

DHL Supply Chain Limited

# Hospital Logistics Centre

## 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.

## Ratings

### Overall rating for this ambulance location

Patient transport services (PTS)

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Hospital Logistics Centre is operated by DHL Supply Chain Limited. The ambulance service provides a patient transport service, and also has the facility to transport high dependency patients.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 22nd February 2017.

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

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

The main service provided by this service was a patient transfer service (PTS). This service provides non-urgent and non-specialist services that transport patients between hospitals, home and other places such as care homes.

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:

- Competent staff
- Staff treating and caring for patients with compassion, dignity and respect
- Positive communication between staff and patients
- Staff expressing passion about their job and dedication to ensuring patients were provided with good care
- Strong team work
- Excellent patient care

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

- Poor compliance with safeguarding policies
- Lack of staff appraisals
- Lack of clinical governance structures within the service

Following this inspection, we told the provider that it must take some actions to comply with some regulations contained in the Health and Social Care Act 2008 and that it should make other improvements. We have also issued the provider with four requirement notices. Details are at the end of the report.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

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

# Hospital Logistics Centre

## Detailed findings

### Services we looked at

Patient transport services (PTS)

# Detailed findings

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## Background to Hospital Logistics Centre

Hospital Logistics Centre is operated by DHL Supply Chain Limited. The service opened in the mid-1990s. It is an independent ambulance service in Wembley in the London Borough of Brent. The service primarily serves the communities of the North West London area.

The service has had a registered manager in post since 09/09/2011. At the time of the inspection, a new manager had recently been appointed and was registered with CQC in 21/02/2017.

## Our inspection team

The inspection team included a CQC lead inspector, Monisha Parmar, other CQC inspectors, and two specialist advisers - one with expertise in ambulance management and one who was an emergency care technician clinical supervisor.

The inspection team was overseen by a Head of Hospital Inspection.

## How we carried out this inspection

During the inspection, we visited the main Wembley depot. We spoke with 30 staff including; registered paramedics, patient transport drivers and management. We spoke with 13 patients and one relative. We also received 18 'tell us about your care' comment cards, which patients had completed before our inspection.

There were no special reviews or investigations of the service on going by the CQC at any time during the 12 months before this inspection. The service had been inspected twice, and the most recent inspection took place in November 2012, which found that the service was meeting all standards of quality and safety it was inspected against.

## Facts and data about Hospital Logistics Centre

The service is registered to provide the following regulated activities:

- Patient Transport Services

- Triage
- Medical advice provided remotely

# Detailed findings

There were 105 patient transport drivers that were employed by the service full time with an additional 52 agency drivers. There were 10 members of staff that worked in a central control office and 13 members of staff in customer services. There were also 14 members of staff in management. The accountable officer for controlled drugs (CDs) was the registered manager.

## Track record on safety

- Zero never events, which are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death.
- Six clinical incidents: zero no harm, six low harm, zero moderate harm, zero severe harm, zero death.
- Zero serious injuries.
- 682 complaints through the Patient Advice and Liaison Service (PAL's). The data was collected from the trust in which this service operates in. As well as formal and informal complaints and also through an electronic incident reporting system.

# Patient transport services (PTS)

Safe

Effective

Caring

Responsive

Well-led

Overall

## Information about the service

## Summary of findings

### Are services safe?

We do not currently have a legal duty to rate independent ambulance services. However, we found the following issues where the service provider needs to improve:

- There was a large storage facility for medical and non medical stock however, some stock was found to be out of date both in the storeroom and on the ambulances such as the spill kits.
- There was incorrect storage of medical gases, the manager was immediately notified and an action plan was put into place to correct this.
- Although an asset register did exist, the recording for medical equipment was not in line with best practice, and we could not be sure if all equipment was serviced.
- Staff did not understand the term safeguarding; and did not receive any updates in this training and therefore would not have an understanding in modern slavery and FGM (female genital mutation).
- The safeguarding lead was only trained to a level 3 against a requirement to be trained to a level 4 in safeguarding.
- There was a lack of shared information and feedback of complaints, concerns and incidents that occurred within the service to front line staff. This meant that learning from incidents was not evident.

# Patient transport services (PTS)

- Although vehicles were clean, the schedules for cleaning did not show how vehicles that were taken home after a shift were cleaned.
- However, we found the following areas of good practice:
- Staff knew how to report incidents. Six reported incidents had occurred between January 2016 and December 2016.
- There was a lone working policy, and safety measures in place to keep crew safe.

## Are services effective?

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

We found the following areas of good practice:

- Local policies were up to date.
- Staff used portable electronic devices to review patient needs, mobility constraints and patient details.
- The service showed improvements in their key performance indicators monthly.
- The service conducted thorough recruitment checks. All staff DBS (Disclosure and Barring Checks) checks were in place prior to employment. There were clear DBS requirements in the recruitment process.
- The service had good communication with the trusts for which they provided a service.

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

- The service did not benchmark themselves against the performance of similar providers. This meant that the service did not know how effective they were in relation to other providers.
- Although the service had informed us that they conducted annual appraisals, staff appraisals for 2016 had not been completed. We requested appraisals for 2015 but this could not be located.

- Staff had not received Mental Health Act or Mental Capacity Act training even though staff revealed that they sometimes transported patients living with mental health conditions.

## Are services caring?

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

We found the following areas of good practice:

- Excellent communication between drivers and patients.
- Strong relationships between drivers and patients.
- Excellent driving skills, as stated by patients and observed by the inspection team.

## Are services responsive?

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

We found the following areas of good practice:

- Bookings were made one day in advance; this meant that resources and staffing were also planned for.
- Renal patients required treatment that can last years. This service created a system called renal mapping; which highlighted the closest renal units to a patient's address. This meant that transportation times in the ambulance were reduced.
- The service had changed their fleet to meet patient needs and improve capacity at the same time.
- Transport lounges provided patients with refreshments for patients.
- Response rates to complaints were 100% and the time in which complaints were responded to was continuously improving.

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

- There was no formal way of disseminating learning and feedback from concerns, complaints and incidents.

## Are services well-led?



# Patient transport services (PTS)

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

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

- There was no vision and values statement specifically for Hospital Logistics Centre in relation to patient transport and care.
- There were no clinical governance arrangements in place.
- There were formal staff meetings, but no formal staff meetings that included the drivers.

However we also found the following areas of good practice:

- The risk register was up to date.
- Performance indicators were reviewed on a monthly basis.

## Are patient transport services safe?

### Incidents

- There were no never events, which are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. Six clinical incidents: zero no harm, six low harm, zero moderate harm, zero severe harm, zero death. There were no serious injuries.
- Incidents were reported immediately by contacting the shift manager. A written statement was also required from the driver, which was then sent to management. These incidents were then inputted onto an internal electronic system and discussed at monthly management meetings.
- Staff we spoke with knew how to report an incident and knew where to locate the correct forms for incident reporting.
- In December 2016, there were no injuries reported and a total of seven road traffic collisions (RTC's). There was a total of 58 road traffic collisions between January 2016-December 2016.; we saw evidence of RTC's being documented.
- A third party subcontractor is defined as a firm that carries out work as part of larger organisation. This service hires third party subcontractors to cover additional work. One line manager was responsible for managing all third party subcontractors, who would be informed of any incidents involving a subcontractor. The incident would then be escalated to the subcontractor where an investigation would take place. The outcome of this investigation would then be sent back to DHL and reviewed.
- Incidents were reviewed by the health and safety manager, and incidents involving patients requiring renal dialysis were reviewed by the renal coordinator. In medicine, dialysis is a process for removing waste and excess water from the blood and is used primarily as an artificial replacement for lost kidney function for people with kidney failure.

# Patient transport services (PTS)

- There were no processes in place for feedback of incidents to the crew at this service. Staff we spoke to said they were not always told about any learning following an incident.
- The duty of candour is a regulatory duty that relates to openness and transparency and require 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.
- Reporting polices at the service did not mention a duty of candour.
- Staff did not know what the term duty of candour meant. However, there was evidence of this practice within this service. We gave various members of staff scenario questions where a duty of candour would be required and staff were able to answer these question appropriately. For example, we asked one member of staff what response was given if a patient had injured himself or herself whilst being transported. The staff member said they would apologise to the patient, ensure the injury was dealt with at A&E and report it to management.
- Managerial staff told us they would visit patients in person at home to apologise for extreme delays in transportation. There were also dedicated members of staff who would apologise to different groups of patients for example patients that were having dialysis would receive apologies from the renal coordinator where an error had occurred.
- Over the last 12 months there were no reported never events for this service. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death.
- Between January 2016 – December 2016 there were six incidents reported. Because of the low number, there were no trends to be found within the incidents reported. Incidents reported included injury to staff whilst manual handling patients.
- These reports were easily produced by a push of a button and data was calculated monthly.
- We were shown these reports, which were detailed and included data such as the number of escorts that were used, the number of cancelled jobs and the number of aborted jobs.
- These results also showed data regarding the number of crew required per job. The patient's mobility was reported. For example, the number of patients using a wheelchair in December 2016 was 14,408. This data was then used to forecast the number of staff required for the following months, along with the type of vehicles required for the job.

## Cleanliness, infection control and hygiene

- We observed vehicles were clean. Cleaning of the ambulances was done daily by two members of staff using a branded cleaning product. Deep cleans were scheduled every six weeks by an outside company. There was a colour-coded system for mop buckets, yellow for ambulances, red for toilets and blue for kitchens; mop heads were replaced daily. We asked the provider how they disposed of water used to clean the ambulance floor. We were told that drivers disposed of dirty water in the outside drain in the yard. Cleaners used a boom system called aqua boom, which is a spill containment system to collect water that was disposed of offsite.
- Staff wore clean uniforms, that were cleaned by staff at home.
- We saw staff wiping down equipment with cleaning wipes after being in contact with patients.
- We saw staff use appropriate Personal Protective Equipment (PPE) whilst handling patients such as gloves.
- We saw staff using the alcohol gel to clean their hands after each patient contact.
- Other PPE was available on the ambulances such as face masks. We did not see any compliance with staff being bare below the elbows. Their policies stated that all uniform issued to DHL staff will be short sleeved to comply with the “bare below elbows” police. However all staff were seen with long sleeve high visibility jackets; this meant that if one patient had an infection the driver and other patients could be a risk to this infection.

## Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service had an electronic system in place to monitor their daily activities in a report format.

# Patient transport services (PTS)

- We looked at an infection prevention control audit conducted in December 2016. This audit looked at six sections of the depot including the kitchen, the environment, waste disposal, the cleaners cupboard, vehicles, and a more generalised section which included items such as 'signage demonstrating a good hand washing technique'. The results of this audit showed the overall compliance at 86%. The provider had a compliant target of 85% or above.
- The audit documented only one open risk where an action was still required, which was 'vehicle not arriving in a condition ready to go on the road'. The mitigation was to 'ensure that the vehicle specification is agreed unambiguously'. The contingency plan was to 'run on existing fleet'. The next audit was due to be conducted in March 2017.
- We received conflicting information in relation to deep cleaning of vehicles. Managers told us that deep cleaning of ambulances was done every six weeks. This was contradicted by ambulance staff who thought this was not happening. We saw a list of the cleaning schedule, which included vehicles that were taken home after being used. These vehicles were marked as not clean. Therefore, we could not be sure that these vehicles were being cleaned at home, every six weeks. This is an infection control issue.

## Environment and equipment

- The depot was visibly clean and tidy during our inspection. There was a large notice board in the reception foyer and other notice boards were in the corridors near the bathroom. However, a fire door was propped open at all times during the inspection, which obscured some of the information on the notice board in this corridor. This contravenes the Regulatory Reform (Fire Safety) order 2005. The information on the notice board was a mixture of corporate DHL information and hospital logistics specific information
- The toilets were clean; however, the sinks were very small and did not have a mixer tap. It was difficult to achieve effective hand washing in these sinks. There were signs on the soap dispensers to demonstrate how to wash your hands appropriately. We saw a small tower of lockers that had limited access as the doors opened onto one side of one cubicle in the female toilets. There was a separate store cupboard in the female toilets but this was not accessible. This meant that the cleaning equipment used was left out in the open in the female toilets. This is again an infection control issue.
- The storeroom for medical equipment was locked on our initial inspection but on the second day of our inspection, we found the storeroom was unlocked. The storeroom had shelves that were tidy and consumables were well laid out in sealed boxes. The floor was cluttered and access to the back of the storeroom was difficult. On further investigation we also found an out of date HSE (health safety and environment) medium sterile dressing, dating 2015/09 the Health and Safety manager assured us that stock will be rechecked for any more out of date products. There was a sufficient amount of stock and spare equipment with the storeroom for both adults and children.
- We conducted independent observations on 12 vehicles. There was no consistency within the vehicles in terms of the stock found inside. For example, one vehicle had vomit bowls, urine bottles, blankets and linen. Four vehicles had child travel seats available whilst two vehicles inspected did not. On another vehicle, we found an out of date paediatric oxygen facemasks dated October 2014 and an out of date adult facemasks dated November 2016. Another vehicle was missing linen. Hand sanitiser dispensers were fitted to the interior and were in working condition; however, this was not consistent with all vehicles. We saw complaint posters on the inside walls, but no leaflets. We observed two lots of the required number of oxygen cylinders in all the vehicles that we inspected and all of these were secured safely. The number of oxygen cylinders and the safety precautions taken in the ambulances were in line with the Department for Transport, Guidance for the Carriage of Gas Cylinders on Vehicles; Revision 1: 2015.
- We found several out of date spill kits on board several of the ambulances that were ready to go out to pick up patients. We informed staff and these were replaced straight away.
- MoT files were kept in a locked cupboard on all vehicles. There were only five vehicles that were due for a MoT. All vehicles had the correct paper work including road tax and service records.

# Patient transport services (PTS)

- Repairs to vehicles were recorded in a defects log, kept in a folder on each vehicle. To report a defect three forms were required to be completed, a white copy, which was kept in the folder, a blue copy that is sent with the vehicle for repair and a yellow copy that was completed once the defect was repaired and stored in the folder. We saw copies of the defect forms that had been completed by the crew. A database was kept of all the defects, which we were shown whilst on inspection. The database including relevant information such as; the date the defect was reported, the registration of the vehicle, the date the vehicle was sent for repair and so on. Damage to vehicles was rare. The last vehicle repair was in July 2016.
- We observed several members of staff using a Vehicle Daily Inspection (VDI) checklist at the beginning of their shift. This checklist covered both the internal and external checks. These included checking that all seat belts were functional, and restraining straps (used to immobilise wheelchairs) were present. External checks included checking the vehicle for any damage and checking oil levels.

## Medicines

- We saw Entonox was stored correctly with additional security provided by a chain and padlock arrangement to prevent misuse. (Entonox is a gas which can be inhaled and used as a pain medication; most commonly used in childbirth, following trauma, or as part of end of life care).
- We noted that the storage of large oxygen cylinders with a digital valve was not in line with best practice.
- These cylinders were leaning against one another and there was no mechanism in place to prevent these from falling over. They were heavy in weight and liable to falling over, potentially causing serious injury. Best practice is to store cylinders vertically and securely to prevent them from toppling as stated by the British Oxygen Company (BOC).
- We also noted a large a quantity of oxygen cylinders with a standard valve, which were stacked one on top of another. Best practice is that these cylinders are stored in a rack that enables the safe removal of individual cylinders to ensure appropriate stock rotation, as stated by BOC.

- We also noted highly flammable material stored next to the medical gases storage facilities. Best practice for the storage of oxygen is to not keep large quantities of combustible material (such as paper or cardboard) near the oxygen cylinder storage area, as stated by BOC
- We informed the general manager who was required to action these risks immediately. The service spoke to BOC and reviewed health and safety executive guidelines. The service has since chosen to upgrade their storage facility to rectify these issues.

## Records

- Ambulance crews used an electronic device known as a Personal Digital Assistance (PDA) to access patient information. The PDA would display the patient's condition and what the job entailed. This replaced paper records. The PDA was also a monitoring device; monitoring the drivers position via the use of GPS (Global Positioning System), for safety. The PDA allowed ambulance crews to accept incoming jobs as well as log completion times of jobs. This data could then be pulled from the PDA to create a record of the patient journey and be used for KPI (Key Performance Indicator) data.
- There is a requirement to ensure that all medical devices are serviced. Best practice is that this information is contained in an asset register. This would enable the service to identify when an asset was purchased, its service records and when the equipment is next due for a service. The service had an asset register.
- The provider used equipment such as defibrillators, suction units and patient monitors that required a service in line with the manufacturer's guidelines and in accordance with Medicines & Healthcare Products Regulatory Agency (MHRA). This provider was not in line with MHRA with all of their medical devices.
- We found items such as the suction unit inside the ambulances that were missing on the asset register therefore; we could not be assured that these items were serviced.
- We also found items such as the vital signs monitor, used to measure heart rate, blood pressure, pulse

# Patient transport services (PTS)

and oxygen levels on the asset register labelled inconsistently with the labels on the medical device itself. This meant that we could not be sure if these medical devices had been serviced.

- We found service records were difficult to interpret and were not fully recorded. Invoices were used to determine whether devices such as an ambulance trolley were serviced in 2015. Best practice is to have this information available in a spreadsheet format or in a database that can be readily searched and identify items due for a service. We saw no such database during our inspection.
- We were told by management that every six months half of the fleet was taken off the road and equipment was serviced for one week. The second half of vehicles was then serviced the following week.

## Safeguarding

- Safeguarding vulnerable adults and children was part of the mandatory training for all clinical staff and once completed no further training was offered. Therefore, staff did not participate in annual refreshers for safeguarding training, which meant there was no assurance that staff were up to date with the changes on national guidelines and recommendations.
- The head of training, who was trained to safeguarding level one, trained staff in safeguarding, to level one. National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that those providing training must provide evidence to ensure the content is approved and considered appropriate against the relevant level.
- The presentation that was used for training was not up to date. There was no mention of modern slavery; there was also a lack of guidance on what to do regarding a safeguarding concern.
- The safeguarding lead was trained to level three in safeguarding. The safeguarding lead should be trained to a level four as per national guidelines.
- Staff did not know who the safeguarding lead was.
- National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that all

ambulance staff including communication staff should be trained to level two. This applies to all clinical and non-clinical staff that have contact with children/young people and parents/carers.

- There was no level two safeguarding training for staff.
- Staff had difficulty in understanding safeguarding but knew they needed to report this to the control centre.
- We spoke to staff at the control centre who had no insight into safeguarding. This meant that we could not be sure if safeguarding concerns were escalated to the relevant people.
- With regard to frontline staff reporting safeguarding incidents, the safeguarding lead told us that drivers should raise safeguarding concerns straight away by completing the form located in the red folder on their vehicle. We were shown this folder by staff on the ambulances.
- The provider would then alert the local authority and phone the relevant trust to alert them of the safeguarding concerns. The process was outlined in a flowchart which we were shown.
- The provider did have a safeguarding policy. However, this was out of date, as it did not mention that the Care Quality Commission (CQC) needed to be informed of safeguarding concerns.
- The previous safeguarding concern was reported a week before the inspection. CQC was not informed of this safeguarding alert.

## Mandatory training

- We found significant shortcomings in the level of mandatory training completed.
- We spoke to the human resources business partner who showed us training levels for staff that needed to complete Certified Supply Chain Specialist Training (CSCS). This course enabled staff to become a Certified Professional within the Supply Chain industry and consisted of several interactive modules; from foundation to specialist function and leadership modules.

# Patient transport services (PTS)

- 25% of staff had completed this training, 66% of staff were scheduled in for training within the next four months. The remaining 9% will complete their course throughout the year during mop up sessions.
- Drivers' initial training consisted of a two-week office based induction training.
- We saw the training matrix used to highlight members of staff that were up to date with their training and those whose training was out of date. The matrix showed that all 148 members of staff were up to date on their manual handling training and had up to date training in 'smiths driving course'. Eighty- one members of staff had their skills checked to be up to date out of 148, 67 members of staff were not yet due for this check.
- All 148 members of staff had up to date training for first aid.
- All 24 emergency medical technicians (EMT's) had in date training for medical gases and the automated external defibrillator.
- We saw that there was no annual refresher training for safeguarding, customer care, use of ambulance tail lifts and ramps, additional winter checks, dealing with a possible collapse behind closed doors, familiarisation of the ambulance car and walk around (ambulance) checks. This meant that no updates were given for these particular training courses.
- Senior management told us that field trainers conducted observations on crew. A form called the DHL Vehicle Audit Tool was used to do this. This form was made up of seven sections: uniforms, first aid, cleanliness/infection control, waste, maintenance of vehicle, linen and environmental. There was an additional box for additional comments. This form did not assess the skills required for the job for example manual handling.

## Assessing and responding to patient risk

- Emergency Medical Technicians confirmed that if a patient deteriorated they would contact the call centre for advice. The control centre would then direct them to the nearest hospital.

- There was no training given for staff to deal with disturbed or violent patients. This meant that staff safety was at risk, as they were not appropriately equipped to deal with these patients.
- Staff told us they were transporting patients living with mental health issues. This meant that the service was transferring patients with mental health issues, learning disabilities and dementia with no formal training around this. This meant there were no safeguards in place to protect staff and patients from risk.

## Staffing

- We were told that agency staff were encouraged to apply for permanent posts.
- Staff told us that there were not enough people employed for the amount of work to undertake. At the time of inspection, there were eight crew vacancies.
- There was a lone working policy. We were told by staff that they would need to set their PDA to lone working mode. If the alarm was initiated this would go straight to the control centre who would then aid the driver, by either offering assistance over the phone or by arranging for help from other crews or the police.
- We were told that junior staff were often paired up with staff who had more experience after their induction; to provide support and act as a mentor.
- The company had a major incident plan in place, which followed the direction of three levels of command Gold (strategic), Silver (tactical) and Bronze (operational) command. The plan highlighted key people and their role in an emergency and was produced after consultation from individual hospital trusts to ensure compatibility.
- The major incident plan outlined the role of the company in the event of an emergency at any of the hospital sites they were contracted to. Their aim was to assist the trust patient discharge.
- The appointed persons for the roles must have appropriate training in how to discharge the responsibilities of that role adequately. Where this is not the case there is a danger that the level of support required for that individual will result in the Bronze commander micro managing them or undertaking the role themselves.

# Patient transport services (PTS)

- National Occupational Standards (NOS) are the mandatory systems used to define what is expected of competent individuals. Organisations must provide those people who are expected to undertake a command role with the training and exercise opportunities that are relevant to the role they will be performing. However, we were told that the member of staff that held the Gold command role was only trained for a Bronze command role.
- The fire risk assessment was found to be more than two years old. There was also no record of planned fire drills. However, on arrival we were told where to congregate in case of a fire, and as a result of the audit a fire evacuation was carried out on 21st October 2016.
- The external audit also found that the layout of the yard needed to be changed to provide safer routes for both pedestrians and vehicles. This had not been done by the time of inspection.
- Health and safety legislation requires that landlords carry out risk assessments for the legionella bacteria which cause Legionnaires Disease (a serious lung infection) and therefore maintain control measures to minimise the risk. We saw that there was now an annual agreement for monthly checks in place following the external audit.
- However, when we looked at the safeguarding policy this was out of date and did not include reporting safeguarding concerns to the Care Quality Commission (CQC).
- We saw no evidence that managers were able to check if all staff had read the latest versions of their policies.
- We spoke to a member of staff who informed us that many of the ambulance crews were using search engines on the world wide web to keep up to date with national guidance.
- Staff we spoke to stated that there was no opportunity for continual professional development.
- We did not see any substantial evidence of staff maintaining their competencies.

## Assessment and planning of care

- The solution designs team monitored key data every six months such as how many vehicles were required and staffing levels needed. The patient journey data and historical data was also used to estimate how many patients per hour per vehicle could be transported.
- Crews used their portable electronic device to review the patient they were about to transport. The device showed them numerous and relevant patient information for the job. This information would allow the drivers to prepare their vehicles before picking up the patient.
- The patient's medical condition was also stated here, including the mobility of the patient or how many crewmembers were needed for this job.
- We observed the drivers making all the necessary safety checks prior to a journey. When we reached the patients address, the patient was instructed to remain seated until the driver was able to offer the patient assistance in leaving the vehicle.

## Response times and patient outcomes

- Key performance indicators monitored the patient time on a vehicle, arrival times and collection times and showed an improvement in their response times.
- For example the services performance for completing journeys between 0-6 miles in 60 minutes was 93.3% in January 2017 compared with 92.8% in December 2016.

## Are patient transport services effective?

### Evidence-based care and treatment

- We were not assured that staff received sufficient support from the provider to ensure that patients were treated in line with best evidence based care and treatment.
- All staff were given a compact disc at induction containing all off the providers current policies. If staff required another copy or a specific copy of a policy, this would be requested through their line manager or human resources.
- We looked at the provider's local policies. We saw that some policies were in date such as manual handling, which was reviewed in 2016, and next due for a review in 2018 and a mobile phone policy, which had also been reviewed in 2016, and next due for a review in 2018.

# Patient transport services (PTS)

- Arriving on time with zero minutes of lateness was 86.2% in January 2017 compared with 82.6% in December 2016.
- Collection times under 90 minutes was 92.7% in January 2017 compared with 90.9% in December 2016.
- For non-renal journeys, arrival times between 45 minutes early – 0 minutes late were measured monthly and was down to 74% in January 2017 from 76% in December 2016.
- The service did not benchmark their achievements, ambitions or goals against other providers. This meant that the service did not know how effective they were in relation to other providers.
- An external auditing company audited health and safety in September 2016. The audit report stated that the patient transport service had good systems and strong implementation. Good systems referred to the management of risk as a moderate number of non-conformities and or/high number of observations identified. Strong implementation referred to the management of risk as low number of non-conformities (no majors) and/ or some observation identified.
- The audit found that the provider had undertaken no risk assessment or produced a method statement to control risks. The provider had since then, set up an audit tracker displaying audit findings and actions opened and closed, all actions had been dealt with in a timely manner and were all closed.

## Competent staff

- There were no staff appraisals for 2016. We asked to look at 2015 appraisals and this could not be found. We spoke to the provider regarding this matter and we were assured that appraisals were booked in for 2017. Although when we spoke to staff they were unaware of this.
- Staff induction comprised of a two week classroom process, with a test at the end.
- We spoke with staff who told us that induction consisted of topics such as an orientation, health and safety training, manual handling training, customer care and infection control. Additional training was given to Emergency Medical Technician's (EMT) such as First

Person on Scene (FPOS) basic and intermediate, medical gases, automated external defibrillator training and so on. We saw modules in induction that were completed and signed by members of staff.

- We spoke with four Emergency Medical Technicians (EMT) who all said that there were no opportunities for development as an EMT. Staff said they did not 'feel like a proper EMT' due to the lack of interventions that they could perform. Two EMT's stated that they would like training for blood glucose monitoring and tracheotomy, this had not been provided by the provider.
- Field trainers were members of staff that would accompany EMT paramedics and provide further advice. There was no feedback given from this supervision and the EMT staff would not receive a copy of the observation form used by the field trainer.
- There was no training in cultural needs or religious awareness.
- Staff were fully trained in the importance of dialysis, and knew the consequences without treatment would be fatal.
- The service conducted thorough recruitment checks. We saw that all staff DBS checks were in place prior to employment. There were clear DBS requirements in the recruitment process. This meant that the service checked that all staff were fit and proper for the job.

## Coordination with other providers and multi-disciplinary working

- DHL showed examples of multi-disciplinary working with the local hospitals for which they provided a patient transport service. DHL coordinators attended bed meetings with different hospitals. The provider actively worked with the trusts to assist with patient flow and discharge, by arranging suitable numbers of staff and vehicles to the hospitals that required patient transportation.
- We found that the booking form indicated if a patient had a current DNACPR order.
- The DHL control centre also notified crews when patients had a DNACPR order; via their PDA.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards



# Patient transport services (PTS)

- We saw that there was no training in the Mental Health Act, Mental Capacity Act or in dementia awareness in the training matrix.
- Despite this staff regularly transported patients from mental health hospitals and wards. Staff we spoke with told us that mental health patients were transported with an escort. The service did not transport patients under the Mental Health Act Section 136.
- Staff had poor understanding of both safeguarding, deprivation of liberty (DoLs), and the mental health and mental capacity acts. Staff stated that would pass on any issues to control but didn't understand what were the signs of abuse were or why the mental health and mental capacity act as well as deprivation of liberty safeguards may be appropriate.

## Are patient transport services caring?

### Compassionate care

- Throughout our inspection we observed staff demonstrating empathy and compassion towards the patients. We observed staff greeting patients on arrival in a warm and welcoming way.
- Staff addressed patients politely and in a respectful manner and treated them with kindness during the journey.
- Staff maintained dignity at all times, and ensured patients were covered with a blanket when necessary.
- We observed staff checking the patients' details before picking up patients from clinics, for example their name, their medical condition and if a wheelchair was required.
- We spoke with six patients who regularly used the service for dialysis and they were all very positive about the staff. Some comments included 'they are very good', 'I am happy with the service', 'I am happy with my driver'.
- The drivers would often ensure that patients were settled at their destination before leaving.
- Patients stated that their drivers were 'brilliant', and good at their job. It was evident that the drivers were committed to their job and thoroughly enjoyed their interaction with their patients.

- Staff had provided food for the three day Christmas period to patients with poor mobility, that were returning home for the holidays without food.

### Understanding and involvement of patients and those close to them

- Staff always kept the patient informed of what they were about to do, for example when the driver needed to wheel the patient up the ramp at the back of the ambulance and also when the driver fixed the patients seatbelt in place.
- We observed staff communicating with patients whilst on their journey, politely and in a professional manner.
- We observed staff informing patients of speed bumps in the road.
- We observed staff informing patients of how long their journey was without being prompted.

### Emotional support

- We observed the staff communicating with patients whilst on their journey, asking the patients about their wellbeing and taking a genuine interest.

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

### Service planning and delivery to meet the needs of local people

- The service booked and prepared patients transport one day in advance. The service had a planning team which was responsible for this. This meant drivers could be allocated to jobs in advanced and ensure the necessary tools were available for the job.
- The hospitals in which the patients were treated at provided the relevant information for these bookings. Such as the mobility status of the patient and the patients personal details.
- Bookings were reviewed every three months in case a patient's condition or mobility changed.
- Some patients were scheduled in annually. For example, renal patients were booked in annually as these patients required long- term treatment. The patient's

# Patient transport services (PTS)

transportation needs were also assessed by the driver; who would see their patient three times a week. The driver would alert control if the patient's condition deteriorated and required the use of a wheelchair.

- Patients were able to call the service themselves to book transport.
- A briefing of patient bookings occurred daily at the service, so that management were aware of the daily activities.
- We saw evidence of monthly reviews of the types of patients transported, mobility constraints, aborted jobs and cancellations that were then organised in a monthly management pack and sent to the trust for discussion.
- Monthly discussions were held with the trust to ensure that the right crew were sent for the right jobs, with the hope of decreasing wasted journeys.
- Renal patients were over 50% of the workload and planning for these patients was efficiently coordinated by the renal coordinator. Renal mapping was a system created by this service, whereby the provider and the trust would use efficient communication to ensure that patients were treated at the closest renal unit to their home.

## Meeting people's individual needs

- We spoke with staff in the transport lounge at the local hospital hired by DHL Supply Chain Limited. Staff there who told us patients were always offered a hot drink, or, if they had been waiting for more than 30 minutes, a sandwich was also offered. A packed lunch could be provided as well, and six had been ordered for patients the day before we inspected. The packed lunch consisted of a piece of fruit, a cup of juice and a sandwich.
- Special attention was paid to patients with diabetes. Patients notes were viewed on their electronic system by the staff in the transport lounge which alerted staff to the patients' medical condition. This meant that staff could pick out the patients who required extra attention, and offer food or drink accordingly.
- Many patients who required this service were patients needing dialysis. A typical patient's treatment schedule was four hours a day and three times a week. There were three shifts a day to support the volume of these

patients. These were 8am to 1pm, 1pm to 6pm and 6pm to 12pm. The renal coordinator ensured that drivers were with the same patients to help build a rapport between the driver and their patients. We spoke to staff and they were happy with this decision and they preferred this way of working. They had the opportunity to know their patients and provide a more consistent service. Ambulances took three or four patients per journey. A typical journey would last an hour from collection of the first patient to the end point destination at the hospital.

- Staff who completed these journeys were fully trained in the importance of dialysis. We asked a member of staff what he would do if a patient requiring dialysis refused transport. The staff member said they would do their very best to persuade the patient to get on board as without treatment there could be fatal consequences. We observed these journeys on the second day of our inspection. They were planned well in terms of arriving on time for patient appointment times and maximising the number of patients per route with the minimal time on the ambulance.
- We were shown evidence that the provider had met the individual needs for patients and were willing to go the extra mile to ensure patients health and wellbeing was at the forefront of journeys. For example providing support to patient's family members and adhering to extreme medical cases where staff were required to have specific training to transport these patients.
- We asked staff how they would communicate with patients whose first language was not English. Some staff said they communicated by hand gestures. We also witnessed a crew member who had learnt a few words in Punjabi and Hindi in order to be able to effectively communicate with his regular patients.

## Learning from complaints

- DHL had a set number of days in order to respond to different complaints; complaints from the Patient Advice and Liaison Services (PALS) had a three day response. Complaints from an electronic reporting system had a 10 day response. Formal complaints were completed within 28 days and informal complaints were completed within one week. Formal complaints were sent to weekly meetings to be discussed. Response rates were 100%.

# Patient transport services (PTS)

- Complaints from PALs were responded to by the provider within an average of 2.3 days in January 2016; which was 0.7 days within Target. In December 2016, the response rate was an average of 2.8 days; still in target by 0.2 days.
- In January 2016 the response times from the complaints from the electronic reporting system was an average of 68 days, 58 days out of target. This had improved to an average of 3.8 days in December 2016, seven days within target.
- Formal complaints were responded to by the provider within an average of 34 days in January 2016; six days out of target. This had improved to 12 days on average in December 2016; 16 days within target.
- Complaint response rates to patients had improved from 75.7% in December 2016 to 93.8% in January 2017. This meant in January the service was only out of their target by 6.3%.
- However there was no formal way of disseminating learning from complaints or concerns down to the crew.
- We asked ambulance staff how they would come to learn about a complaint or concern; staff responded by saying 'if we see another crew member we may talk about it then'.
- The service investigated complaints to improve the quality of the transportation provided, by looking at corrective and preventative action (CAPA) plans. This is where an organisation looks into their processes to eliminate causes of undesirable situations. The service had a root cause analysis process to look at why an event occurred and used CAPA to devise an action plan to avoid the event from happening again. For example the service received a complaint from a patient who expected transportation at 11.15pm to take them home. The service did not have the correct equipment available at that time of day to complete that journey. The service had recognised that this situation could occur again. To prevent further delays at night the service had reviewed the equipment available at that time of day and changed standard operating procedures to ensure equipment was available in the evenings.
- The service changed their vehicle fleet in August 2016 to support the increase in the number of patients that required wheelchairs. All cars were replaced with Small Wheelchair Accessible Vehicles (SEAV's).
- In order to meet patient needs the service had also brought new Large Wheelchair Accessible Vehicles (LWAV's). These could be configured in different ways in accordance to the patient's mobility. This increased the capacity inside the vehicle to a single stretcher, two wheelchairs and seven patients who did not require mobility aids.
- The provider held a vehicle supply contract that allowed a change to the fleet number in accordance to the activity within the business; this was reviewed every six months. This also ensured vehicles were new and kept up to date.
- The service hired a porter in one local hospital to bring patients from different clinics within the hospital to the transport lounge, between the times of 10am and 6pm. This meant that patients were boarded onto the ambulances more quickly as the drivers had only one point to collect patients from.
- The service also decided to open transport lounges longer each day which meant that patients had a comfortable place to wait if their transport was delayed.
- The drivers all had a small electronic device in order to access their next job. These provided details needed for the job. For example the address of the patient, or the ward, the patients name and any conditions the patient may have, were all available for the driver. However this device needed to be constantly refreshed to upload the latest data and often drivers would start a job which had already been cancelled. As the device did not automatically refresh this would result in a wasted journey.
- The service introduced support workers, that had two roles. One was to carry spare equipment such as wheelchairs and to deliver this equipment to crews that required them. This meant that ambulance crews were not going back and forth for broken wheelchairs or missing equipment and were able to concentrate on their next job. These support workers were also required to provide support to crews in order to help lift a patient.

## Access and flow

# Patient transport services (PTS)

- The provider had set up a watch list for those patients who had been left waiting for transport for extremely long periods of time. There was a dedicated team who would ensure these patients would not have the same negative experience with them again. These patients were flagged up to drivers as a matter of priority.
- We spoke to patient bookings staff who managed and assessed eligibility for patients. We were shown on a screen an 18 question eligibility form that included mobility, co-morbidity, fragility and vulnerability.
- The patient assessment was repeated every six weeks to ensure changes to a patient are monitored.
- Existing medical conditions was added to the booking as free text.
- There was also the ability to record the type of crew required for the transportation.
- The booking form did not have the structure to capture infectious diseases such as MRSA (methicillin-resistant Staphylococcus Aureus) or C-diff (Clostridium difficile), this would only be done as free text.
- The provider had employed more DHL staff instead of using subcontractors to ensure they increase the quality of the overall patient experience trained by DHL for DHL.
- The provider had employed more field trainers to complete patient assessment to ensure correct understanding of patient transport needs.
- The provider has purchased new and additional equipment including increasing the stair climber capacity.
- The provider had new ambulances for transportation, which meant that the vehicles were more reliable and that they could ensure the fleet suited the needs of patients.
- There were no values specifically for DHL Hospital Supply Chain Limited relating to patient transport and care.
- DHL supply chain had a strategy to achieve by 2020 that has three pillars for success; focusing on world class execution, connecting people and processes and growing in new segments and markets.

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

- There were no clinical governance structures in place.
- There were no formal staff meetings involving drivers.
- There was also no clear clinical criteria in the service level agreement setting out the types of patients the service would and would not transport.
- We saw a risk register at the service. We saw evidence of individually scored risk assessments for some equipment and plans were put into place to mitigate risk.
- Most of the risks identified had been actioned and closed, with only one outstanding action required.
- The risk register was last reviewed on the 13 December 2016.
- The provider had a database which tracked the key performance indicators (KPI's).

## **Leadership / culture of service related to this core service**

- The general manager was responsible for the day to day contract relationship with the senior hospital management team, and led the service overall.
- There were a number of other managers with individual responsibilities:
- The head of operations was responsible for bookings, and day to day activities and the staff within those functions. The role also covered the annual quality audits of taxis and third party providers and their daily performance. The head of operations was also responsible for all ambulance staff and their performance as well as the vehicle fleet.
- The account development manager was responsible for supporting the general manager.

## **Are patient transport services well-led?**

### **Vision and strategy for this this core service**

- We spoke to the manager who was able to tell us about the corporate values for DHL. However, all other staff we had spoken with were unable to recall these values.

# Patient transport services (PTS)

- There was a customer service manager who was responsible for addressing all patients' concerns and also dealt with hospital liaisons on site.
  - The quality and data manager managed the review in performance from a quality point of view.
  - There was a third party manager who was responsible for staff taxis and hopper buses, and their contracts, pathology contracts and performance for third party providers.
  - There was a health, safety and training manager who was responsible for compliance with health and safety and ensuring risks assessments were up to date along with staff training.
  - The service had an IT manager who attended weekly meetings with all other managers.
  - Managers said they worked well together and had clear roles and responsibilities. However, ambulance staff stated that they were unsure about the individual responsibilities of all of the managers.
  - Ambulance staff stated that there were no formal routes of communication from management to staff and no staff meetings for them to attend.
  - Ambulance staff stated that communication with the control team had improved. However, they said that there was a strong focus on numbers rather than patients.
  - Ambulance staff we spoke with enjoyed their work and were happy with their job. However, they stated that at times that did not feel appreciated or valued; with little to no appreciation for long distance patient transportations.
  - Staff reported a culture that did not encourage candour, openness and honesty. For example staff felt that there was a blame culture within the service if things go wrong.
  - Ambulance staff said that managers did not listen to their opinions to promote any change within the service. Ambulance staff said the culture was an 'us and them' situation between the managers and the drivers.
  - Management often celebrated festive holidays at work and had snacks on certain days of the week which were not extended down to other members of staff.
  - Ambulance staff said that the only communication with managers was often due to disciplinary action. However, they said newer members of management were pleasant to talk to and had built a good rapport with ambulance staff.
- Public and staff engagement (local and service level if this is the main core service)**
- There was an employee opinion survey in January 2017 and the results were displayed on a notice board. Employee satisfaction levels were as follows: employee engagement 57%, communication 52%, teamwork 70%, active leadership 51%, and future strategy 54%. An action plan was put into place as a result of this survey which included holding more team meetings, updating the notice board more efficiently and improving communications methods.
  - We were shown the results from a friends and family questionnaire from the month of January 2017. The questionnaire had six questions, regarding the recommendation of the service, cleanliness, the drivers driving, assistance into the hospital and back at home, and whether or not the patient had been given a time for their return journey. There was also a comments section.
  - 35% of patients that had used this service were extremely likely to recommend this service to family and friends if they required the use of this particular service.
  - 94% of patients reported that the vehicle they had travelled in was clean and tidy.
  - 100% of patients reported good driving from their drivers.
  - 100% of patients had been given a time for their return journey.
  - 90% of patients reported that on arrival to the hospital the driver had assisted them to their appointment clinic.
  - 90% of patients reported that they were seen safely into their home once they had gotten off the vehicle.
  - The comment section however included a mixture of positive and negative comments such as 'just plain rubbish', 'badly organised', and 'long wait but the drivers are good and the staff in the lounge are great fun'. It was unclear what measures was put in place to improve this feedback.

# Patient transport services (PTS)

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

- Staff we spoke with showed an interest in developing their personal training, however this could only be achieved if staff booked in training courses in their own time.
- In the near future the provider intended to use a notice board to display safety issues or themes of the month for example, manual handling, supervised operations and look at the use of personal protective equipment. This is a work in progress with the aim of learning from incidents.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding.
- The provider must disseminate any learnings from incident reporting to all staff
- The provider must improve the governance of the service.
- The provider must train staff in the Mental Capacity Act 2008.

### Action the hospital **SHOULD** take to improve

- The provider should check their ambulances and stock room for out of date stock.
- The provider should update their asset register.
- The provider should monitor the cleaning on the vehicles that are taken home after a shift
- The provider should introduce a formal staff meeting for their drivers.
- The provider should conduct regular staff appraisals, to gain an insight in the needs of their drivers.
- The provider should improve the culture within the service.

## 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

Transport services, triage and medical advice provided remotely

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Systems and processes were not established and operated effectively to protect service users from abuse and improper treatment because:

- the Safeguarding policy was out of date
- the service was not reporting safeguarding to the CQC
- the policy did not mention modern slavery or female genital mutation
- the manager was informed that safeguarding lead should be greater than level 2, the safeguarding lead has now been trained to level 3, which is still incorrect, as the lead should be trained to level 4 according to national guidelines
- safeguarding trainer trained to level 1- National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that those providing training must provide evidence to ensure the content is approved and considered appropriate against the relevant level
- all staff trained to level 1, should be level 2
- children use the service, therefore training is not at the right level
- staff could not identify the term safeguarding or give examples of abuse
- no MCA training/ DoLs or dementia awareness and staff reported transporting patients from mental health hospitals
- staff did not receive safeguarding refreshers

13 (1)(2)(4)(b)



This section is primarily information for the provider

## Requirement notices

### Regulated activity

Transport services, triage and medical advice provided remotely

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

All premises and equipment used by the service must be properly used and properly maintained. Oxygen must be stored safely in accordance to BOC regulations.

Medical devices must adhere to all MHRA guidelines. This information must be available in a spread sheet format or database that can be readily searched and identify items due for a service.

Regulation 15 (1)(d)(e)

### Regulated activity

Transport services, triage and medical advice provided remotely

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor, or improve the quality and safety of the service provided because:

- there was no clear method of disseminating incidents to staff evident whilst interviewing the ambulance crew
- crew were not told of any action plans from incidents
- crew were not informed of positive or negative comments from patients
- there no formal staff meetings involving drivers where such information could be disseminated.
- there was poor communication between management and staff

Regulation 17(2)(a)

### Regulated activity

### Regulation

This section is primarily information for the provider

## Requirement notices

Transport services, triage and medical advice provided remotely

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed. They must receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.

There was no evidence that the service had performed annual appraisals for staff for over two years.

Regulation 18(2)(a)