from serious incidents from any of the company's locations nationwide. We saw minutes of meetings, which recorded detailed discussions of incidents and action taken to minimise the chances of them re-occurring.

Cleanliness, infection control and hygiene

- The provider did not have a policy stating staff should not attend work for 48 hours after being unwell with diarrhoea and vomiting, in line with NHS guidance on preventing the spread of gastroenteritis. This meant staff may attend work while still infectious, and may put their patients at risk of contracting the illness, although there was no evidence to suggest staff were attending work while unwell. We raised this concern with the provider's senior managers during our inspection.
- The station had three vehicle make ready operatives (VMROs). The VMROs cleaned high dependency (HDU) and patient transport (PTS) ambulances against a standard schedule, including those that operated from other locations in the county. Until January 2017, the station manager took swabs from vehicles and used equipment held on site to analyse the samples for pathogens. Results of the analyses were entered on the provider's health and safety monitoring software. However, the provider told us they had temporarily suspended the swab test regime at the time of our inspection, during the company's restructure, following a risk assessment based on consistently high-quality results over the preceding year. The provider was in the process of training a group of senior ambulance care assistants to carry out quality audits, including monthly swab tests of high-risk locations on vehicles. The new system was scheduled to be operational by the end of June 2017.
- The VMROs carried out deep cleans on HDU ambulances every two weeks, and on PTS ambulances every four weeks.
- However, the make ready schedule did not include every ambulance every day, and staff were expected to leave their ambulances cleaned at the end of their shift.

Staff told us this did not always happen, and they often had to clean their ambulance at the beginning of their shift. They told us they were under pressure to go out on patient transfers as soon as their shift started, and several said they came in early, unpaid, to make sure their ambulance was clean before starting work. We saw minutes of meetings where staff had raised this issue, and managers had reiterated the need for ambulances to be left clean at the end of each shift. Managers had advised staff to report any instances where they found this had not happened, using the provider's incident reporting system. We saw evidence in the provider's incident report log that staff were reporting these occurrences, and appropriate action was taken to address each report.

- The VMROs also looked after the premises cleaning. Cleaning checklists were uploaded to the provider's health and safety monitoring software. During our inspection, we saw the premises were visibly clean and tidy.
- We saw ambulance staff ensuring their vehicles were clean and tidy during their shift, while on standby in between patient journeys.
- The provider only used disposable, single patient-use sheets, blankets and pillowcases on its ambulances. We saw staff changing single-use linen after each patient use, and cleaning stretchers and seats with anti-bacterial wipes between each journey.
- All of the provider's ambulances had 'spill kits', which meant staff were able to deal with spillages of bodily fluids safely.
- Clinical waste was removed from ambulances at the end of their shift and stored in sealed yellow bags, in a locked clinical waste skip, awaiting collection for disposal. This complied with the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste. This document also states waste containers should be tagged or labelled in a manner that identifies the individual producer. However, we checked ten clinical waste bags in the skip and found only four of them had been labelled. The station manager told us they were trying to encourage staff to label the bags.
- All ambulance staff we saw were 'arms bare below the elbows', in line with infection prevention and control best practice.
- Ambulance staff told us they had received training on infection prevention and control (IPC) during their induction period. We saw training records which confirmed this, and evidence of 100% compliance with annual IPC training for PTS, HDU, control and hospital-based staff.
- Control staff passed details of patient-specific infection risks to ambulance crews when allocating the journey to them, via hand-held electronic data terminals.
- We saw staff using antibacterial gel and washing their hands, using effective techniques, in line with the World Health Organisation's 'Five moments for hand hygiene' guidelines.
- There were no shower facilities or lockers at the provider's premises. This meant staff were unable to keep a change of uniform at work in case theirs became contaminated. It also meant when staff members' uniforms had become soiled, they had had to wear it while they travelling home to change and, if necessary, shower.

Environment and equipment

- The provider had 59 vehicles assigned to its Shrewsbury base. These were: five high dependency (HDU); two bariatric ambulances; 11 stretcher ambulances; 13 multi-seat ambulances; and 28 wheelchair-carrying ambulances.
- Access to the HDU garage was controlled by an electronic fob, kept in a keysafe secured with a digital lock.
- HDU vehicle keys were kept in a keysafe with a digital lock, inside the garage.
- The staff rest and dining area was inside the HDU garage. Staff told us it was unsuitable as it was a corner of a large, open-plan building and became very cold during the winter, especially during night shifts. The rest area was not partitioned off from the vehicle bays and staff also told us it became contaminated with exhaust fumes when vehicles moved. They told us they often chose to sit in the ambulance for their break rather than use the designated rest area. The provider told us HDU

staff on nights were able to use the training room, which was enclosed, heated and separate from the vehicle garage, for their breaks and when they were on stand-by between jobs. The provider also told us signs were displayed in the garage, informing staff the garage doors should be open for ventilation when vehicle engines were started.

- Managers and the mechanic used a bespoke fleet management software package to monitor vehicle servicing, MoT test and vehicle excise licence due dates, defects and repairs. The system was linked to the ambulance crews' data terminals to monitor vehicle mileages, and predicted likely service dates according to each vehicle's odometer reading.
- The fleet management system also monitored the servicing schedule for equipment such as carry chairs and stretchers on each ambulance. Each item of equipment had an individual asset number which allowed the system to track its location and service history. The provider's mechanics had received training from the manufacturers of the manual handling equipment used on the ambulances, and were qualified to carry out equipment servicing. All equipment on the provider's ambulances was serviced annually.
- We were shown vehicle servicing records which evidenced every vehicle at the location was up to date with its service schedule at the time of our inspection.
- Engineers from an external company carried out servicing on the provider's defibrillators and electrocardiograph machines.
- The provider employed vehicle mechanics who were based at the station. We were shown the workshop, which included a hydraulic vehicle lift. We spoke with one mechanic who told us they were able to carry out most common repairs and vehicle servicing.
- Defective ambulances were clearly identified in three ways: staff displayed a laminated sheet describing them as 'VOR' (vehicle off road) in their windscreen, attached a 'VOR' tag to the vehicle keys and parked it 'nose-in'. Operational vehicles were all reversed into parking bays, so defective vehicles parked facing the opposite direction stood out and were easily identified. These measures meant staff would not inadvertently take defective vehicles out on their shift.
- Ambulance crews recorded vehicle defects on their handheld data terminals. Defect reports were automatically sent to the workshop manager, who added details to the fleet management system to plan repairs.
- The provider rotated its vehicles around its different bases, to avoid some vehicles accruing considerably higher mileage than others and maximise their useable life. For instance, vehicles used in rural areas often had much longer patient journeys than those in urban areas and consequently travelled more miles in a year until swapped. The provider replaced its ambulances when they were six years old, which meant vehicles were removed from service before they became unreliable.
- The station vehicle make ready operative cleaned and stocked HDU and PTS ambulances against a standard schedule in preparation for crews to use on shift.
- Staff and managers told us if equipment was found to be defective during a shift, they would report it to control and complete an incident report form.
- Two intermediate care technicians told us the provider's ambulances were all well-maintained and in good condition, and they rarely experienced breakdowns or defects.
- Three PTS ambulance drivers told us their vehicles were well-maintained and well-equipped.
- We saw staff using vehicle winches to assist patients who used wheelchairs into and out of ambulances, in line with the parent company's moving and handling policy. Patients told us staff always used the winch, and did not push their wheelchairs up or down vehicle ramps manually.
- On two ambulances, we saw patients who used wheelchairs being secured safely before being transported home. Staff secured the wheelchairs to the ambulance floor using purpose-built clamps, then ensured the patient was safe in the chair using a three-point seatbelt, which they also fixed to purpose-built securing points in the ambulance floor.

Medicines

Patient transport services (PTS)

- We saw medical gases stored safely on the provider's premises, in line with the British Compressed Gases Association's Code of Practice 44: the storage of gas cylinders.
- Engineers from external companies carried out servicing of ambulance-based oxygen delivery systems.
- Apart from medical gases, no medicines were carried on ambulances or administered by staff based at the location.

Records

- Control staff sent patient and journey details to ambulance crews via handheld mobile data terminals. Information sent included patients names, contact telephone number, collection and destination addresses, and any special notes about the patient's mobility needs or medical conditions.
- Ambulance crews' handheld data terminals were secured with a password.
- The provider did not use any paper records for patient journeys. All patient records were stored electronically on its computer-aided despatch and booking systems.

Safeguarding

- Control room staff were trained to level 1 safeguarding children and vulnerable adults; ambulance crews were trained to level 2; and senior managers received level 3 training. We were shown records which confirmed 100% of PTS, HDU, control room and hospital-based staff were up to date with safeguarding training.
- Control room staff told us when ambulance crews called them with a safeguarding referral, the call handler always transferred the call to a manager to take details.
- Ambulance staff explained the provider's process for raising safeguarding concerns. They told us they would contact control to raise the initial concern, report the matter to their line manager and complete an incident form. Some staff gave us examples of safeguarding referrals they had made.
- From January to December 2016, ambulance staff at the location had made 19 safeguarding referrals.

Mandatory training

- We were given a copy of the provider's training and development policy, which set out the frequency and types of training to be provided to various staff groups. The policy stated all staff were required to complete training.
- Mandatory training for PTS staff included first aid, infection prevention and control, equality and diversity, health and safety, conflict resolution, fire awareness, manual handling, information governance, dementia awareness, manual handling, oxygen therapy, 'do not attempt cardiopulmonary resuscitation' (DNACPR), and deprivation of liberty (DoLS) and mental health awareness. We were given records evidencing 100% of staff in this group had completed all training apart from conflict resolution, fire awareness, oxygen therapy, DNACPR, DoLS and Mental Health and manual handling.
- Compliance levels for oxygen therapy, DNACPR and manual handling were all over 94%. Conflict resolution and DoLS and mental health awareness compliance rates were low, at 7% and 9% respectively, however this was because new courses had been introduced for both subjects in January 2017 and the provider was at the start of its three-year training cycle for them. Fire awareness compliance was 71%, however again a new course had been introduced mid-2016 and the provider was part way through its two-year training programme for the subject. Dates were scheduled for staff who had training outstanding. We were shown records which showed over 98% of staff had completed of the previous training courses covering conflict resolution, DoLS, mental health awareness and fire safety.
- We spoke with two intermediate care technicians (ICT), who told us an external training company had provided their emergency driving training. We saw training records which evidenced 29 of the 32 ICTs at the location had completed emergency driver training through this programme. The remaining three had completed emergency driver training with other providers, before commencing employment with Medical Services Limited.

Assessing and responding to patient risk

Patient transport services (PTS)

- Ambulance staff had access to a clinical advisor, via the control room, 24 hours a day, seven days a week. Staff told us they were able to request advice if they were concerned about any aspect of a patient's condition either before or during their journey.
- The provider's incident report log included numerous incidents involving patients becoming unwell during their journey, up to and including cardiac arrest. Each incident of this type recorded appropriate actions by the crew involved, who sought immediate medical assistance either from clinical staff at hospitals or from an NHS ambulance service.
- Ambulance staff received training in conflict resolution, and were encouraged to risk assess patients who may be aggressive or violent during their journey. Where necessary, drivers on single-crewed vehicles could request a double-crewed ambulance to transport a patient if they did not feel safe on their own.
- We were shown a copy of the provider's Lone Worker Policy, which set out the legal framework surrounding solo working and detailed the actions taken by the provider to minimise the risk to its staff when working on their own.

Staffing

- We were given records which showed 43 staff had left the provider and 26 had been appointed, from January to November 2016, which represented a nett loss of 17 staff, and a turnover rate of 21%. This was better than the parent company's national staff turnover rate of 28%.
- In November 2016, the provider's sickness absence rate was 2.9%, better than the parent company's target of 3%, but worse than its national average of 2.7% for the same month.
- The provider employed a medical director on a retainer. The medical director oversaw all clinical practice used by ambulance staff, through clinical governance meetings and reports.
- Call-handling and despatch staff in the control room worked overlapping shifts between 8am and 8pm. The shift pattern ensured the greatest number of staff were on duty throughout the provider's hours of peak demand.
- The provider employed 36 intermediate care technicians (ICTs), 88 patient care attendants and five control room staff. At the time of our inspection, the provider did not have any vacancies.
- High-dependency ambulances were always crewed by ICTs, which ensured staff had appropriate skills to provide care for patients during transport. Patient transport ambulances were normally crewed by patient care attendants, however occasionally ICTs would cover PTS shift shortfalls.
- During times of peak demand, the provider occasionally sub-contracted its work to other private ambulance services, to minimise delays for patients. From January to December 2016, 1,648 patient journeys were carried out by sub-contractors. This represented only 1.3% of the journeys for which the provider was responsible.

Response to major incidents

- The provider's ambulance and control staff had not had any training in responding to major incidents. The provider told us they had recognised this learning need during redevelopment of their business continuity and major incident plans in January 2017, and training for all staff groups was planned to be completed during 2017.
- The provider had a detailed business continuity plan, which included actions to be taken to mitigate the impact of a number of possible situations that could impact on its ability to provide its service. These included fuel shortages, severe weather, staff shortages, premises, utilities and IT failures and responses to mass casualty or major incidents. Managers we spoke with were aware of the plan and knew how to access it.

Ambulance staff told us they were aware of plans to reduce the impact of adverse weather, although these had not had to be implemented. They said the workload tended to decrease naturally if severe weather was forecast, as patients with less urgent needs often cancelled their appointments or had them cancelled by the healthcare provider. This allowed the provider to concentrate on providing a service to those patients in most need.

Are patient transport services effective?

Evidence-based care and treatment

Patient transport services (PTS)

- In accordance with the provider's policies, call handling staff had different flowcharts to assess patients' eligibility for transport, depending on whether the call was being made by the patient or their representative, or a healthcare professional. Different flowcharts were used depending on whether the transport was required on the same day or was an advance booking. The flowcharts included ensured call handlers obtained accurate patient details, and included questions about the patient's mobility needs, any access issues at the collection or destination addresses, the patient's medical conditions and whether anyone would be escorting the patient. Patients and healthcare staff were also able to book transport through an on-line form if they preferred.

Assessment and planning of care

- The provider's fleet management software interfaced with its computer-aided despatch system to plan ambulances to transport jobs automatically, according to vehicle type and capacity.
- Control staff passed case details to ambulance crews using hand-held electronic data terminals. Ambulance staff told us patient information included details of any mental health concerns, infection control alerts, mobility needs and special notes, for example if the patient was living with dementia.

Response times and patient outcomes

- Each driver used a personal-issue fob to log on to the ambulance's telematics system, before the engine could be started, which identified the crewmember who drove on every individual journey during the shift. The provider's fleet management software provided managers with data on the manner and efficiency of each member of staff's driving. Information included acceleration and braking rates, driving and cornering speeds, fuel efficiency and, in the case of HDU vehicles, whether blue lights were in use on each journey.
- Each ambulance had a set of red, amber and green lights on its dashboard. At the end of each journey, when the driver switched off the ignition, one of the lights illuminated to give an indication of how smoothly and efficiently the vehicle had been driven, based on analysis from its on-board telemetry. This gave staff instant feedback on the quality of their driving. The system also sent reports to the provider's managers, to allow them to monitor staff members' driving patterns.
- The vehicle tracking system also allowed managers to replay a vehicle's journey, including its speed, acceleration, braking and cornering forces. This helped managers by providing evidence for incident and complaint investigation and for use in staff appraisals.
- Immediately prior to our inspection, the provider's tactical control group of managers had started to hold weekly meetings to review issues such as weather conditions, fleet and staff availability which could affect their ability to meet the demands of their local contracts.
- The provider's contracts included 25 key performance indicators (KPIs), based on the length of time patients waited for transport, or on how close to their appointment time patients arrived at hospital.
- From April 2016 to January 2017, Medical Services Limited (Shropshire) achieved or performed better than its target for 11 KPIs, and performed worse than target for 14 KPIs. The provider performed best for KPIs relating to collection of patients whose discharge from hospital had been planned the preceding day, achieving 87%, 93% and 96% against benchmarks of 80%, 85% and 90% respectively.
- The service performed worst for KPIs relating to patients being transported to and from appointments for cancer treatment and dialysis. Against benchmarks of 95%, 90% and 99% for patients undergoing dialysis it achieved only 91%, 76% and 98%, and for patients receiving treatment for cancer it achieved 48%, 86% and 83% against targets of 95%, 90% and 99%. To address the poor performance against these KPIs, the provider told us rota changes were planned for March and April 2017. These changes would increase the number of crews available at times when patients receiving dialysis or treatment for cancer needed transporting to or from hospital.

Competent staff

- Following receipt of pre-employment checks, including a Disclosure and Barring Service (DBS) report, driving

licence and references, new staff were given a two-week induction period. This was followed by a flexible period of shadowing experienced staff, before being deemed competent.

- The provider's volunteer car drivers were subject to the same pre-employment checks as its employed staff.
- Ambulance staff told us their induction training included mental health awareness, first aid, infection prevention and control and corporate information. We saw a copy of the company's PTS induction course prospectus, which included modules on each of those subjects.
- The provider's electronic staff records system generated reminders for managers to update each staff member's DBS checks once every three years.
- We were given records which evidenced all staff, apart from those still in their probation period or who were voluntary car drivers, had had an appraisal from January to August 2016.
- In line with the parent company's 'driving licence check policy', we saw managers carried out annual driving licence checks for all staff who were expected to drive ambulances or other vehicles, as part of their appraisal process.
- Ambulance staff told us the provider provided them with high quality training, appropriate to their role. Examples of subjects covered included specialised equipment, anatomy and physiology, oxygen therapy and emergency care.
- Intermediate care technicians, who worked on the provider's HDU ambulances, were trained to 'first person on scene' level, with additional training to allow them to manage intravenous lines that had been inserted by healthcare professionals.
- Staff told us the provider's training provision was responsive to needs they identified. They gave us an example of a standing aid that was on the ambulance, and told us they were uncertain about how to use it when it first arrived. They raised this with their manager, and the provider arranged training for all the staff who might use the aid.

Coordination with other providers and multi-disciplinary working

- The provider took bookings for transport from patients, GP practices, hospitals and other health care professionals, in line with its contract from local clinical commissioning groups.
- A manager, known as a site co-ordinator, from the provider was based in the reception area of each hospital for which they provided patient transport.
- We spoke with the site co-ordinator at one hospital. They told us their role was to act as liaison between the hospital and the provider, and as a 'trouble-shooter' in the event of any issues arising. They told us they felt the role was effective as it gave patients and hospital staff a point of contact on-site, and allowed the co-ordinator to see when patients were waiting for transport longer than they should have been.

Access to information

- The control room at Atcham did not operate 24 hours a day. Outside of its operating hours, staff had to contact the national control room in London; however they told us they often had conflicting instructions about job priorities, especially at the start of early shifts, from the two control rooms. They also told us they frequently had difficulty getting any reply on the telephone from the national control room. We saw problems contacting the national control room recorded in team meeting minutes. We also saw details of a managers' meeting in which the provider acknowledged the recent transition to the national control room out of hours had had an impact on their local performance. Training was being provided for staff in London to address these issues.
- Ambulance staff told us only one of the ambulances based at the location was equipped with a satellite navigation system. Many staff bought and used their own satellite navigation equipment.
- Where necessary for patient and staff safety, ambulance staff were made aware of any medical or mental health conditions their patients may be living with as part of the case details sent from the control room.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were shown a copy of the provider's parent company's policy on capacity to consent, which detailed patient consent, how to seek it and what should be done if consent is withdrawn; consent for children and

young people, including 'Gillick competence'; and how to assess a patient's mental capacity and what action should be taken if the patient did not have capacity. The policy explained the principles of the Mental Capacity Act 2005, including the assumption that a patient has capacity unless staff have reason to suspect otherwise, and the duties to act in the patient's best interests, in the least restrictive manner.

- The provider's 'capacity to consent' policy also included a section explaining deprivation of liberty safeguards (DoLS), although ambulance staff would not be involved in any application. This section of the policy ensured ambulance staff had an awareness of DoLS in case they were involved in transporting a patient who was subject to an application.
- We saw records evidencing training on DoLS, consent and mental capacity was provided for all ambulance staff during their induction.
- Ambulance staff demonstrated a good understanding of patient consent and mental capacity. They gave us several examples of patients refusing certain aspects of their care and explained how they managed the situations, respecting the patients' rights. They told us training on capacity to consent formed part of their induction and refresher programmes.
- We saw an HDU ambulance crew providing transport from hospital to a hospice for a patient who had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place. The crew checked the DNACPR paperwork before moving the patient and ensured they had a valid copy with them. They demonstrated good understanding of the procedures needed to manage a DNACPR properly.

Are patient transport services caring?

Compassionate care

- Patients we spoke with told us ambulance staff were kind, considerate, helpful and friendly.
- We saw ambulance crews introducing themselves to patients, and treating patients with care and compassion throughout our inspection.
- While waiting for a discharge letter on a hospital ward, we saw a crew decide to move a patient into a side room to protect their dignity, rather than waiting in public view.
- We saw a member of an ambulance crew waiting inside a hospital with their patient while the other crewmember went outside to unlock and prepare the ambulance, so the patient did not have to wait outside in the cold.
- We also observed an ambulance driver checking a patient was comfortable and warm enough before starting their journey, and offering them a blanket. We saw ambulance crews taking time to assist patients on and off ambulances, without rushing them.
- We saw ambulance staff contacting control to confirm patients' future bookings, and reassuring them everything had been arranged for them.
- Ambulance crews engaged in pleasant, chatty interactions with patients they were transporting, reassuring them and putting them at ease.

Understanding and involvement of patients and those close to them

- Ambulance staff demonstrated a willingness to involve relatives in patient care. For example, we saw an ambulance crew waiting for a relative to return from taking a patient's luggage to their car, to allow them to travel with the patient. The crew explained to the relative where they would be, and reassured them they would not leave without them.
- We saw one ambulance driver asking a patient about the best route to take to their home, and involving them in the decision based on their local knowledge.

Emotional support

- One patient told us the ambulance staff put their mind at ease, and "took the worry out of their hands". The patient said they often became worked up on the way to hospital and the ambulance staff always chatted to them and calmed them down.
- Another patient told us they had received bad news while in hospital and became very upset. They said a member of staff from the provider had noticed and had looked after them until they were settled again.

Patient transport services (PTS)

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

Service planning and delivery to meet the needs of local people

- The provider was contracted by local clinical commissioning groups to provide all patient journeys for patients registered with GP surgeries in the county of Shropshire, and inter-hospital transfers between hospitals in the county. The contract also included a contingency for patients in Shropshire who needed transport, but who were not registered with a Shropshire GP surgery.
- The contract required the provider to supply an NHS-funded transport service to patients who met the medical eligibility criteria set down by the Department of Health. The provider reported details of booking trends, activity by location and clinic, eligibility assessments, mileages and 'exceptions' (incidents where patients waited longer than the time specified in each contract) to their commissioners each month. This allowed the commissioners and provider to assess whether the contract was providing an appropriate level of service to patients, and to review it where necessary.
- The provider was also contracted by a charity to provide transport to and from a hospice in Telford.
- The provider had two bariatric ambulances, equipped to transport patients whose weight meant their needs could not be met safely by other vehicles in the fleet.
- The provider employed 'call ahead patient escort staff' (CAPES). CAPES were based at the two main hospitals served by them. They telephoned all patients the day before their booked journeys to confirm the ambulance was still required, to reduce the number of unnecessary ambulance journeys and improve availability. CAPES worked to a standard flowchart on each call they made, ensuring they confirmed all relevant information for each patient journey.

Meeting people's individual needs

- The provider had recently arranged for staff to have access to a telephone translation service, for situations when they were caring for patients who did not speak or understand English. We saw posters on station notice boards and information on all ambulances informing staff of the service and how it could be accessed.
- Ambulance staff told us they had training on looking after patients living with dementia. They said they sometimes transported patients living with dementia on single-crewed ambulance cars but would risk assess each journey to ensure the patient was safe to travel in that vehicle. They told us they discussed each patient with staff or family, depending on where they were travelling from. If there was any doubt that the patient could be kept safe in a single-crewed vehicle they would contact control and request a double-crewed ambulance.
- Ambulance staff demonstrated an awareness of patients living with learning disabilities. They told us, where necessary, the control room staff accepted bookings for carers to travel with patients, to minimise their distress.

Access and flow

- Control room staff at Shrewsbury had a goal of answering all external telephone calls within three rings. If calls were not answered within 45 seconds, they were diverted to another control room elsewhere in the country. We saw call answering records which showed between November 2016 and January 2017, the Shrewsbury control room had received 35,748 incoming telephone calls. Almost 100% of those calls had been answered within the 45 second target; 185 had either exceeded 45 seconds ringing before being answered, or had not been answered before the caller hung up.
- The control room at Shrewsbury was open from 8am to 8pm, Monday to Friday. Outside those hours all calls were handled by the control room at the parent company's head office in London.
- Ambulance staff told us they experienced problems when the local control room was closed and their calls were handled by the national control room in London. They told us it frequently took a very long time for the national control room to answer their calls, and they had mixed instructions from the two control rooms during the morning and evening handover periods. Ambulance staff told us the conflicts in instructions and the delays in being able to get through to the national control room sometimes meant patient were left waiting

longer than they should have been, although no specific incidents had been reported.. Control staff told us they felt the national control room staff did not understand the challenges faced in the Shropshire locality.

- Patients told us the provider always telephoned to let them know if their transport was delayed.
- CAPES also provided support for ambulance drivers on arrival at hospital. They assisted with moving patients off ambulances and, when necessary, helped patients to get to the appropriate hospital department. This reduced the amount of time drivers were committed at hospital and meant they were available for further patient transport journeys sooner.
- CAPES were trained to work on ambulances, so were able to form part of an ambulance crew if needed, to escort patients home.
- We were shown a list of outstanding patient journeys on one ambulance driver's data terminal, which included several patients who had been waiting longer than two hours for their transport home from hospital. We spoke with ambulance staff who told us this was a common situation from mid-afternoon onwards most days, and said they were often late taking their mealbreaks to help clear the backlog. The provider gave us data showing from July 2016 to January 2017, on average 1.3% of their patients waited longer than two hours for collection.
- The provider had produced a leaflet titled "Non-Emergency Patient Transport Service in Shropshire, Telford and Wrekin", for people who enquired about PTS transport. The leaflet explained the qualification criteria for transport, and gave contact details for MSL, local councils who also provided transport, NHS England's 'help with medical costs' service and the two clinical commissioning groups covering Shropshire.

Learning from complaints and concerns

- We saw notices on ambulances headed 'We value your feedback', giving details on how to make complaints or pass on compliments. We were given a copy of a leaflet telling patients and their representatives how to make a complaint or raise concerns about the provider. The leaflet explained the options available to people who used the provider's service, and gave a telephone number, email address and postal address for the provider's patient experience team. However, we did not see the leaflets were available on the provider's patient transport and HDU ambulances.
- A senior manager told us they received, on average, 20 complaints each month about the provider's Shrewsbury location. We were given records which showed the provider had received 11 complaints per month, on average, from February to September 2016.
- Records showed a number of different methods of learning from complaints. For example, where a complaint related to the actions of individual staff members, the staff had individual counselling and notes were added to their personnel files. Where wider issues were identified by investigations, the provider ran additional training sessions for the staff groups involved. We also saw changes in shift patterns and the provider's operating procedures had been made in response to complaints, to reduce the risk of the situations giving rise to the complaints reoccurring.
- We saw anonymised feedback from patients displayed on the HDU garage wall, where staff were able to see it.
- We were given a copy of the first issue of the parent company's national 'patient experience' newsletter, produced for staff in January 2017. The newsletter showed trends in complaints in each of the provider's regions, the three most frequent reasons for complaints, guidance on best practice when logging complaints and contact details for the patient experience team. The three most frequent reasons for complaints were that patients had waited too long for transport, transport had not arrived, and patients had arrived too lat for their appointment.
- We were shown details of 20 recent complaints to the provider. We saw all of them had been investigated and closed, and responses sent to the complainants, within seven weeks of receipt.
- We were given a copy of the provider's national complaints and concerns policy. The policy was comprehensive and included clear processes for receiving, investigating and responding to complaints. However, the policy was overdue for review, bearing a review date of August 2015.

Patient transport services (PTS)

Are patient transport services well-led?

Leadership / culture of service related to this core service

- A station manager was responsible for operational, cleaning and make ready staff at the station, and a second manager supervised the control room. The station manager reported to a regional manager, who was responsible for the Shrewsbury location and two other sites. The control room manager reported to a national control manager based at the parent company's head office, in London. The regional manager and national control manager reported to the parent company's executive team.
- Staff in the control room described the control manager and regional manager as supportive and approachable. They said the national control manager visited the Shrewsbury base at least once each month.
- Control room staff told us the human resources manager was visible, friendly and approachable.
- However, ambulance staff told us, apart from the station manager, they rarely saw any of the provider's senior managers.
- The majority of ambulance staff we spoke with told us they felt the new parent company had imposed changes without any genuine consultation. They told us a consultation process had taken place about changes to their rotas and shift patterns, and they had all been offered one-to-one meetings with managers to discuss their offers, but their opinions had been ignored. They told us local managers had not supported them, and after the consultation period staff had been told they had a choice of accepting the change or being given 30 days' notice to leave.
- However, other ambulance staff told us they were happy with the consultation process and understood the reasons changes to the shift patterns were necessary, to maximise ambulance availability at times of peak demand and reduce waiting times for patients.
- Control room staff told us they were happy, and described the centre as a nice place to work.

Vision and strategy for this this core service

- The provider's parent company's values were 'fast, efficient, helpful, competent, reliable and accessible'. The values had been developed by Falck Danmark A/S before they took over control of Medical Services Limited, and applied to all companies in its group, worldwide.
- Five members of ambulance staff told us the values were a "bone of contention", as they didn't feel senior managers demonstrated these values in their dealings with ambulance crews.
- Ambulance staff told us they felt the parent company's values "didn't apply" to senior managers.
- The parent company's vision was to become the largest emergency provider in Britain. Control staff told us this was displayed on their notice boards and they were aware of it.
- We were shown a presentation of the Falck Medical Services' 'Fit for Fight 2016' strategy, which detailed the company's business strategy following its acquisition of Medical Services Limited in that year. The strategy focused on a number of areas, including cost reduction, transparency and organisational culture, efficient use of resources and IT support.
- The presentation included details of the group's strategy for 2017 to 2022, and listed short, medium and long-term objectives culminating in becoming the provider of choice, recognised industry experts, creating a strong recognition of the Falck brand and expanding into new activity areas. Managers we spoke with demonstrated a sound understanding of the 2016 and 2017 to 2022 strategies.

Governance, risk management and quality measurement

- As well as a national risk register held at corporate level, each of the company's locations held its own risk register, which listed risks common to all locations and those individual to specific sites. We were given a copy of the risk register for the Shrewsbury location, which detailed 24 risks specific to the Shropshire service, together with actions to be taken and a comprehensive quality improvement plan to mitigate the risks. Of the 24 risks, six were initially graded as 'high', 17 as 'medium' and one as 'low'. Following actions to reduce the risks,

three remained graded 'high' and 10 'medium'. The remaining 12 risks had been eliminated by measures the provider had put in place. Local managers were aware of the risk register and its contents.

- The three remaining 'high' risks related to: care of patients at the end of their lives, and of the provider's staff providing this care; confusion around which of the provider's policies and procedures were current and in force; and recruitment to the 16 vacancies carried by the location.
- The parent company held fortnightly conference calls for managers from all of its sites to share and discuss risk information. We were shown minutes of the calls, which evidenced information about operational issues was shared across all of their locations.
- We saw minutes of fortnightly operational risk meetings, during which local managers discussed matters such as human resources, training, complaints, incidents and fleet management.
- The provider's medical director chaired any meetings where clinical input was required.
- The provider had a 'duty of candour' policy, which included an explanation of the duty and its background, what type of incident would trigger it, the process to be followed and the potential consequences of failing to comply with it. The policy had been implemented in December 2016 and circulated to managers to cascade to all staff.
- The provider compiled monthly performance reports for the commissioners of each of its contracts, and monitored the quality of its performance as part of this process.

Public and staff engagement

- Some ambulance staff told us they had very little communication from their managers, and did not have any team meetings. However, we saw minutes of bi-monthly team meetings for ambulance staff groups, which included provider-wide and team-specific matters, safeguarding, incidents and complaints, actions from previous meetings and feedback from staff to be raised with senior managers.
- Ambulance staff told us they were supposed to have one-to-one meetings with their managers every two months, but these rarely took place. The provider told us bi-monthly one-to-one meetings were not part of their management process at the time of our inspection, however staff did not appear to be aware of this.
- Staff told us they received the provider's parent group's staff magazine every two months.
- Control room staff told us their manager had kept them informed about recent changes that had taken place, through regular emails.
- The provider had not carried out a staff survey in 2016, following the takeover by the Falck group and a decision to align itself to Falck's global policy of conducting staff surveys every two years.
- The provider conducted patient experience surveys twice a year, on one day in January and one in July. In these surveys, patients were asked 18 questions about areas of their journey, such as how they were looked after by the provider's staff, how quickly they were collected, how well the provider communicated with them, how they found the booking process and how comfortable they found their journey.

Innovation, improvement and sustainability

- At its Shrewsbury base, the provider was going through a period of restructuring its ambulance crews shift patterns to better match times of peak demand.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure it has a robust policy and procedure to ensure its staff do not attend work when potentially infectious, particularly for at least 48 hours following an episode of diarrhoea or vomiting.

Action the provider SHOULD take to improve

- The provider should review arrangements for staff decontamination following incidents on ambulances, and storage of spare uniform at the premises.
- The provider should assess the current staff rest and dining area for suitability and consider providing an area that can be maintained at a comfortable temperature during cold weather, and is segregated from ambulance parking bays.
- The provider should review its complaints and concerns policy to ensure it is up-to-date.
- The provider should audit and formalise its PTS ambulance cleaning procedures.
- The provider should ensure clinical waste bags are labelled in accordance with paragraph 5.25 of the Department of Health's Health Technical Memorandum 07-01: Safe management of healthcare waste.
- The provider should ensure staff consistently receive feedback when they report incidents.

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 Care and treatment must be provided in a safe way for service users. The registered person must do all that is reasonably practicable to mitigate any risks to the health and safety of service users of receiving care or treatment; and the registered person must assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. The provider did not have a policy in place to ensure staff did not attend work for 48 hours after being unwell with diarrhoea and vomiting, in line with NHS guidance on preventing the spread of gastroenteritis. Regulations 12 (1), 12(2)(b), 12(2)(h)