Met Medical Ltd

Met Medical Ltd

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 known to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Met Medical Ltd is an independent ambulance service. The service provides patient transport services to private patients and some NHS healthcare providers, mainly in Hertfordshire and surrounding areas.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 March 2018, along with an unannounced visit to the service on 03 April 2018.

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 issues that the service provider needs to improve:

- The provider did not have effective systems and processes in place for recording controlled drugs in line with the Misuse of Drugs Regulations 2001. The systems that were in place were not being followed. This was escalated to external agencies following our inspection.
- The provider did not have robust processes in place to monitor and assess patient outcomes and the quality of the service.
- The provider did not have a clear policy and governance process in place to support the identifying, recording, reporting and investigating of all incidents. Not all incidents had been reported or discussed.
- The provider did not have a documented patient eligibility criteria and exclusion criteria in place for the transportation of patients. There was also no formally documented criteria for which skill mix of staff were required for different types of patients.
- The provider did not have robust governance processes in place to support the identifying, recording and management of risks to patients, staff and the service. Not all risks had been identified and some risks had not been recorded or acted upon.
- The provider did not have effective systems and processes in place to develop and review policies. Not all policies were reflective of the service and not all policies were adhered to.
- The provider could not be assured staff had the appropriate level of life support training for adults and children. Systems and processes were not in place to collect and monitor this information.

However, we found the following areas of good practice:

- Patient records had detailed risk assessments and were legible. Patient records were stored securely.
- Most staff had completed mandatory training. There was evidence of an induction process for new staff.
- Effective safeguarding adults and children procedures were in place and were understood by staff.
- Audits were undertaken in relation to medicines and infection prevention and control.
- Patient care was observed to be kind and compassionate. Patient feedback was positive.

Summary of findings

- A fire safety risk assessment had been completed.
- The service had received no formal complaints from March 2017 to February 2018.

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. We issued the provider with two requirement notices that affected patient transport services. Details are at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		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.

Met Medical Ltd

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Detailed findings

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Background to Met Medical Ltd

Met Medical Ltd opened in 2016. It is an independent ambulance service in St Albans, Hertfordshire. It has nine vehicles: four ambulances and five ambulance cars and often hires additional vehicles from an external ambulance hire company. The service provides patient transport services to private patients and some NHS healthcare providers, mainly in Hertfordshire and surrounding areas. Additionally, first aid and ambulances are provided for events and film/TV studios, on both a regular and occasional basis as well as occasional repatriation. Services were provided by emergency care assistants, technicians and registered paramedics.

The service has had a registered manager in post since 2016. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is managed.

This inspection was Met Medical LTDs first CQC inspection. There had been no previous inspection activity undertaken for this provider.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in NHS and private ambulance providers. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspections.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Met Medical Ltd is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC regulates the patient transport services provided by Met Medical Ltd. It is unclear what percentage of the business this makes up as this was not monitored by the provider at the time of the inspection. The other services provided are not regulated by CQC as they do not fall into the CQC scope of regulation. The areas of Met Medical Ltd that are not regulated are attendance at sports, training and television/film events.

The service is registered to provide the following regulated activities:

- Transport services
- Treatment of disease, disorder or injury

Met Medical Ltd provides a range of transport services for patients to and from independent, private and NHS facilities. This includes the transportation of patients who use wheelchairs or require transportation on a stretcher. Journeys include inpatient admissions, outpatients' appointments, non-urgent transfers between hospitals and discharges from hospital. A repatriation service is also provided from airports throughout the country.

During the inspection, we visited Met Medical Ltd ambulance base. We spoke with 11 staff including; registered paramedics, technicians, and management. We spoke with one patient. During our inspection, we reviewed seven sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service had never been inspected before.

Activity (March 2017 to February 2018)

In the reporting period March 2017 to February 2018 there were 703 patient transport journeys undertaken. This included one child. 96% of these journeys were undertaken from October 2017 to February 2018.

One registered paramedic, and one student paramedic (also a qualified ambulance technician) worked at the service, which also had a large bank of 92 temporary staff that it could use.

Track record on safety

- There had been no reported never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There had been two reported clinical incidents.
- There had been no reported serious injuries.
- There had been no reported complaints.

Patient transport services (PTS)

Summary of findings

Met Medical Ltd is an independent ambulance service. The service provides patient transport services to private patients and some NHS healthcare providers, mainly in Hertfordshire and surrounding areas. One registered paramedic, and one student paramedic (also a qualified ambulance technician) worked at the service with a substantive support team. There was a bank of 92 temporary staff that the service routinely used. The service has nine vehicles: four ambulances and five ambulance cars and often hires additional vehicles from an external ambulance hire company.

Systems and processes for managing and recording controlled drugs were not followed. There was no written patient eligibility criteria or exclusion criteria for transportation of patients. Patient outcomes and service activity was not monitored or analysed. There was no deteriorating patient policy or incident reporting policy in place at the time of our inspection. There was no evidence that staff had the appropriate level of life support training for adults or children. Governance arrangements for reviewing and developing policies were not robust and not all risks had been identified or acted upon.

Service leaders did not take the appropriate action to address all of the concerns raised during the inspection. This was escalated to external agencies following our inspection.

Are patient transport services safe?

Incidents

- There was no incident reporting policy in place. There was a process in place to report and respond appropriately to incidents. All staff we spoke with were aware of the process. The incident reporting system was paper based. On completion of an incident report form, the form was logged electronically. Incident forms contained details of the incident and the immediate action taken. The registered manager reviewed each form and action taken to investigate every incident. A record of any learning and actions taken was added to the incident report form. These were shared with staff via a private social media page and newsletters. There had been six incidents reported from March 2017 to February 2018. We reviewed the six incidents reported, which included the fire brigade being called out despite there being no fire and verbal abuse towards staff members. We saw that staff were included in the investigations and verbal abuse towards staff members was discussed with other service providers when necessary. No serious incidents, or incidents that resulted in harm had been reported.
- Not all incidents were discussed in clinical governance meetings. Following our inspection and on review of clinical governance meeting minutes from August 2017, the minutes showed there had been two clinical incidents but stated these would be discussed at the next meeting. We saw no evidence of this in the subsequent meeting minutes. Both clinical incidents had not been shared during our inspection and there were no incident forms stored in relation to clinical incidents at the time of our inspection. This meant that not all incident report forms were being stored appropriately. There was a risk that the registered manager had lost sight of some incidents, therefore there was a missed opportunity to identify trend, lessons learned from incidents and sharing of information with staff.
- Most staff understood their responsibilities to raise concerns and record safety incidents and near misses. However, not all incidents had been reported. For

example, there were two occasions whereby the on-call phone had not been answered. This had not been reported as an incident. No patient safety incidents had been reported.

- There had been no reported never events from March 2017 to February 2018. A never event is a , patient safety incident that has the Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The registered manager and the operations manager told us they were responsible for investigating incidents however this was not formally documented anywhere as there was no incident reporting policy.
- The service had a system for managing safety alerts and these were reviewed, acted upon and closed appropriately.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The provider had a duty of candour policy in place, which described their responsibilities under the duty of candour legislation. Staff had an awareness of the requirements of duty of candour. Staff received training on duty of candour during their induction. We did not see any incidents reported that had required application of duty of candour.

Mandatory training

- The service provided mandatory training to staff and had systems in place to monitor staff's compliance with mandatory training.
- There were 39 mandatory training modules. Most were completed online and included adult and children safeguarding, Mental Capacity Act 2005, basic life support, conflict resolution, infection control, manual handling, privacy and dignity, consent, dementia awareness, information governance and privacy and dignity.
- A robust programme of mandatory training was in place for all staff. This included face-to-face training and e-learning, which was accessed on the internet. Staff could access online training on the computers in the ambulance station and from home.
- Staff maintained a database that ensured compliance with mandatory training. The management team told us they took this seriously. We saw evidence that staff who were not up to date with mandatory training and new staff who had not yet completed the required training were not allowed to work for the service until they had done so.
- The data on compliance with mandatory training as of March 2018 showed 100% compliance for all substantive staff and 76% compliance for bank staff.
- The service maintained a record of staff induction training and we saw all staff had had an induction recorded.
- All staff with driving responsibilities had completed the necessary training. A copy of their driving qualification and license was stored in their staff file. A mandatory driving assessment was completed for each member of staff. This was the responsibility of the operations manager. There was a risk-based approach in place for reassessing staff.

Safeguarding

- There were systems, processes and practices in place to protect adults, children and young people from avoidable harm.
- The safeguarding policies for both adults and children, dated February 2018, was accessible online and outlined what safeguarding was, its importance, identified adults and children at risk and provided definitions of types of abuse. The policy provided a flow chart to advise staff of immediate actions to take to raise a safeguarding alert.
- The registered manager was the appointed safeguarding lead for vulnerable adults and children. They had been trained to level three. This did not meet national guidance. National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that named health professionals in ambulance organisations should be trained to level four. There were also no arrangements in place for the

provider or the registered manager to seek advice from a safeguarding lead from another external organisation. We raised this with the registered manager. Evidence was provided following our inspection which showed the registered manager and the operations manager had booked places on a safeguarding children training level four course in May 2018.

- All substantive staff and 86% of bank staff had received level three safeguarding training for children and adults. National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that all ambulance staff including non-clinical staff should be trained to level two safeguarding children and paramedics working with children, young people and/or their parents/cares should be trained to level three. The training records we reviewed supported this.
- Staff were knowledgeable about what constituted adult or child abuse and knew how to report any concerns. We saw evidence where staff had made a safeguarding referral when they were concerned for their safety and emotional wellbeing as result of their condition.
- All staff we spoke with were aware of what to report and how to make a safeguarding referral when required. Staff we spoke with were knowledgeable about the processes for recognising and referring a safeguarding concern. We reviewed two safeguarding referrals made to the local authority by the registered manager following staff raising concerns about a patient.
- There was no standard operating procedure for the transport of patients under the age of 18.
- Disclosure and barring service (DBS) checks were carried out for all staff. The service had a policy and checklist to complete to ensure staff had up to date DBS certificates on file. The registered manager and HR administrator told us there were plans to review DBS checks every three years however this had not yet been implemented. Some staff had provided DBS certificates from 2013 and 2014.
- Female Genital Mutilation (FGM) was included in safeguarding training, which all substantive staff and 84% of bank staff had completed. Staff were aware that they have a mandatory reporting duty to report any cases of FGM.
- The company had recently introduced Prevent duty e-learning training as a mandatory training. Prevent duty training is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways to prevent people from being drawn into terrorism. Evidence provided showed that all staff including bank staff had completed the e-learning module.
- There was no formal protocol in place for safeguarding referrals in the event of work that was undertaken on behalf of other NHS providers however we saw evidence that safeguarding referrals made by the service had been discussed with the NHS provider that the patient had been transported to and from.

Cleanliness, infection control and hygiene

- The service had systems in place to maintain cleanliness of vehicles and equipment. At the time of our inspection equipment and the premises were visibly clean.
- We observed that hand sanitising gel dispensers were fitted in each of the vehicles we inspected and that each container had been replenished. We observed staff using sanitising gels during our inspection. We also observed staff using the gel before and after patient contact.
- We looked at six vehicles and they were visibly clean and tidy with the exception of one vehicle having visibly dirty cupboards despite records showing it had been deep cleaned the day before. Ambulance interior surfaces and equipment were visibly clean. However, no records of daily checks had been completed.
- Two of the ambulance vehicles had a ripped seat and a ripped trolley which was an infection prevention and control risk to patients. This had not been identified as a concern by the provider or recorded as an issue on the fleet management system. We raised this with the provider who took action to mitigate the risk by appropriately covering up the tears. We saw evidence of this during our unannounced inspection.
- Personal protective equipment (PPE), such as disposable gloves in a range of sizes, was available for staff to ensure their safety and reduce the risk of cross contamination. PPE was stocked on all vehicles, with additional supplies stored in an equipment storage cupboard in the office area. However, we found that

aprons and goggles were stored in unidentifiable boxes and were inconsistently stored on each vehicle. This meant they were not easy to find and not readily available to staff who were not familiar with the vehicles. This also meant that in the event of spillage, staff would not have PPE readily available to reduce the risk of contamination. We reviewed this during our unannounced inspection and found cupboards containing PPE had been labelled and were stored in the same cupboard on each vehicle.

- The service provided appropriate waste disposal systems, which included domestic waste, clinical waste and sharps bins. Clinical waste bins were available in vehicles we inspected.
- Sharps bins were readily available in ambulance vehicles and in grab bags used by paramedics. However, we found the date assembled was not completed in three out of six sharps bins we looked at. The World Health Organisation recommends that the person assembling the container should put the date of assembly, their name and signature on the container in permanent ink as well as the precise location of the container. We reviewed this during our unannounced inspection and found action had been taken to ensure sharps bins had been dated.
- There were colour-coded bins in place for both general and clinical waste. Clinical waste was stored on site at the ambulance station, and was collected at prearranged times when necessary. The clinical waste bin was locked. This meant clinical waste could not be removed from the bin and therefore did not present a health and safety risk.
- During our inspection, a sharps bin was stored next to four bottles of drinking water in one of the vehicles. There was a risk of contamination. We raised this with staff who immediately removed the sharps bin and the bottles of water from the vehicle. There was an additional sharps bin on the ambulance which was fixed in to place.
- Spillage wipes were available in all vehicles we looked at. Staff we spoke with knew the process of decontamination following transportation of patients with suspected communicable diseases.
- Heavily soiled linen was placed in soluble bags and double bagged in red bags. There was a laundry drop box in place for sheets and blankets used for private patients. These were sent to a private laundrette for washing and were sent back clean in sealed bags.
- For NHS patients, crews could obtain clean linen such as sheets and blankets from the hospital that the patient was being transported from.
- During our inspection, we observed good compliance with uniforms being worn in a clinical setting, including operational staff adhering to the 'arms bare below the elbows' principle for infection control purposes.
- Staff washed their uniforms at home. We reviewed the infection prevention and control policy, which stated that staff are responsible for the daily laundry of their uniforms.
- Deep cleaning took place monthly and was delivered by the fleet manager. We reviewed the vehicles deep clean history for February and March 2018. The service did not carry out any formal checks following deep cleans therefore the registered manager could not be assured deep cleans had taken place to the required standard. Staff acknowledged this as an area for improvement. During our unannounced inspection, the provider had purchased a swabbing machine and there were plans in place to use this to monitor the quality of deep cleaning going forward.
- Infection prevention and control audits were undertaken quarterly. We reviewed audits undertaken in October 2017 and January 2018 which both showed 100% compliance. Infection prevention was discussed at clinical governance meetings and minutes showed staff were provided with copies of audits and action plans. We requested to see the action plans following audits on inspection, however these were not provided.

Environment and equipment

- The service had systems in place to ensure the safety and maintenance of equipment. The maintenance and use of most equipment meant that there was always safe, ready to use, equipment for the vehicles.
- The station was secure. Access to the site was via an identification 'swipe card' and an individual pin number

was also required. This meant if a card was found by an unauthorised person, they could not gain access. All visitors were escorted onto and off the site. CCTV was also in operation.

- Staff kept vehicle keys in a key safe with a digital lock, inside the ambulance station. The resource centre we visited had keypads on external doors to restrict unauthorised access.
- The service had a robust system in place to ensure all vehicles were maintained and serviced appropriately and in a timely manner. For example, the fleet manager maintained a central log that included details: of each vehicle, make, model, registration, last service mileage, details of the next service due mileage and current mileage. The update of the actual mileage attuned the mileage to the next service. The central log also included details on the MOT, service history and tax due dates. Evidence seen at the time of our inspection showed all vehicles had been serviced and maintained. This was in line with manufacturer's recommendation and national guidelines.
- The service was compliant with Ministry of Transport (MOT) testing and servicing of the vehicles. We reviewed the vehicle management system which was comprehensive and monitored when each vehicle was next due for servicing, tax and MOT. All 13 vehicles had appropriate service, MOT, and insurance arrangements in place. This included the four hired vehicles. All keys were kept securely within the property.
- Medical equipment was stored and ready for use. Clinical staff checked the medical equipment. This ensured the equipment was working and whether additional equipment was needed.
- The 'kit bags' were reviewed and checked on a monthly basis. If equipment had been used, staff completed a form to show what had been used which meant the fleet manager could replace the items in the kit bag. Senior staff told us kit bags were opened, checked and re-sealed monthly to make sure all equipment was in place and consumables were in date. All equipment and medical supplies seen were fit for use. Appropriate storage facilities were available and secure. Equipment not fit for use had 'do not use' labels on them.
- A system was in place for the management of faulty equipment. If a piece of equipment was identified as being faulty, it was removed from use and documented on a record sheet. Arrangements were made to fix the fault so it could be returned as swiftly as possible. The service had back up equipment to use whilst items being fixed.

Medicines

- The registered manager was responsible for the provision and ordering of medicines. The operations manager took responsibility for the safe management of the storage of medicines.
- Medicines were stored in a central locker system, the keys for these lockers were only available to staff who were able to utilise the medication.
- Routine stock checks and tags were in place to ensure safe storage of medicines.
- Both paramedics and technicians had 'grab bags'. The medication bags were signed out by the person taking control of the medication, and signed back in at the end of their duty. At the time of inspection, we saw documented evidence that medication was logged out on a record sheet.
- 'Grab bags for technicians contained laminated crib sheets which showed all medicines in the bags including the presentation, indications, actions and contra-indications. Staff told us this was suggested by a new technician and worked well for staff who were new in post.
- The service did not store controlled drugs (CDs) (which are medicines that require an extra level of safekeeping and handling) as it was not registered with the home office to store CDs. Paramedics carried their own CDs which were sourced through a pharmacy. Staff said they would record the batch number and expiry date on the patient transfer form.
- During our inspection, we found a CD book in a locked cupboard in one of the ambulance vehicles. A senior member of staff had signed in two morphine sulphate 10mg/ml injections (an opioid drug used to treat moderate to severe pain) in June 2017. These medicines were not available at the time of our inspection. They had not been reconciled and there was no evidence of when and how it was administered. This was not in line with the provider's CD interim policy or best practice guidance. We raised this with the registered manager

and requested an explanation of where the medicines were. The response received following the inspection did not address the concerns raised in relation to missing CDs. The provider told us that the CD book found in the ambulance was in place as part of a trial in 2017 so that paramedics could note all drugs administered on each shift. The provider told us the CD book left on the ambulance was an oversight. Therefore, we were not assured that the provider had effective systems and processes in place for recording controlled drugs in accordance with the Misuse of Drugs Regulations 2001.

- The service stored opioid overdose reversal medicines in paramedic's 'grab bags'. Staff said they had not been required to administer Naloxone and would complete an incident form if Naloxone was administered to a patient.
- There was a specific cupboard for storing medications. This cupboard was kept locked. The room temperature was checked daily and all were within acceptable limits below 25 degrees centigrade as per World Health Organisation guidelines. However, we found staff monitored the room temperatures but did not know what the minimum or maximum room temperature should be. We raised this with the registered manager and the operations manager who acknowledged this was an issue and said this would be addressed. During our unannounced inspection, we found maximum and minimum storage temperatures had been obtained for each medicine stored and was being monitored.
- Intravenous medicines, such as, paracetamol (for moderate pain), glucose (used to treat low blood sugar), Sodium chloride (used to replenish with dehydration and other medical conditions that require additional fluids) were available and staff said these could only be administered by registered paramedics.
- Staff also stored oral antibiotics. We were told that these medicines were for doctors' use only and were rarely administered to patients however the service had no doctors on the bank. We raised this as a concern. Information received following our inspection stated that the service stored these medicines for when the service recruited doctors on a consultancy-only basis.
- We looked at three paramedic 'grab bags' and three 'grab bags' for technicians. Medications used by technicians included inhalers (for difficulty in breathing), and analgesia.
- We found tranexamic acid stored in paramedic 'grab bags'. Tranexamic acid is a medicine used to treat or prevent excessive blood loss from major trauma, nose bleeds, and heavy menstruation. These medicines can be administered by paramedics but require authorisation from a prescriber in the form of an appropriate clinician or following patient group directions (PGDs). PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. However, the service did not use PGDs. We raised the safe prescribing and administration of this medication with the provider. Following our inspection, the provider said tranexamic acid was carried by paramedics to be used when prescribed by doctors. This meant that paramedics had access to medicines they were not authorised to administer however the medicines were only being administered when they had been authorised by an appropriate clinician. A standard operating procedure was developed following our inspection which states tranexamic acid may only be administered under the authority of a prescriber.
- There was an alert system in place for the replacement of damaged or used medicines. Each 'grab bag' contained a list of medicines in the bag including the expiry dates. Staff disposed expired medicines through a local pharmacy.
- The service had sealed obstetrics (child birth) bags in place which were designed for use in child birth. The sealed bags included nappies, gloves, aprons and umbilical cord clamps in preparation for obstetric emergencies.
- A medical gases supplier provided oxygen and nitrous oxide (a medical analgesic gas) in cylinders. We saw cylinders were stored in a locked cage in a well-ventilated area as recommended by the British Compressed Gases Association. There was clear signage in place to differentiate between used and empty cylinders and the two were not stored together.

- Staff said patients and their relatives were solely responsible for their own discharge medicines from the hospital.
- Monthly medicines audits were undertaken but did not include CD audits on paramedics' own medicines. From July 2017 to February 2018, audit results showed an average of 97% compliance. Areas for improvement were identified through the audit such as storing of medicines on vehicles overnight.

Records

- Each ambulance vehicle had a patient report form which was a record of pick up and drop off times. We looked at 7 patient record forms and medicine charts and saw that they were accurate, complete, legible, and up to date. The service audited the completion of the forms. We requested a copy of the audit results during our inspection however these were not provided. This meant we could not be assured that all issues with record keeping were identified or actioned.
- Patient information was recorded on paper templates, which were temporarily stored securely in locked cupboards at the service address after use. These were then scanned onto a computer and encrypted. Paper records were shredded once scanned. Electronic patient records were only accessible to the registered manager and the operations manager.
- Planned and in-progress patient journeys were displayed electronically on a screen. This was visible to all staff members at the station.
- The service had an appropriate system in place for the confidential storage of electronic staff records. Staff records were only accessible to the registered manager, the operations manager and the human resources assistant.
- Ambulance staff we spoke with were aware of special notes. Special notes were documented on the patient record forms and included relevant information about patients' do not attempt cardiac pulmonary resuscitation (DNACPR) status and mental health needs.

Assessing and responding to patient risk

- There was no written criteria or exclusion criteria for transportation of patients. Staff were aware of their responsibility to assess and respond to patient risk. For example, we looked at seven patient records and saw ambulance crews recorded patient observations and any treatments provided during transfers and shared this information with staff on arrival at the destination.
- There were also no formally documented criteria for which skill mix of staff were required for different types of patients. There was a risk that staff may transport patients that should be excluded as there was no documented exclusion criteria. The registered manager confirmed exclusions were patients with complex mental health needs and babies weighing less than four and half kilograms.
- When working with NHS trusts, the service was not given clear information on the clinical condition and acuity of the patients they would be transporting in advance as this was not known prior to the day. Skill mixes of staff were provided to the NHS trust and the trust decided which patients were suitable for the staff to transport. We could not be assured that skill mixes were suitable at all times for the type of patients being transported. We raised this with the management team during inspection who told us staff completed a risk assessment when they arrived at the pick-up location. Staff contacted the on-call manager if they felt it was unsafe for them to transport the patient or if they felt they did not have the skills to care for the patient during transport.
- The registered manager could not provide evidence that staff had the appropriate level of life support training such as intermediate and advanced life support training. Therefore, we were unsure if staff had the relevant skills and knowledge to deal with emergencies and deteriorating patients.
- The operations manager confirmed that staff did not have training in paediatric life support despite the service transporting children. One child had been transported in the time period from March 2017 to February 2018 and children are not excluded from using the service. This meant there was a risk that staff did not have the appropriate paediatric life support training to respond to a child if their condition deteriorated.
- There was no deteriorating patient policy in place at the time of inspection. Following our inspection, we saw evidence that a deteriorating patient policy had been developed dated May 2018. There was an out of hospital

cardiac arrest policy, stroke policy and coronary syndrome policy which covered the assessment and management of said patients. Staff we spoke with were knowledgeable about what they would do in the event that a patient deteriorated whilst being transported. Staff were able to locate the policies on the intranet.

- Not all staff had the skills to stabilise a patient if a patient deteriorated. If patients deteriorated during transportation, depending on the skill mix of the crew and the level of training received, staff were able to provide emergency support and stabilise a patient as required and would either call emergency services for back up, or transfer to the nearest acute hospital. All staff on the ambulances had been trained to ambulance technician or emergency care assistant level as a minimum, which gave them the initial skills to notice if a patient was deteriorating, and when to call emergency services for help. However, this process was learnt during induction and was not formally documented as there was no deteriorating patient policy in place at the time of our inspection.
- Staff were informed of active 'do not attempt cardiopulmonary resuscitation' orders (DNACPR) prior to a planned transfer. On any occasion where DNACPR had not been discussed prior to transfer, it was the responsibility of the crew members to request the patients DNACPR status and associated documents. During our inspection we observed a handover between hospital staff and ambulance staff. DNACPR information was not requested or discussed by ambulance staff. This was not in line with the Met Medical Ltd DNACPR policy which states the crew should ensure they receive the information and paperwork at the point of patient handover. The policy also states that during handover the crew should establish if the patient is for resuscitation.
- Staff completed risk assessments for all planned activities. This included a risk assessment of the patient's conditions, their location, and access to the building. Staffing was also risk assessed to ensure that staffing numbers and abilities were appropriate to the needs of the patient. We observed a crew member risk assessed a patient's home on arrival to ensure it was safe and met the patient's needs when transporting them from hospital to their home.
- The service had a transfer of patient's policy. This included communication between the service and the planned destination and documentation. Alert calls were made to the hospital, as per the Joint Royal Colleges of Ambulance Liaison Committee guidelines and included the patients' age, sex, and a brief description of injury.
- There was an on-call paramedic and manager at all times. Staff had access to clinical support via the on-call paramedic and advice about logistical issues via the on-call manager. Two members of staff reported the on-call phone was not always answered. We raised this with the registered manager and the operations manager who told us this had only happened on two occasions and the staff members were contacted back immediately. This had not been reported as an incident.
- Staff had received training in conflict resolution. Staff we spoke with said they knew what steps to take if faced with an aggressive or violent patient. Staff told us they had never experienced a violent patient but they had been subject to verbal abuse by other healthcare professionals that were not employed by Met Medical Ltd. They told us their priority was patient and staff safety when in a challenging situation. We saw evidence that episodes of verbal abuse and conflict had been reported as an incident and investigated.

Staffing

- Staffing levels and skill mix were planned, reviewed, and risk assessed for planned activity including patient transport services. However, skill mixes were not always planned in advanced for short notice transport services such as NHS work. The NHS provider were informed of the skill mix on the day and the NHS provider decided which patients were suitable to be transported according to the skills of the staff available.
- The service employed eight substantive members of staff. The service had a bank of 92 staff members. The bank was made up of 60 student paramedics who were employed as ambulance technicians, 17 registered paramedics, 12 ambulance technicians and three emergency care assistants.
- Substantive and bank staff were both required to complete the induction programme and mandatory

training. Staff were inducted by the operations manager who had developed a detailed and robust induction programme. Staff told us the induction provided was informative and clear.

- The service used an electronic scheduling system where staff could input their availability. They would then be assigned shifts according to their availability and business requirements. This was usually done six weeks in advance where the service had planned activity already booked in.
- Managers often posted requests for unfilled shifts on a private social media page which staff had access to. In the event that a shift was not filled, the members of the management team would fill it. We saw evidence that this had happened once in March 2018.
- Staff were given adequate breaks. Staff alternated driving duties every three to four hours on long journeys. Staff working 10 to 12-hour shifts received a break of 30 minutes to one hour. Staff told us they sometimes took downtime between patient journeys to use toilet facilities and get refreshments.

Anticipated resource and capacity risks

- A standby crew was available daily for any last minute or ad-hoc transport requests. They were also available to provide support to other crews and cover for sickness or staff cancellations should it be required.
- The service understood and managed foreseeable risks such as adverse weather. We saw evidence that during snowfall staff were contacted and told to leave extra time for their journeys to work. Managers obtained temporary four by four vehicles which increased patient and staff safety during adverse weather. Large amounts of grit and shovels were located on the premises.
- Potential capacity risks were taken into account when planning services. Seasonal fluctuation in demand was recognised by the management team. This included a higher number of event bookings in the summer and the need of NHS hospitals and their patients during winter months. This was addressed by making more shifts available on the scheduling tool, forewarning staff that extra resources would be required, and an ongoing recruitment drive.
- Planned changes to safety was assessed and implemented. For example, managers told us they felt some of the ambulances were worn. Four new ambulances were on order at the time of our inspection. On the day of our inspection a new bariatric stretcher had been serviced and fitted.
- Managers also told us the monitoring of safety was key to service developments and therefore a new head of operations who had experience in monitoring safety and performance had been recruited but was not yet in post.

Response to major incidents

- There was no major incident policy in place. The management team told us they had plans to fund a major incident awareness session and exercise.
- There had been no major incident training exercises or rehearsals and not all staff knew what to do in the event of a major incident despite each vehicle containing major incident flash cards.
- Plans to respond to incidents at an event were documented on the event plan however this did not cover major incidents.
- There was a business continuity plan was in place however this was not dated. The plan had not been reviewed or exercised. This was not in line with the business continuity plan. The specific roles documented in the report were different to those that the provider currently had in place. For example, the service didn't employ local security personnel and the regional technical manager.

Are patient transport services effective?

Evidence-based care and treatment

- All staff employed by the provider had pre-employment checks, references and training/skills assessments records to ensure that they were competent and suitable for their particular role.
- Staff had access to policies and procedures in paper copies at the station, and by logging on to the online staff intranet portal. Staff also had access to the intranet at home. We reviewed documents that demonstrated staff had received a comprehensive induction to ensure they had appropriate training and awareness of policies and procedures. However, there was no formal process

for ensuring staff had read and understood the policies. In addition, not all policies required had been developed and some did not include the relevant information.

- The service did not have a comprehensive local audit schedule, although there were some audits around infection prevention, completion of patient record forms and medicines.
- All staff were familiar with and knowledgeable about the Joint Royal Colleges Ambulance Committee (JRCALC) guidance.
- National Institute for Health and Care Excellence (NICE) guidelines were followed for sepsis and the management of the deteriorating patient.

Assessment and planning of care

- For pre-booked activity, staff were made aware of patients' conditions, journey details and any additional information, through information provided at the time of bookings. Met Medical planned transport accordingly, for example by ensuring they had the appropriate equipment with them to meet the needs of the patient, or by requesting a registered paramedic to carry out patient journeys if a patient had higher dependency needs. The patient notes also made crews aware of any protection plan in place.
- Skill mix of staff was not adjusted for journeys that were not booked and planned in advance due to the bookings made at late notice. For example, patient transport for NHS providers. There were no service level agreements in place with NHS providers or clinical commissioning groups. This meant there were no formally agreed criteria of which patients Met Medical staff were transporting to and from hospitals and they were not always informed of their needs in advance.
- Staff identified patients by confirming their full name, home address and destination address to ensure they had the right details and were going to the correct destination.
- Patients' nutrition and hydration needs were considered and there were some arrangements such as bottled water in the vehicles, which could be given to the patient if required.

Response times and patient outcomes

- The service did not monitor key outcome data. The service did not have any key performance indicators. For example, staff were unable to provide the number of journeys or patients transported at the time of our inspection. This information was collated by the management team following our inspection. The number of patient transport journeys was provided.
- The number of bookings the crew attended on time was not recorded or monitored. The amount of time patients spent on vehicles was also not monitored. We raised this as a concern during our inspection and were told a head of operations had been employed. The registered manager told us the monitoring of activity and outcomes would be their responsibility once they were in post in April 2018.
- The registered manager told us their service had expanded and the number of on the day bookings had increased. However we saw no evidence of this as this was not routinely monitored.
- Patient record forms were audited for completeness. However the service had not reviewed the records to compile key outcome data.
- The service accepted allocated work details, which were recorded electronically and were used to inform the resource required in order to effectively fulfil the booking.
- The lack of monitoring activity and outcomes meant that the service did not benchmark or compare against other similar providers.
- There were no service level agreements or contracts in place with providers therefore we were unable to review how demand that exceeded contracted levels was managed.

Competent staff

- The provider was unable to provide evidence that staff had all of the appropriate qualifications and experience for their role within the service. This included life support training.
- The service had systems in place to manage recruitment processes. For example, we reviewed eight staff files and found evidence of satisfactory references being

requested and reviewed, driving license checks and professional registration certificates. Bank and substantive staff underwent the same recruitment checks, induction and training programme.

- The service undertook Disclosure and Barring Check (DBS) checks on both substantive and bank staff prior to their employment.
- There was a robust induction process and recruitment checklist in place. We saw evidence that all staff had received an induction.
- We saw evidence that all substantive staff had received annual appraisals. All bank staff were offered appraisals and 30% of bank staff had received an appraisal.
- We saw evidence that all staff had received training in basic life support as part of their annual mandatory training. The operations manager was a life support provider and was able to train staff when they joined the service.
- Staff did not have paediatric basic life support training. The registered manager told us that all technicians had intermediate life support (ILS) training and paramedics had advanced life support (ALS) training. However, the service did not monitor this and were unable to provide evidence that staff were trained in ILS and ALS. This meant we could not be assured that staff were competent to provide the level of life support required for their role.
- All staff received annual training in managing anaphylaxis and epilepsy.
- Clinical supervision was conducted through observational peer reviews undertaken by the operations manager. However, these were informal and were not recorded. This meant we could not be assured that action was taken when staff competencies were assessed as requiring improvement, intervention or additional training.
- Continuing professional development (CPD) training sessions were being held monthly from March 2018 and different team members were delivering training on particular topics. We saw a training calendar which showed there were planned themes to deliver training on resuscitation, safeguarding, manual handling, infection prevention and echocardiogram readings.

Coordination with other providers and multi-disciplinary working

- When staff transferred patients between services, they received a formal handover from staff at the transferring hospital.
- Staff telephoned care providers if there was a delay with the transfer of a patient.
- All staff members reported good multi-disciplinary working. All necessary staff, including those within an operational and corporate role were involved in assessing and delivering patient care and transport.

Access to information

- Staff accessed relevant information, which was confirmed at the time of booking on the patient record form. This was supported by their own assessment of the patient.
- The service had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) policy dated January 2018. The policy stated that crew members attending an NHS transfer should ensure they receive information about DNACPR status from the nurse during handover. Most staff we spoke with were knowledgeable about the policy and process of asking for DNACPR documentation. However, we observed a handover and the DNACPR status was not checked or requested.
- When a private ambulance journey was booked, it was the responsibility of the member of staff taking the booking to ensure DNACPR status and any advanced care plans were discussed and recorded. This information formed part of the special notes. All crews had access to special notes.
- There was an access to patient records policy and a leaflet for patients should they wish to request a copy of their records held by the service. Patient record forms could only be accessed by the registered manager.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 (MCA), consent, and Deprivation of Liberty Safeguards (DoLS) were included in the mandatory training. Data showed that al substantive staff and 96% of bank staff had received MCA/DoLS training at the time of our inspection.

Patient transport services (PTS)

- The service had a policy on consent, dated November 2016. This included definitions and guidance on assessing capacity and specific situations where consent may be more complex. Paramedics and technicians we spoke with understood consent, decision-making requirements and guidance.
- The consent policy included best practice guidance on gaining consent when transporting and treating children. Young people aged 16 and 17 were presumed to have the competence to give consent for themselves. Consent for children under the age of 16 was gained from the child's parental guardian.
- We observed staff gained verbal consent prior to transporting an adult patient.

Are patient transport services caring?

Compassionate care

- Staff maintained patients' privacy and dignity, by using clean blankets to cover them and ensuring they closed the vehicle door before moving or repositioning patients.
- Feedback comments from patients using the service were positive. For example, one patient said "paramedics were amazing, I cannot thank them enough". Another patient said "caring, professional and compassionate".
- Staff would check if patients required anything from a supermarket if they had been an inpatient for some time or had just returned from holiday.
- Two patients commented on the cold temperatures in the ambulance but said staff provided them with additional blankets and increased the heating.
- All staff we spoke with demonstrated a consideration for the emotional wellbeing of patients and their relatives.
- We observed compassionate, respectful and caring interactions between staff members and a patient.

Understanding and involvement of patients and those close to them

- Crew members kept patients and/or their relatives updated if there were likely to be any delays.
- Staff were able to recognise when patients and those close to them required additional support to help them understand and be involved in their care during a patient journey. Staff also knew how to access the additional support when required.
- Patients relatives and those close to them were invited to provide feedback as well as the patient. Feedback was positive.

Emotional support

- Staff understood the impact that a patients' condition, care and treatment would have on their wellbeing.
- We saw evidence of an occasion where staff supported a vulnerable patient and escalated their concerns about emotional wellbeing appropriately.
- Crew members said they had never had a patient die in their care during a patient journey however they had received training in communication which included communicating with patients' relatives in the event of a distressing event.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- Service delivery was based on informal agreements held with an NHS health service provider, pre-bookings of self-pay patients and forecasting of ad-hoc bookings. We saw evidence of informal agreements and planning of the service with commissioners and NHS providers. For example, at the time of our inspection there was an agreement that two crews and two vehicles would be based at an NHS hospital each day for their use. There was no end date to this informal agreement.
- The service rostered staff with different qualifications to meet the needs of people who had pre-booked patient transport. However, transport services provided to NHS providers were booked at late notice and therefore the qualifications of staff were not planned in line with the needs of the patients.

Patient transport services (PTS)

- A seven-day service was provided from 8am to 6pm. This was flexible and the service operated 24 hours a day if there was a need outside of these hours. Staff said they had no issues with working extended hours if required providing they were informed in advance.
- Staff in the contact centre monitored and tracked vehicle speeds and locations using a tracking system and could send messages to drivers if speed limits were exceeded.

Meeting people's individual needs

- Staff had access to a telephone interpretation service and would ring through when needed, to facilitate the communication needs of patients that could not speak English.
- Staff told us they were experienced at dealing with patients with a learning disability and people living with dementia. For example, they would adjust communication to suit the needs of the patient.
- The registered manager told us the service was unable to transport patients with complex mental health needs and babies weighing less than four and half kilograms. However, as there were no formally documented exclusion criteria outlining which patients the service was unable to transport.
- The service did not have stretchers for bariatric (heavier) patients until the day of our inspection. Staff had not received training and did not have the appropriate equipment to meet the needs of bariatric patients. A new bariatric stretcher was fitted on one of the ambulances on the day of our inspection. The operations manager said training was planned for staff in April 2018.
- All managers and on-call staff had phones and would inform crew staff about clinical resources required for journeys.
- The service provided bottled water to keep patients hydrated during long journeys.
- We observed a crew member carrying out a risk assessment of a patient's home whilst the other crew member stayed with the patient. This was to ensure it was safe for the patient to be transferred from the ambulance into their home. Crew staff told us they often did this when a patient had been in hospital for any length of time.
- Additional blankets were stored on vehicles and were used when patients felt cold.

Access and flow

- Self-pay patient journeys were either booked in advance or on an ad-hoc basis. However, the registered manager told us there had been an increase in pre-planned work for customers such as NHS trusts and ambulance providers. Customers, such as NHS trusts and ambulance services, telephoned or emailed the registered manager or the operations manager to request a booking.
- The registered manager reviewed bookings each week and on a daily basis and ensured appropriately trained staff were allocated to pre-booked patient journeys.
- Turnaround times and the number of pre-booked jobs attended on time were not monitored. The provider was unable to provide evidence to show resources were where they needed to be at the time required. However, the operations manager told us staff were allocated additional time to allow for road works and traffic when travelling to a patient which usually resulted in the crew arriving early. We saw no evidence of this as this was not monitored.
- No patient journeys had been cancelled from March 2017 to February 2018. The operations manager told us that they would only cancel a journey if it was absolutely necessary and the reason for cancellation would be explained to the patient or their relative.
- Patients and relatives were kept informed of delays by telephone. Care homes and hospitals, where they were the destination for the patient, were also informed of any delays.

Learning from complaints and concerns

- The service had a complaints policy in place, which was reviewed in March 2018. The policy stated all complaints would be acknowledged within two working days of receipt, unless a full response to the complaint can be given in five working days. This gave clear guidance to

staff on how to record a complaint and how it would be investigated. The registered manager was responsible for managing and investigating complaints. Timescales for a response was 28 days for all complaints.

- The complaints process had been converted into an easy read flow chart for crew members. Staff were knowledgeable about the complaints process however we did not see the flowchart displayed or stored on vehicles.
- The Independent Healthcare Sector Complaints Adjudication Service (ISCAS) is contracted by Met Medical to provide a fair and impartial third-party adjudication service for all complaints that Met Medical was unable to resolve.
- The service had a mechanism for recording verbal complaints. One verbal complaint was recorded from March 2017 to February 2018. This was around the way in which a member of staff spoke to an NHS staff member. The complaint was investigated appropriately however there was no evidence of learning documented.
- On review of patient feedback forms, we found some patients had complained verbally to staff about feeling cold. These verbal complaints had not been recorded or discussed at governance meetings.
- The service had received no formal complaints from March 2017 to February 2018. As a result of this, we saw no evidence of learning from complaints or concerns. We were told complaints would be discussed at the governance meetings should the service receive a complaint.

Are patient transport services well-led?

Leadership / culture of the service

- The service had a registered manager in post, who was responsible for the daily running of the service. This included provision of staff, equipment ordering, and reviewing bookings. The registered manager was also the director of the company and was a registered paramedic. We were not assured that the registered manager fully understood the requirements of the Health and Social Care Act 2008 and associated regulations. We were not assured that the registered manager was aware of or compliant with record keeping requirements for Schedule 2 CDs as outlined in The Misuse of Drugs Regulations 200.
- Leaders were not knowledgeable about what should be reported as an incident. They were also lacking oversight of activity such as the number of journeys completed, number of events covered and the number of children they have transported.
- The operations manager had been in post since 2016 and was completing their final exams to become a registered paramedic at the time of our inspection. The operations manager supported the registered manager with the daily running of the service. They were also responsible for completing driving assessments, providing training and materials, staff inductions and daily checks on medicines.
- The company had recruited a head of operations who was due to commence employment in April 2018.
- The company used an independent consultancy company to support them in writing policies and procedures.
- There was a clinical manager employed by the service who provided support and clinical advice to the management team. The clinical manager was a registered paramedic. However, some staff we spoke with were not aware of who the clinical manager. The clinical manager had not attended the last two clinical governance meetings.
- All staff spoke positively about the leadership of the service. They told us that leaders were visible and approachable.
- Staff told us they enjoyed their role and working for the company. All staff we spoke with were committed to providing a caring transport service for patients.

Vision and strategy for this this core service

- The vision for the company was to provide a market-leading, highly professional, and well-equipped ambulance service. Staff we spoke with knew what the vision was.
- All staff we spoke with were not aware of the company values with the exception of the registered manager and the operations manager. The company values were:

- Forward thinking
- Dependable
- Caring and compassionate
- Client focussed
- Team focussed
- Clinical excellence
- Constantly innovating
- The company strategy was to improve compliance, fleet, training facilities, premises, financial growth, and systems and processes. This was supported by a documented 2018/19 development plan. This was still in draft at the time of our inspection.
- The registered manager told us they hoped to continue to expand the service and discussions had been held about the procurement of services with an NHS provider.

Governance, risk management and quality measurement

- Clinical governance meetings were held quarterly. Meetings included discussions around patient safety, clinical effectiveness, governance, patient focus and care environment.
- Incidents and complaints were discussed at these meetings. On review of the meeting minutes for 2017 and 2018, we found there was a lack of continuity and completion of actions. For example, in August 2017 the meeting minutes showed there had been two clinical incidents that both incidents were to be discussed at the next meeting. On review of the next meeting minutes in January 2018, these incidents were not discussed and the registered manager told us there had been no clinical incidents reported from March 2017 to February 2018. There was a risk that the clinical governance committee had lost sight of incidents that had been reported and were not storing all incidents in the incident folder we reviewed during our inspection.
- We were not assured that governance arrangements for reviewing and developing policies were robust. For example, some policies were dated November 2016 but had only been written in March 2018 according to the operations meeting minutes dated 2 March 2018. This included the patient transfer policy. In addition, there was no incident reporting policy, deteriorating patient policy or exclusion criteria in place at the time of our inspection. We found policies were disconnected and did not include all relevant information. For example, the controlled drugs policy dated November 2016 was inaccurate and stated the company had a home office licence to hold stocks of CDs. This was not the case and an interim CD policy, also dated November 2016 was in place but the two policies did not contain any reference to each other. Following our inspection, the provider told us they had taken some action to ensure review dates were accurate on each policy and amendments to policies were clearly documented.
- We were not assured of the safe management of CDs. We found a CD book that listed CDs that the provider was unable to account for. We formally requested information about the unaccounted CDs however; the response received following the inspection did not address the concerns raised.
- Audit documentation was incomplete and did not always have the time period recorded. We saw no detailed action plans in relation to audits. There was no evidence of paramedics' own stock of controlled drugs (CD) being reviewed in line with the services own interim CD policy.
- The registered manager told us there were regular risk management meetings. We requested evidence of the meeting minutes but this was not provided. We were told the risk register was reviewed quarterly however we saw no evidence of this.
- The risk register contained 43 risks. Of the 43 risks, 21 of the risks were categorised as 'people risks'. These included risks to staff and patients such as risks associated with moving and handling patients and medication errors. Other risk categories included organisational management and environmental risks.
- Not all risks to patients and the service had been identified by the registered manager. This included infection prevention and control risks, and the lack of monitoring of life support training. Some risks had been identified by the registered manager but had not been added to the risk register. This included not monitoring key outcome data and the impact this had on the providers ability to improve the service.

- The risk register did not contain the date the risk was created and the date it was last reviewed. It was unclear when each risk was last updated or how the low, medium and high risks had been categorised.
- Updates and changes to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) were discussed at the clinical governance meetings and actions were taken to ensure this information was cascaded to staff.
- Environmental risk assessments had been carried out where appropriate, including in relation to fire safety.

Public and staff engagement

- The 2018 staff survey asked staff how they felt about the company, the team and any improvements they felt the company should make. Only 14 of the 100 employees responded. 11 out of 14 respondents felt the company valued their patients. The majority of staff did not answer the questions related to feeling valued and feeling part of a team. Three out of four of the respondents said they did not feel valued. Five members of staff said they did not feel supported and four said they did.
- We raised the staff survey results with senior staff who told us a suggestion box was implemented following a recent staff survey. Senior staff had introduced this to support staff. Staff completed suggestion forms and dropped them in the box. No other actions had been taken following the staff survey results despite suggestions for improving the service being made.
- Staff meetings were not held as the majority of staff were bank. Staff were kept up to date with relevant information and news via the intranet portal and a private social networking page.
- Some patient surveys were carried out. The company asked for an email address at the time of booking and a link to an online patient survey is sent via email. No other methods of seeking patient feedback was used which meant only patients who had an email address and had booked in advance were able to provide feedback about their experience. Patients who were transported by Met Medical Ltd on behalf of an NHS trust were not asked for feedback.
- There was an employee assistance programme in place for staff. Staff were able to contact the employee assistance team for confidential advice and support about work and non-work-related matters.

Innovation, improvement and sustainability

- Opportunities for improvement and innovative practice were not always taken. For example, the service did not routinely collect information on outcomes or have any key performance indicators in place. This meant the information could not be shared with staff to improve outcomes.
- The service did not collate and analyse patient feedback or staff feedback information which meant not all concerns raised in feedback surveys were cascaded to staff or acted upon. This was not in line with the receiving patient feedback policy dated November 2016 which stated that surveys were compiled into reports and results were disseminated to staff.
- Concerns raised during our inspection around safeguarding training and infection prevention and control were addressed prior to our unannounced inspection. However, not all concerns had been addressed in relation to medicines management.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure systems and processes for recording controlled drugs are in line with the Misuse of Drugs Regulations 2001.
- The provider must ensure there are robust processes in place to monitor and assess patient outcomes and the quality of the service.
- The provider must ensure there is a clear policy and governance process in place to support the identifying, recording, reporting and investigating of all incidents.
- The provider must ensure there is a documented patient eligibility criteria and exclusion criteria in place and available to all staff.
- The provider must ensure staff have the appropriate level of life support training for adults and children. Systems and processes must be in place to collect and monitor this information.
- The provider must ensure governance processes support the identifying, recording and managing risks to patients, staff and the service.
- The provider must ensure there are effective systems and processes to develop and review policies.

Action the hospital SHOULD take to improve

- The provider should consider collating information on specific service activity.
- The provider should review the quality of audits undertaken and associated documentation.
- The provider should review infection prevention and control processes in place, including the quality assurance processes following deep cleaning of vehicles.
- The provider should consider implementing documented agreements with external providers for service activity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (a) and (b) **How the regulation was not being met:** The provider did not have effective systems and processes in place for recording controlled drugs in line with the Misuse of Drugs Regulations 2001. The provider did not have robust processes in place to monitor and assess patient outcomes and the quality of the service. The provider did not have a clear policy and governance process in place to support the identifying, recording, reporting and investigating of all incidents. The provider did not have a documented patient eligibility criteria and exclusion criteria in place. The provider did not have robust governance processes in place to support the identifying, recording and management of risks to patients, staff and the service. The provider did not have effective systems and processes in place to develop and review policies.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) **How the regulation was not being met:** The provider could not be provide evidence that staff had the appropriate level of life support training for adults and children. Systems and processes were not in place to collect and monitor this information.