Medical Services Ltd

Medical Services Ltd (Luton)

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 Ltd (Luton) is operated by Medical Services Ltd. This independent ambulance service provides emergency and urgent care and a patient transport service.

We carried out this unannounced inspection on 16 January 2017 because we had received information of concern about the service. We did not inspect all elements of each key question, as this was a focused inspection.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided was patient transport services. Where our findings on Medical Services Ltd (Luton) – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the core service.

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:

- Effective standards of cleanliness and hygiene were maintained within the service.
- Generally, there were appropriate systems in place regarding the safe handling of medicines.
- All staff we spoke with understood their responsibilities to raise, record and report safeguarding concerns.
- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of safe care and treatment on the days of our inspection.
- Appropriate arrangements were in place for the recruitment of staff and the service had a suitable policy in place.
- There was a formal process in place for gathering information and recording details relating to a patient's medical condition when bookings were made.

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

- Staff understood their responsibilities to report incidents although they were not always given feedback so learning could be embedded in the service.
- Duty of candour processes had not always been followed.
- Generally, the service had systems in place to ensure the safety and maintenance of equipment; however, these were not always followed.
- At the time of our inspection, there was no registered manager (RM) in place for the service. There had not been an RM in place since July 2015.
- Effective systems were not in place to assess, monitor and improve the safety and quality of the care and treatment provided.
- There was a lack of effective processes to ensure learning from all incidents was disseminated throughout the service and to all staff.

Summary of findings

- There was not an effective system in place to respond to complaints about the service.
- There was not a full understanding of all the risks in the service underpinned by effective systems to assess, mitigate, and monitor ensuing actions to reduce the risk of avoidable harm for patients.
- Risks found on inspection had not been recognised by the service.
- Storage facilities for controlled drugs did not meet safety standards.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. We also issued the provider with two requirement notices that affected the patient transport service. Details are at the end of the report.

Edward Baker

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)		The lack of a registered manager had not been actioned by the provider for over a year. There were ineffective governance systems in place at the service to fully understand all risks the service and to ensure learning from all incidents and complaints was used to drive improvements in the service. Storage of controlled drugs was not appropriate. Duty of candour requirements had not always been followed. Staffing levels, staff competency, safeguarding awareness and infection control procedures were satisfactory. The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of safe care and treatment on the days of our inspection. Appropriate arrangements were in place for the recruitment of staff and the service had a suitable policy in place. There was a formal process in place for gathering information and recording details relating to a patient's medical condition when bookings were made.

Medical Services Ltd (Luton)

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Medical Services Ltd (Luton)

Medical Services Ltd (Luton) is an independent ambulance service providing patient transport and emergency ambulance services to NHS trusts across central England. Medical Services Ltd (Luton) is one of nine Medical Services Ltd locations and provides services across Hertfordshire, Bedfordshire and surrounding areas.

The service is registered for the regulated activities of:

- transport services, triage and medical advice provided remotely,
- treatment of disease, disorder or injury, and
- diagnostic and screening services.

We inspected, but have not rated, elements of four of the five key questions including safety, effectiveness, responsiveness and well-led.

The service had not had a registered manager in post since July 2015. At the time of the inspection, there had not been an application to register a new manager or notification to us of the absence of a registered manager.

Our inspection team

The team that inspected the service comprised a CQC lead Inspector Charlotte Walker and three other CQC Inspectors. The inspection team was overseen by Phil Terry, Inspection Manager.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Medical Services Ltd (Luton) predominantly provides patient transport services to NHS trusts within the Hertfordshire and Bedfordshire area: a high dependency patient transport service is also provided when required. The service has contracts with four clinical commissioning groups to provide these services. The service also provides a smaller emergency response service for the NHS ambulance trust within the region.

Medical Services Ltd (Luton) employs paramedics, emergency medical technicians, intermediate care technicians, ambulance care assistants, and patient escorts. There are also call handlers, human resources personnel and non-clinical staff based at the location. Overall, 212 staff are employed at Medical Services Ltd (Luton).

The service had a controlled drug's accountable officer who was also the nominated individual across all Medical Service Ltd locations.

During the inspection, we spoke with 12 staff including clinical staff, maintenance staff, and managers. We did not speak to any patients or relatives due to the nature of the inspection.

This inspection was carried out following concerns raised relating to patient safety, and was unannounced due to the nature of the concerns raised. 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 has been inspected once previously in November 2013, when the service was found to be meeting all standards of quality and safety it was inspected against at that time.

Due to the service providing predominantly patient transport services, with a small emergency ambulance provision, all evidence will be reported under one core service. Where evidence only applies to emergency ambulance provision this will be detailed.

Activity (July 2016 to January 2017):

- From January 2016 to December 2016, the service carried out 239,654 patient transport journeys.

Track record on safety:

- No never events had been reported in the period July 2016 to January 2017.
- From July 2016 to January 2017, there had been 102 incidents reported: one of these had been classified as a serious incident.
- The service received 414 complaints from July 2016 to January 2017.

Patient transport services (PTS)

Summary of findings

The lack of a registered manager had not been actioned by the provider for over a year. There were ineffective governance systems in place at the service to fully understand all risks the service and to ensure learning from all incidents and complaints was used to drive improvements in the service. Storage of controlled drugs was not appropriate. Staffing levels, staff competency, safeguarding awareness and infection control procedures were satisfactory.

The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of safe care and treatment on the days of our inspection. Appropriate arrangements were in place for the recruitment of staff and the service had a suitable policy in place. There was a formal process in place for gathering information and recording details relating to a patient's medical condition when bookings were made.

Are patient transport services safe?

We do not currently have a legal duty to rate independent ambulance services. We did not inspect all elements of this key question, as this was a focused inspection. We found the following areas where the service needs to improve:

- Staff understood their responsibilities to report incidents although they were not always given feedback so learning could be embedded in the service.
- Duty of candour requirements had not always been followed.
- Generally, the service had systems in place to ensure the safety and maintenance of equipment; however, these were not always followed.
- Storage facilities for controlled drugs did not meet safety standards.

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

- Generally, effective standards of cleanliness and hygiene were maintained within the service.
- There were appropriate systems in place regarding the safe handling of medicines.
- All staff we spoke with understood their responsibilities to raise, record and report safeguarding concerns.
- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of safe care and treatment on the days of our inspection.

Incidents

- Staff understood their responsibilities to report incidents although they were not always given feedback so learning could be embedded in the service.
- An electronic system was in place to report incidents throughout the service. Staff initially completed incident details on a paper form and this would then be inputted onto the electronic system for investigation and further review. There was an on-site incident and complaints' assistant who had oversight of all incidents reported within the location. Incidents were then escalated to the incidents and complaints' manager at another location. Incidents were overseen at a provider level by the

health, safety and quality manager. The incidents and complaints' assistant was responsible for investigating allocated incidents: this staff member had not received any formal training for carrying out this role.

- From July 2016 to January 2017, there had been 102 incidents reported: 20 of these were categorised as staff incidents, 59 were categorised as patient incidents, 10 were categorised as medicines' management incidents and 13 were categorised as equipment incidents.
- There had been a number of serious incidents (SIs) across the provider's services nationally in relation to patient harm following misuse of equipment. This included one SI at this service where a patient sustained significant harm due to not being correctly strapped into a wheelchair in August 2016. We were informed by the provider that learning points were shared across all locations to avoid such incidents occurring in future and that staff had been trained in the safe use of lap belts. However, we observed that five further incidents had occurred in relation to wheelchair misuse, resulting either in a near miss or in patient harm. The service did not specify the level of harm in their incident reports.
- Staff told us they did not routinely receive feedback following the report of an incident.
- From March 2015, all independent healthcare providers were 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. Staff were aware of the Duty of Candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident. The service had a policy in place that defined when the principles of duty of candour should be followed. We saw that Duty of Candour processes had not been followed the regarding the one SI that had occurred as the provider's policy had been not followed in this case as a letter had not been sent within the provider's defined timescales. The service did not always categorise levels of harm to patients for all incidents so it was not always clear when duty of candour would be triggered.
- We saw that when an incident had occurred, the person involved in the incident was told when they were affected, given an apology, and informed of any actions taken as a result.

Cleanliness, infection control and hygiene

- Generally, effective standards of cleanliness and hygiene were maintained within the service. We observed the premises and vehicles to be visibly clean on the day of our inspection.
- The service had an infection control policy in place and this contained details of staff responsibilities, guidance, and training requirements.
- We reviewed seven vehicles during our inspection and found them all to be visibly clean throughout. Equipment contained within vehicles was also clean and stored to ensure it remained free from dirt or dust.
- The staff using the vehicles carried out daily cleaning. These included ensuring surfaces of trolleys and equipment were cleaned following use. However, we found that three out of seven vehicles did not contain disinfectant wipes to enable this cleaning to occur.
- Vehicle maintenance operatives (VMOs) were employed by the service. Their role was to ensure that vehicles were ready for use prior to shift commencement. We spoke with the two VMOs who were employed and they were clear of their responsibilities.
- Deep clean schedules were in place to ensure regular thorough cleaning of all vehicles. This involved equipment being removed and all internal and external areas being fully cleaned by the VMOs. We observed that these schedules were up to date and all vehicles had received a deep clean within the necessary time frame. If a vehicle became contaminated or very dirty during the course of its use, the vehicle would be returned for a full deep clean by the VMOs.
- We observed that the sluice area in the premises was tidy and well maintained. Chemicals were stored securely and were appropriate for the service. Information relating to the control of substances hazardous to health regulations (COSHH) was available within the sluice area and contained relevant details to ensure those using chemicals were able to do so safely.

Patient transport services (PTS)

- Mops for different areas of the service were segregated in line with guidance and a suitable procedure was in place to separate clean and dirty mop heads. Guidance on which areas each colour mop should be used in was visible within the sluice area.
- The service provided appropriate waste disposal systems, which included domestic waste, clinical waste and sharps. The appropriate containers were in place during our inspection, however some sharps bins did not always have the date of commencement of use recorded on them. This was not in line with national guidance for the safe management of sharps: Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- There were colour coded bins in place for both general and clinical waste. Clinical waste storage bins were secure and were collected regularly by an external provider.
- Alcohol hand gel and personal protective equipment provision varied across vehicles. Five out of the seven vehicles we reviewed did not contain aprons or sleeve protectors which provide staff with barriers during cleaning and patient bodily fluid contact. Three out of seven vehicles did not contain alcohol hand gel to allow staff to disinfect hands between patient contacts when hand-washing facilities are unavailable. This was escalated during our inspection.
- 97% of staff within the service had completed training in relation to infection control.

Environment and equipment

- The design, maintenance, and use of facilities and premises kept people safe from avoidable harm. Generally, the service had systems in place to ensure the safety and maintenance of equipment; however, these were not always followed.
- Prior to the commencement of each shift, staff were required to complete vehicle daily inspections (VDIs). VDIs required staff to check the suitability and safety of the vehicle and equipment. Electronic records of VDIs were required to be completed before the system would allow staff to book onto the vehicle. This system ensured 100% compliance of VDI completion.
- We observed that some equipment was not suitable or safe for use, including one wheelchair that had a faulty lap belt. We found items of single use equipment including dressings, advanced airway devices and suction catheters that had passed their expiration date on all six out of the seven vehicles we reviewed. Vehicles used for emergency work appeared to be overstocked with cupboards and bags that were difficult to close due to the amount of equipment stored within. This meant there was a larger amount of equipment for VMOs to check, therefore items could be missed and go past their expiration date. In an incident reported in July 2015, out of date equipment was found on vehicles and this was due to overstocking. There had been no action to rectify this and therefore avoid out of date equipment remained on vehicles. Concerns relating to equipment were escalated to managers on site and rectified immediately.
- Equipment stores within the premises were organised and well maintained. Equipment was secured and only accessible to authorised staff. The station manager was responsible to stock checks and ordering of equipment.
- All patient equipment had received a service or appropriate electrical equipment testing within the necessary time-period. Equipment did not have stickers on to show the date it was last serviced, but did have barcodes so that this could easily be checked by staff if they were unsure of its' safety and suitability for use. Records of services and electrical equipment test histories were kept electronically. The electronic record contained details of when each item of equipment required its next service. An external provider carried out services and electrical equipment tests. We saw evidence that equipment had been subject to electrical appliance equipment testing and had been calibrated.
- On six out of the seven vehicles we reviewed, the fire extinguishers did not show a record of when they were last serviced and therefore it was not clear if they were safe and suitable for use. We were provided with a record of fire extinguisher checks, but these were not identifiable per extinguisher. Therefore, we could not be assured that all individual fire extinguishers had received the necessary safety checks.
- Vehicles were maintained by an onsite mechanic. We observed that all service histories, MOTs and insurances for vehicles at the location were up to date. The mechanic kept records of when vehicles were next due services and MOTs. Vehicles would go back to

manufacturers as necessary for larger scale work. All seven vehicles we reviewed were in working order and had no external damage or faults. Records seen evidenced this.

- The service occasionally transported children. All vehicles with trolleys contained the necessary seat belts/restraints to ensure children could be transported safely. Managers told us that children would not be transported in the multiple seater ambulances as the service did not provide booster seats, but children could be transported in van style ambulances if their own seats were provided to ensure patient safety.
- The premises car park was shared by other companies; the gate to the car park was open during office hours, outside of these hours the car park was secured. All vehicles within the car park were kept locked. The premises building was kept secure and visitors were required to use a call bell system and identify themselves prior to entering the building. On entering the premises visitors were required to sign in.
- We found that appropriate risk assessments, including fire safety, had been conducted on all aspects of the environment and premises. There were five fire marshals and four first aiders within the service, who these were, were displayed throughout the premises. Fire safety signage was displayed throughout the premises and fire exits were easy to identify.
- Staff who worked in control rooms had not received display screen equipment assessments to ensure their workspace was safe and suitable for them. Staff also did not have headsets to allow them to type and talk at the same time. Staff resorted to holding phone between their ear and shoulder to allow them to type: this could result in staff injury. This was escalated during our inspection.

Medicines

- Generally, there were appropriate systems in place regarding the safe handling of medicines, however, storage facilities for controlled drugs did not meet safety standards.
- The service had a policy in place for medicines management, which reflected national guidance. This policy documented the steps necessary to ensure medicines were kept, administered and disposed of in a safe way. Staff had received the necessary training in relation to managing and administering medicines according to their skill level.
- Compressed gas cylinders were stored within a secure caged area, with signage to advise staff and visitors that compressed gases are being stored. However, small sized cylinders were not stored in brackets or chained to ensure they remain upright in line with guidance. This was escalated during our inspection. Empty and full cylinders had separate storage to allow easy identification.
- Medical gases were stored in appropriate fittings within all vehicles to ensure they were secure.
- The service carried a range of prescription only medicines (POMs) and controlled drugs (CDs) that met their contractual requirements. All medicines were only accessible to authorised staff.
- We saw that POM storage cupboards were secure, organised and not overstocked. The station manager was aware of the importance of secure storage of medicines and was responsible for maintaining them. Weekly audits were conducted by the station manager relating to stock level.
- Controlled drugs storage did not meet the required level as advised by the Home Office. The CD cupboard was attached to the wall of the storage cage. It is a requirement that CD cupboards are secured to a wall and fixed with bolts that are not accessible from outside the cupboard, and also fitted with a robust multiple point lock. We escalated this to the managers of the service who said that action would be taken to address this. At the time of this report, we had not received assurance that this concern had been addressed.
- Ambulance staff would collect the necessary CDs at the commencement of their shift, signing to say they have removed these from the store. At the end of their shift, any unused CD's would be signed back in and records were maintained of any drugs used. We reviewed the CD record books and found them to reflect the amount present in the store. However, we were advised that prior to our arrival the station manager had discovered two missing vials of morphine, and was currently in the process of investigating this. The on-duty manager had

taken the necessary steps to begin tracing the missing vials, and alerting the controlled drug accountable officer of the organisation as well as informing the police.

- Following administration of a CD, if there was any remaining in the container, this was disposed of into a specific container to neutralise the drug and ensure appropriate disposal. We saw these used in line with the provider's policy and stored in the correct way.
- We reviewed the 10 incident reports relating to medicines' management. Five of these incidents related to out of date medicines being discovered during checks. Following three of the incidents, a new medicines' management process was put in to place to improve quality checks and audit processes. However, two further incidents relating to out of date medicines and stock omissions had occurred with no further actions being put into place.
- CCTV was present within areas of medicine storage. Tapes of recordings were reviewed following any discrepancies in medicines. Signs were visible to show staff and visitors that CCTV was in use on the premises.

Records

- We did not review clinical records as part of this inspection.

Safeguarding

- Policies were in place for safeguarding children, young people and vulnerable adults. We reviewed these policies and found that they did not contain the most up to date national guidance and some sections were unclear how they related to the subject of safeguarding. We escalated this to senior managers during the inspection and were informed that a review of these policies was in progress and these concerns would be addressed.
- Safeguarding policies contained clear guidance for staff on how to report safeguarding concerns. If a concern was identified, this was reported directly to the provider's control room supervisor, who would then make a referral to the relevant local safeguarding authority. Flow charts were present throughout the premises to demonstrate the correct procedure to staff.
- 97% of staff had attended the relevant levels of safeguarding training level 2 for both adults and children. Paramedics were required to attend level three safeguarding children training, with all other clinical staff requiring level two safeguarding training. This was in line with the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document 2014
- All staff we spoke with understood their responsibilities to raise, record and report safeguarding concerns. Staff we spoke with provided an example of where they had identified a safeguarding concern and how they had reported it following the service procedure.

Mandatory training

- Mandatory training was carried out by the service on topics including, manual handling, equality and diversity, infection control and information governance. Life support training relevant to clinical roles was also included in mandatory training sessions. Excluding staff on long-term sickness or on maternity leave, the service had 97% attendance for all topics across all staff groups.
- A record was maintained by the service of when staff would be due training, with reminder intervals at three months and two months. Staff told us that training was not cancelled and that this was easy to access, with subjects relevant for their role.
- All staff who worked on emergency response vehicles had received the required blue light driver training; this was completed by an external provider.

Assessing and responding to patient risk

- Risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Risk assessments were completed as part of the booking process. Staff we spoke with were aware of the individual risks associated with the patients they saw. Criteria were in place to assess whether patients were suitable for the service provided. This criterion was utilised by control staff upon taking bookings.
- Patient information, including their acuity, was provided to call handlers during the booking process. The appropriate crew level and experience was discussed with those booking the transport. Emergency ambulance crews provided to the region's NHS

ambulance trust had set standards of the required crew level and experience within the contract. We observed that the crews' experience level met the contractual requirements.

- A patient's resuscitation status was required to be provided during the booking process. If a patient was found to have a 'do not attempt cardiopulmonary resuscitation' order in place and this was not communicated during the booking process, the journey would be cancelled in line with the provider's policy. It was the responsibility of the service making the booking to provide full information regarding patients' resuscitation status as part of the booking process.
- If a patient deteriorated during transportation, the crew would call the provider's control room or the hospital which the patient was being discharged from/admitted to for further advice. We observed through incident reports that this occurred and crews would then either continue the journey or call 999 for further support as necessary. All instances of patient deterioration were recorded as incidents to enable investigation to establish the root cause of the patients' deterioration.

Staffing

- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of safe care and treatment on the day of our inspection.
- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. We saw that rotas and shift patterns were aligned to demand. The service employed 212 staff, and 189 of these were patient facing roles. We observed that staff received the necessary rest breaks and time between shifts in line with the working time directive.
- Within emergency response contracts with the local NHS ambulance service, skill levels were detailed of what the service should provide. This included having either a paramedic or an ambulance technician on each vehicle providing emergency responses.

Response to major incidents

- We did not review response to major incidents as part of this inspection.

Are patient transport services effective?

We do not currently have a legal duty to rate independent ambulance services. We did not inspect all elements of this key question, as this was a focused inspection. We found the following areas of good practice:

- Appropriate arrangements were in place for the recruitment of staff and the service had a suitable policy in place.
- There was a formal process in place for gathering information and recording details relating to a patient's medical condition when bookings were made.

Evidence-based care and treatment

- We did not gather evidence for this as part of the inspection.

Assessment and planning of care

- Staff in the control room received referrals and bookings from patients and other healthcare providers. There was a formal process in place for gathering information and recording the details relating to a patient's medical condition including any mental health conditions. This included determining the medical status and dependency of patients, including information about any cognitive impairment. As journeys were generally booked in advance, this enabled the service to plan the required staff level, experience, and appropriate vehicle for the transport accordingly. Information about a patient's medical condition was given to the crew when they received the details of the journey.

Response times and patient outcomes

- We did not gather evidence for this as part of the inspection.

Competent staff

- Appropriate arrangements were in place for the recruitment of staff and the service had a suitable policy in place.
- We reviewed staff files as part of our inspection and found that all staff files checked had references,

disclosure and barring systems checks, employment histories and evidence of interviews. Managers told us that if the necessary checks had not been completed then staff could not commence work.

- Driving licence checks were also completed prior to commencement of employment; these were also checked yearly by the service. Databases provided reminders to human resources' staff to advise when checks were required or had expired.
- All staff received yearly appraisals, including non-clinical staff. We observed 92% compliance with staff appraisal during the time of our inspection. The service's target was 100%.
- The service employed some international paramedics from countries including Poland and Australia. Robust processes were in place to ensure their skills were sufficient and that they understood their role and responsibilities. Paramedics who were either newly qualified or international were provided with a preceptorship period to ensure their transition into the role and improve their confidence. The length of time provided was flexible and could be extended when additional needs were raised.
- A mobile phone application was available to all staff and contained operational and clinical updates for the service. Staff could access this whilst at home or work.
- All staff were required to complete supervision shifts twice per year to ensure their continuing competence for carry out their roles.
- All paramedics had their registration checked upon recruitment. Their registration status was checked yearly, with the service's database flagging up staff whose registration required renewing within three months.

Coordination with other providers and multi-disciplinary working

- Coordination with other providers of healthcare was led by site managers who worked out of local NHS trust locations. This enabled communication between the service and hospital staff. Any problems could be dealt with on site and questions regarding patient acuity and requirements of crews could be discussed with the site manager.

Access to information

- We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not gather evidence for this as part of the inspection.

Are patient transport services caring?

We did not inspect this key question, as this was a focused inspection.

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

We do not currently have a legal duty to rate independent ambulance services. We did not inspect all elements of this key question, as this was a focused inspection. We found the following areas where the service needs to improve:

- There was not an effective system in place to respond to complaints about the service.

Service planning and delivery to meet the needs of local people

- We did not gather evidence for this as part of the inspection.

Meeting people's individual needs

- We did not gather evidence for this as part of the inspection.

Access and flow

- There was a control room based within the premises at Medical Service Ltd (Luton) and patient transport bookings were taken through the staff in this area. The control room was operational from Monday to Friday from 8am to 8pm. Outside of these hours; calls were diverted to another Medical Service Ltd location. From January 2016 to December 2016, the service carried out 239,654 patient transport journeys.

Patient transport services (PTS)

- All emergency ambulance calls were carried out through the NHS ambulance trust service where cover was being provided.
- Control room staff told us that they contacted patients a day in advance to confirm their location, pick up time and mobility.
- Monitoring of response times and meeting demand was conducted by the control room supervisors and site managers. Pick up times and meeting appointment times were managed as key performance indicators (KPIs). KPIs were set out in the service's contracts with clinical commissioning groups and local NHS trusts. Abandoned calls and ring times were also monitored to assess quality of the service.
- Site managers had a clear understanding of what transport times were required to be met and when to begin investigating any delays in pick up or drop off times.
- Patients with high priority conditions, including renal patients, were prioritised and the times of transport closely monitored along and performance feedback given to those contracting the transport.

Learning from complaints and concerns

- There was not an effective system in place to respond to complaints about the service. The service received 414 complaints from July 2016 to January 2017. The majority of these complaints related to delays in pick up times or due to missed appointments due to delays.
- 137 reported complaints did not have an associated outcome documented and were closed, therefore it was not clear if any investigation was carried out to establish any causation or necessary service improvements. This was not in accordance with the service's managing complaints policy.
- Vehicles did not contain any leaflets regarding complaints to provide to patients.

Are patient transport services well-led?

We do not currently have a legal duty to rate independent ambulance services. We did not inspect all elements of this key question, as this was a focused inspection. We found the following areas where the service needs to improve:

- At the time of our inspection, there was no registered manager (RM) in place for the service. There had not been an RM in place since July 2015.
- Effective systems were not in place to assess, monitor, and improve the safety and quality of the care and treatment provided.
- There was a lack of effective processes to ensure learning from all incidents was disseminated throughout the service and to all staff.
- There was not a full understanding of all the risks in the service underpinned by effective systems to assess, mitigate, and monitor ensuing actions to reduce the risk of avoidable harm for patients.
- Risks found on inspection had not been recognised by the service.

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

- The provider had recently appointed a head of governance to address areas requiring improvement.

Leadership / culture of service related to this core service

- At the time of our inspection, there was no registered manager (RM) in place for the service. There was an operational manager in the service who was in charge of the day-to-day activities of the service. There had not been an RM in place since July 2015. The service had not notified the CQC of the absence of the RM, which was a breach of the Care Quality Commission (Registration) Regulations 2009. The operational manager of the service and the nominated individual of the provider were not aware of the requirement to notify the CQC of this absence. We raised this as an urgent concern on the day of the inspection. The continuing failure by the provider to fulfil their conditions of registration by not having a registered manager in place at the service to manage the regulated activities represented a substantial breach of the regulations. This risk had not been fully recognised by the service or the provider.
- The nominated individual told us that a managerial restructure was occurring throughout the organisation and once this had been established, then an RM application would be made. We raised concerns with the provider that this was unsatisfactory and the service

required an RM so there was local accountability for the regulated activities that the service was registered for. The provider informed us after the inspection that a person had been identified to take on the role of RM, and we did receive a formal notification of the absence of the RM. At the time of this report, the provider had not made an application for an RM for the service.

Vision and strategy for this core service

- We did not gather evidence for this as part of the inspection

Governance, risk management and quality measurement

- Effective systems were not in place to assess, monitor and improve the safety and quality of the care and treatment provided at the time of the inspection. There was not a full understanding of all the risks in the service underpinned by effective systems to assess, mitigate, and monitor ensuing actions to reduce the risk of avoidable harm for patients. We were not assured that learning from incidents had been effectively embedded throughout the service to minimise the risk of avoidable harm for all patients.
- Risks found on inspection had not been recognised by the service, such as the lack of a registered manager, and the lack of a consistent, systematic approach to the management to responding to incidents and complaints and the inappropriate controlled drugs storage facilities.
- There was no risk register in place specific to the service. A corporate risk register was in place but this did not contain details including which location the risk related to, the date which it became a risk, or who was responsible manage the risk. We were told that any risks relating to the service would be included on the corporate risk register at provider level. The top risks on the corporate risk register were non-compliance with contracts, maltreatment of patients and sourcing and retaining staff. It was not clear if any of the risks related directly to Medical Services Ltd (Luton). All risks within the provider risk register had associated mitigating actions, but no accountable individual documented. There was not clear evidence of how risks pertinent to this service had been fully assessed, mitigated against and how the service was ensuring the actions to reduce risks had been monitored.
- Following serious incidents that had occurred throughout the provider's national organisation, a serious incident panel had been setup. We reviewed the minutes of meetings conducted by this panel and found them to reflect learning from these serious incidents and identified any learning/action points required. Following on from the two serious incidents that the provider had notified CQC about in the past year, where patients had sustained harm due to the inappropriate use of lap belts, we found that further incidents had occurred at this service subsequently due to the poor dissemination of learning and action points to the front line staff. During this inspection, we found one wheelchair on a vehicle with a faulty lap belt. Whilst wheelchair checks were part of the VDI checks, this fault had still not been identified by staff.
- There was a lack of effective processes to ensure learning from all incidents was disseminated throughout the service and to all staff. The service had not taken action to ensure all complaints had been managed appropriately. These risks had not been recognised by the service. We not assured that there was effective managerial oversight of incidents and feedback from patients to learn lessons and to drive improvements in the safety and quality of the service provided.
- We found that policies were in place to support staff within the service, including medicines' management, infection control and safeguarding. All policies had been reviewed within the necessary timeframe; however not all up to date were with national guidance, such as the safeguarding policies. This had not been recognised as a risk by the service.
- The service had recently recruited a new head of governance a few weeks prior to the inspection. Since being recruited, they had assessed the organisation's governance structures and had key identified areas that required improvement. The nominated individual told us that new governance systems were in the process of going through review procedures prior to implementation but there was not a defined timescale for this. At the time of this report, we had not received assurance that these concerns had been addressed so this represented a breach of regulation 17, good governance, of the Health and Social Care Act 2008.

Patient transport services (PTS)

- Health, safety, and quality meetings were carried out weekly. Within these meetings, KPIs, incidents and quality data were discussed. Locality meetings also occurred: these were attended by the provider's executive team along with clinical commissioning groups. Meetings were not always fully minuted to demonstrate a full record of discussions around the quality of services.

Public and staff engagement

- We did not gather evidence for this as part of the inspection

Innovation, improvement and sustainability

- We did not gather evidence for this as part of the inspection

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- To have effective systems in place to assess, record, mitigate and monitor all risks in the service.
- To ensure Duty of Candour requirements are followed at all times.
- To have effective systems in place to ensure that learning from all incidents and complaints is embedded in the service to minimise the risk of avoidable harm for patients.
- To ensure all polices reflect national standards.
- To ensure controlled drugs are stored in accordance with national standards.
- To monitor systems to ensure all equipment and fire extinguishers are serviced as required.

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
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(g) Safe care and treatment.** The regulation was not being met because: • The controlled drugs' storage facilities did not meet the required standard as advised by the Home Office.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance** The regulation was not being met because: • There was no risk register in place specific to the service. A corporate risk register was in place but this did not contain details including which location the risk related to, the date which it became a risk, or who was responsible manage the risk. Risks found on inspection had not been recognised by the service. • Meetings were not always minuted to demonstrate discussions around the quality of services. • There was not effective managerial oversight of incident and complaints' systems to take all required learning to drive improvements in the service. • There was a lack of robust processes to ensure learning from incidents was disseminated throughout the service and for all staff.

This section is primarily information for the provider

Requirement notices

- Policies and procedures did not always contain up to date guidance (safeguarding policies).
- Systems for ensuring all equipment, including fire extinguishers, were not always effective.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The regulation was not being met because: • Duty of Candour processes had not been followed the regarding the one SI that had occurred as the provider's policy had been not followed in this case as a letter had not been sent within the provider's defined timescales. • The service did not always categorise levels of harm to patients for all incidents so it was not always clear when duty of candour would be triggered.