Q Despatch (West) Limited

Q Despatch

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Q Despatch is operated by Q Despatch (West) Limited. The organisation provides non-emergency patient transport services in London and nationally from its 24-hour London control centre on behalf of hospitals and healthcare organisations.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 25 and 26 July 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?

The service provided by this provider was non-emergency patient transport services.

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:

- An established incident-reporting procedure was in place and there was evidence of learning from this. However, there was no formal process in place for disseminating outcome learning to staff and drivers.
- Recruitment processes and compliance with statutory equipment maintenance ensured passengers were carried safely. Healthcare organisations checked this through regular audits.
- The service was benchmarked against legislative guidance and national best practice standards. All contracts were carried out in accordance with the Official Journal of the European Union requirements.
- A 24-hour control centre team provided continual monitoring of demands on the service and provided an immediate response in case of driver delays. In the 12 months prior to our inspection, no patients had missed an appointment due to transport delays.
- All staff and drivers were up to date with mandatory training, including dementia awareness.
- Patients and healthcare organisations spoke positively about their experiences with the provider and we observed staff speak to patients with kindness and dignity during our control centre observation.
- Staff and drivers provided an individualised service to patients and we found evidence of continual service planning to meet patient needs.
- The general manager resolved complaints with an investigation and appropriate action.
- The working culture of the organisation was demonstrably positive and staff and drivers felt respected by the senior team.
- Governance structures were in place at a senior level and there was evidence of continual oversight from and multidisciplinary working with partner organisations.
- The organisation had an ethos of development, adaptability and innovation and demonstrated how it strived to achieve them.

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

- There was room for improvement in the overall organisational approach to safeguarding. This included better training and oversight. The safeguarding lead did not have any formal safeguarding training. It was not clear that staff had a good understanding of safeguarding principles and processes. Following our inspection, the provider informed us that the safeguarding lead had started the process of safeguarding training, and that they had implemented further safeguarding modules into the driver training programme.
- The depth and content of safeguarding training was not always sufficient to ensure staff and drivers could demonstrate appropriate levels of knowledge.

Summary of findings

- There was no centralised system in place to track and monitor trends for incidents, complaints and risks. Following our inspection the provider commented that they would implement a centralised system, as these had previously been recorded on an account basis, linked to specific contracts.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Amanda Stanford
Deputy Chief Inspector of Hospitals, on behalf of the 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)		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.

Q Despatch

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Detailed findings

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Background to Q Despatch

Q Despatch is operated by Q Despatch (West) Limited as a medium-sized enterprise. The service began providing patient transport services for healthcare providers in 2003. It is an independent ambulance service based in London and provides non-emergency patient transport services nationwide.

The service has had a registered manager in post since 31 May 2011.

Our inspection team

The inspection team comprised a CQC lead inspector,one other CQC inspector and a specialist advisor with expertise in ambulance services. The inspection team was overseen by David Harris, Inspection Manager.

Facts and data about Q Despatch

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the provider's head office and control centre as well as a hospital outpatient department from where patients use the service. We spoke with 12 staff, including the senior leadership team and control centre team. We also spoke with four drivers, the manager of a hospital outpatient department, two patients and their relatives. We received feedback from three healthcare organisations that use this service and reviewed 10 patient referral records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was previously inspected in December 2012.

A team of 11 controllers, coordinators and telephonists worked at the service. Transport was provided by 39 drivers and 14 drivers with wheelchair-accessible vehicles. Vehicles were owned by drivers and were maintained in accordance with safety standards set by the provider and the local licensing authority. We found no safety-related or other concerns with the vehicles used to provide services.

Track record on safety

- There had been no never events.
- There had been no incidents that resulted in patient harm.

There had been seven complaints between March 2017 and July 2017.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Patient transport services (PTS) were provided on a non-emergency basis as part of contracts for five healthcare organisations. The organisation operated services with 70 PTS vehicles, including 14 equipped to carry wheelchairs. Between June 2016 and June 2017 the service completed 73,997 patient journeys. The service experienced a 30% increase in demand between June 2016 and July 2017.

Summary of findings

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.

Patient transport services (PTS)

Are patient transport services safe?

- The service reported no never events, serious incidents or incidents with harm for the duration it had been in operation. All of the staff and drivers we spoke with were able to explain how they would use the incident-reporting process.
- Drivers carried infection control equipment in their cars and were trained in its use.
- Equipment was maintained in accordance with national regulations.
- A safeguarding lead was in post and procedures were in place to ensure vulnerable people were protected from harm. However, there was room for improvement in the depth and quality of training. In addition, the safeguarding lead did not have level 3 safeguarding training. Following our inspection, the provider informed us that the safeguarding lead had started the process of level 3 safeguarding training and that they had implemented further safeguarding modules into the driver training programme.
- All staff and drivers were up to date with mandatory training.
- The service responded to increases in demand by deploying more drivers, which was possible by moving drivers from it's private hire function. All such drivers had training in patient transport services.
- Business continuity plans were in place that enabled the service to continue in the event the control centre became uninhabitable.

Incidents

- There had been no never events in the year prior to our inspection, or since the service began operating patient transport services (PTS). Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff and drivers used an established system to report incidents. This included minor incidents such as a short delay in transport and major incidents such as a patient collapsing. The controller in charge of the control centre was responsible for resolving minor incidents reported during a shift and more serious incidents were escalated to a senior member of staff for investigation.
- There was no centralised system to track and monitor incidents in order to identify trends, and no formal system in place to share the findings and outcomes of incident investigations between staff and drivers. Instead, individuals we spoke with said they found out about changes to policy or practice relevant to them by e-mail memos or when the general manager spoke with them. Following our inspection, the provider informed us that they would be implementing a formal system.
- The duty of candour formed part of the provider's complaints procedure and was part of the basis of their ISO 9001-2008 quality standard. ISO quality management systems relate to the extent to which suppliers of services meet established quality and service standards against set criteria. There had been no incidents in the previous 12 months in which the duty of candour applied. However, we saw evidence staff used it by providing people with a truthful explanation when things went wrong.
- We asked three other organisations who used this PTS service about the safety record and incident reporting system. In all cases we were told the senior team took incidents seriously and they had been satisfied with the level of investigation and resolution provided. One secondary care provider had recently audited incident investigations and found they were completed to an appropriate standard.

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

- Senior staff in the control centre team monitored daily performance per contract. This meant a named individual checked journey times against schedules for each contract the PTS held to ensure service level agreements were met.
- We saw from observing procedures in the control centre and from speaking with drivers the service could reroute and reallocate journeys where daily monitoring indicated there was a risk of delays.

Cleanliness, infection control and hygiene

- Drivers carried an infection control kit and were responsible for mainting sufficient stock. This included personal protection equipment such as a spill kit, gloves

and aprons and alcohol hand gel. Although drivers carried vomit bowls, the provider did not issue them with biohazard waste bags that could be used to carry and dispose of the waste safely. This meant there was not always a rapid or safe method of disposing of clinical waste. We asked four drivers about this who told us they would try and cover the waste and take it to the nearest hospital to be disposed of.

- All drivers had access to a valet service in London that operated 24-hours, seven days a week and could provide urgent hygienic and infection control cleaning of cars in the event of a bodily fluid spillage. Where this occurred outside of London, the duty controller was responsible for finding the nearest service to the driver. The organisation's infection control policy ensured drivers did not use their vehicle for patient transport following any spillage until it had been cleaned by a valet company.
- Infection control training for drivers included detailed guidance on maintaining a hygienic environment, including the disinfection of seats and soft coverings. The training also ensured drivers understood good personal hygiene practices such as effective hand-washing techniques and how they could protect immunocompromised patients.

Environment and equipment

- The provider maintained a central record of mandatory Department for Transport vehicle tests (MoTs). At the time of our inspection, all vehicles had passed an inspection in the previous 12 months, which was compliant with Driver and Vehicle Standards Agency requirements. The senior and fleet teams used this record to track service requirements for each vehicle.
- Drivers used a standard operating procedure and safe system of work to support patients who used a wheelchair to be safely transported. For example, drivers were trained to use safety restraints to secure wheelchairs in place and were instructed not to drive if a patient refused the restraint. Driver training included safe patient transfers to and from wheelchairs and safe manoeuvring skills.
- Drivers completed a safety checklist before taking a wheelchair from the base to be used with patients. This included a check for damage and the working function of brakes and foot rests. Where a driver found a fault or damage, they completed a defect form that was actioned by the general manager.
- In addition to the licensing authority, providers who used this PTS service audited vehicles for maintenance and safety. One provider told us their most recent audit had found full compliance with all safety features and routine maintenance.
- Drivers completed a vehicle checklist before the start of each shift that included 22 individual minimum requirements of exterior and interior condition and safety measures such as battery condition and an oil check. Cars only entered service where all of these requirements were met.

Records

- The senior team and control centre staff had worked with hospitals and other healthcare organisations to ensure PTS bookings included personal information that would enable them to provide a safe service. This included the nature of treatment the patient received and whether any special adaptations were needed to the journey or vehicle.
- Drivers we spoke with demonstrated their understanding of transfer notes relating to patients and discussed how they maintained a safe service. This included for patients living with dementia and those who were known to be vulnerable or anxious.

Safeguarding

- The provider's vulnerable adult policy included guidance for drivers on the action to take if they witnessed or suspected abuse and how they could escalate safeguarding concerns. We asked five drivers about this, all of whom demonstrated understanding of the policy and were able to explain the action they would take in a safeguarding situation.
- There was a named safeguarding lead in place. However, this individual had not undertaken formal safeguarding accreditation or training. In addition, although control centre staff undertook training, it was not clear from speaking with them that each individual had a good level of understanding of the principles of safeguarding. This was a potential risk as drivers reported safeguarding incidents to staff in the control room.
- Senior staff demonstrated awareness of safeguarding concerns and issues when accepting work from other organisations. For example, another PTS service regularly booked journeys and then passed these to Q Despatch. However, control staff found the referring

company had not always passed this information to patients and there was not always sufficient information about escorts available. This presented a safeguarding risk as it meant drivers were not fully aware of who should be with the patient. In response, the senior team implemented a minimum standard of information required from referring companies so drivers could always collect patients safely.
- Although staff and drivers undertook safeguarding training as part of their mandatory programme, this was not a formal process that awarded a specific level of training.
- We observed control centre staff confirmed the name and relationship of each escort due to travel with patients as part of the safeguarding protocol during the booking process.
- The provider's safeguarding policy ensured only authorised escorts would be accepted for travel with patients. Named escorts were booked in advance and included on the patient details form. If an escort was present and the driver was not expecting them or could not confirm their identity, they contacted the control centre for assistance. A coordinator would then contact the charge nurse of the discharging hospital ward to find out if the escort could be carried.
- Two providers we spoke with who used this PTS service told us they were satisfied with the safeguarding policies and knowledge of staff and drivers.

Mandatory training

- Drivers undertook a programme of five mandatory training modules. Drivers of vehicles equipped for wheelchairs additionally undertook a module in safe wheelchair operation and transport. At the time of our inspection, the driver team had 100% compliance in all mandatory training, including annual refresher training. Training topics included dementia awareness and infection control.
- Mandatory training for control centre staff was included as part of the induction and shadowing process. However, there was not a central record of this or a documented assessment of individual understanding in areas such as safeguarding and emergency procedures.

Assessing and responding to patient risk

- Drivers and control centre staff used an escalation policy to respond to patients who deteriorated during a journey or whose condition or behaviour concerned them. This included an escalation pathway that determined whether drivers escalated to the control centre, a manager or the emergency services. All of the individuals we spoke with were aware of this.
- Control centre staff told us how they responded to patients who behaved violently to drivers. For example, a controller contacted the hospital ward when one patient had behaved violently towards a driver. Through this course of action, staff identified the patient needed closer care and an escort due to deteriorating mental health. The investigation resulted in more detailed information submitted by the hospital staff who booked a PTS journey and indicated drivers followed the correct procedure when they felt threatened.
- Although drivers carried first aid kits, not everyone had received formal first aid training. This was not part of the provider's mandatory training and there was not an up-to-date record of the number of drivers with completed training. However, all drivers who had worked for the organisation for more than six months had the option of undertaking this training.
- Journeys were booked based on an assessment of patient risk. For example, cars could carry patients with up to two litres of oxygen but only if this could be transported without the need for constant charging. If oxygen tanks needed to be charged, the control centre redirected the booking to an ambulance service.
- Although control centre staff undertook training during their induction on providing care for patients with a DNACPR, there was not a consistent policy for both staff and drivers to follow. For example, two previous incidents had occurred whereby patients had collapsed and their drivers called the control centre prior to calling the emergency services. The senior team investigated both situations as serious incidents and provided drivers with more in-depth training, which we confirmed by speaking with drivers. We saw evidence that after this refreshed guidance, drivers had called the emergency services immediately in urgent clinical situations.

Staffing

- A team of 39 drivers provided PTS in standard cars and 14 drivers provided wheelchair-capable services.
- A team of 11 controllers, coordinators and telephonists ran the control centre 24-hours, seven days a week. Each member of staff had specific responsibilities and there was always a manager on shift with a senior

manager available by telephone out of hours. Control centre staff had additional roles, such as a senior telephonist who was also the manager for patients transported under a renal care contract.

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Schedule 3) specifies the information required in respect of persons employed or appointed for the purposes of a Regulated Activity. The schedule requires an employer to obtain certain evidence, including evidence of conduct in previous employment and a disclosure and barring service (DBS) certificate as determined by the category of employment to be undertaken. We looked at seven driver employment records and found the provider was compliant with this and held proof of driver licensing checks from the Driver and Vehicle Licensing Agency. The provider did not hold DBS certificates because of the requirement that Transport for London hold these instead as the licensing authority. However, the provider maintained evidence of DBS checks and showed us how they could access these at any time through an electronic access portal.
- Where patients required a long-distance pick-up or journey, the driver stayed in a hotel en-route either the night before or the night after. This ensured they were properly rested and could drive safely.
- Between June 2016 and July 2017 there was a turnover rate of 20% amongst drivers, which reflected the nature of similar workforces in London. This had not impacted on the service provided and there had been no change in performance of the service as a result. The provider told us they dealt with the turnover with a constant recruitment drive.

Response to major incidents

- Drivers who worked with the provider on specific medical contracts were licensed to carry patients anywhere in the UK on demand. This meant the organisation could respond to major incidents in London and provide patient transport services at short notice between hospitals and incident sites. For example, during a major incident the provider initiated a PTS service for the British Emergency Ambulance Response Service, who provided positive feedback about safety and responsiveness.
- A business continuity plan was in place and all staff in the control centre we spoke with were aware of this. The electronic systems used to operate the service used remote storage, which meant that if the control centre became uninhabitable, the team could operate the service using laptops and mobile phones at a temporary base. This would ensure there was minimal interruption to the service.

Are patient transport services effective?

- Services were provided in line with a series of policies and safe systems of work that were based on national best practice guidance and benchmarking.
- Systems were in place to ensure control centre staff and drivers were aware of patient conditions in advance. There were protocols in place in the event this system failed.
- An induction and initial training programme was in place but this was informal and did not always provide staff with planned, formal updates or instruction. There was not a structured appraisal plan in place. Following our inspection, the provider informed us they were introducing formal staff appraisals which would be documented and held in their personnel file.
- The provider had demonstrably worked with healthcare providers to improve the information they provided, which enabled the service to be safer and more individualised.
- Staff and drivers provided services against a consent policy that enabled them to reduce the risk of harm to patients whilst enabling them to remain free to make their own decisions.

Evidence-based care and treatment

- Safe systems of work were based on national best practice guidance. For example, wheelchair handling and transporting policies were based on the requirements of the Road Traffic Act 1988 and the Medical Devices Agency 2001 guidance (DB2001/03) in relation to the safe transportation of wheelchairs.
- The organisation was a member of the Licensed Private Hire Car Association, which meant services were provided against established safety and quality assurance guidance. While this provided a service benchmark for the organisation, it also contributed to governance as it included regular auditing from the London private hire regulator.
- The senior team had established a service standard against the guidance of the Kidney Patient Association,

such as the maximum length of time a patient could comfortably sit in a car. The provider had recently initiated an audit process of the service standards although data was not available at the time of inspection.

- The provider audited driver performance within patient transport services (PTS) contracts as each contract had a unique service level agreement. The organisation's contract with a specialist hospital department included a target that no more than 5% of PTS journeys would be late. In the year leading to our inspection 2% of journeys were late, which was better than the target.

Assessment and planning of care

- The hospital or healthcare provider booking each patient journey was responsible for supplying enough information for the PTS to provide an effective service. This included details of recent treatment that might impact a car journey as well as mobility needs and any mental health details that might help the service to provide a more individualised journey. As a non-emergency PTS this provider did not assess or deliver clinical care.

Response times and patient outcomes

- Senior control centre staff and the senior leadership team monitored key outcome data such as response times and timeliness of journeys. The member of staff responsible for each contract monitored this on a daily basis and reviewed data based on individual service level agreements.
- The provider had successfully completed the Official Journal of the European Union (OJEU) requirements for each NHS contract within which it supplied PTS. OJEU is an accreditation and tendering process that acts as legislation for any organisation that receives public money to carry out services and underpins safe and effective operations.
- The service used auditing associated with its ISO 9001 accreditation to ensure services were hallmarked by consistent staff training, quality standards and up to date policies.
- Coordination staff in a 24-hour control centre monitored patient journeys electronically and the start and end time of each journey was time stamped automatically. This meant the senior team could monitor journey times and delays.
- Operations staff monitored driver routes on a daily basis and included average speed against the maximum speed limit for the area and driver responsiveness to traffic delays and road clsoures.
- In February 2016, one of the companies that contracted this provider for PTS conducted a health and safety audit. This measured the service's compliance with local and national safety requirements as well as driver training and the ability of the service to meet patient needs. The audit found the service to be fully compliant in all areas and to meet the quality requirements of the organisation's ISO 9001 standard.

Competent staff

- There was no formal appraisal process in place for salaried staff or drivers. However all of the individuals we spoke with said they felt well supervised and able to approach a senior member of staff at any time. Control centre staff told us the senior team regularly asked how they were doing and asked if they needed help. The provider supplied information prior to our inspection that indicated 83% of drivers and 85% of control centre staff had undergone an appraisal. This contradicted the information given to us during the inspection and we were not able to find the reason for the difference. Following our inspection, the provider informed us they were introducing formal staff appraisals which would be documented and held in their personnel file.
- Each member of staff and each driver undertook an induction regardless of their previous experience. This included introductions to the safe systems of work and other organisation policies on safety and the daily operation. The general manager led inductions, which typically lasted up to four hours but did not include instruction from anyone formally qualified in the topics of instruction. We asked four drivers about their experience of the induction process. Each individual spoke positively about the process and said it was detailed enough to help them in their work. Drivers also completed a two week probationary period followed by a final assessment on performance and ability to provide services to patients.
- Drivers undertook passenger safety training that included 12 subjects, such as emergency procedures and providing assistance to patients who fell. However, there was no system in place to ensure training was in-depth or enough to meet patient needs. We looked at

the training records of seven drivers and found variable documentation in relation to passenger safety. For example, the training record of one driver indicated they had completed the entire training in 15 minutes.

- It was not possible to identify the level of training or competency of individual staff or drivers due to the lack of detail in training records. For example, there was a record of attendance for each member of staff but no details recorded of learning outcomes. The length of some training sessions was also short despite covering a range of complex subjects. This included a training session that included safe systems of work, child and adult safeguarding, infection control and dementia awareness in just 30 minutes.
- The driver recruitment process included a test of road and geographic knowledge specific to London. This included key postcodes and roads and a test of route knowledge between key areas. The general manager used this test to ensure new drivers did not need to rely exclusively on satellite navigation systems when driving. We looked at two rejected application forms and found the organisation maintained a consistent standard of knowledge requirements for new drivers.
- Control centre and salaried staff received training on an ad-hoc basis, such as when the manufacturer of software provided an update or the telephone system was upgraded. There was also no formal training process for new control centre staff, who were trained on an 'on-the-job' basis by existing staff. This meant the team was kept up to date with operating procedures although not as part of a formal process.

Coordination with other providers and multi-disciplinary working

- The provider worked with a specialist hospital service to transport patients to and from the centre from across England. The provider and the hospital provided drivers with information on a multidisciplinary basis to ensure they could meet both patient need and operational requirements. For example, drivers escorted patients into the hospital in person and waited with them in the hospital if they arrived early.
- We observed positive examples of multidisciplinary working. For example, we saw control centre staff contacted NHS hospital departments and services to coordinate care when patients called to cancel transportation.
- We spoke with a manager of a hospital service that used the provider for patient transport. They described the service as "excellent" and said patient feedback had also been very good.
- The provider held formal relationships with emergency ambulance and paramedic organisations and could organise more specialist transport if they could not provide a safe service to a booked patient.

Access to information

- Hospitals or providers contracting this PTS provided the control centre with information if a patient booked to be carried had a do not attempt resuscitation(DNACPR) authorisation in place. However, this was not within the organisation's standard operating procedures and the senior team would liaise directly with hospital staff before deciding if they could accommodate a patient.
- Each car was equipped with an up-to-date satellite navigation system that was linked to the control centre. This meant drivers and control centre staff worked together to use up-to-date traffic information to prepare the most efficient routes for patient journeys.
- The senior team had worked with NHS providers to improve the level of detailed information they were given as part of the transport booking process. This was to enable coordinators to book the most appropriate driver and to ensure drivers were aware of individual needs. This included the type of treatment the patient had undergone and the impact. For example, where a patient had undergone cataract surgery, the hospital indicated the driver should be aware of reduced visual acuity.
- Drivers and staff in the control centre had access to the electronic patient information from the hospital or member of staff who booked the journey. No confidential information was retained by drivers' electronic devices. After each journey was complete, data relating to it was deleted and stored only by the central records system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff and drivers had basic training in the Mental Capacity Act (2005) as part of their induction and mandatory training.
- The provider's safe systems of work included guidance for drivers and staff on consent and their level of responsibility with patients in specific situations. For

example, drivers were instructed that patients had the right to refuse assistance even if the booking from the hospital indicated they should be helped. Drivers we spoke with demonstrated knowledge and understanding of working with patients in such circumstances, including how they could protect patients from harm and seek assistance from the control centre.

Are patient transport services caring?

- During our observations control centre staff had conversations with patients and their relatives that demonstrated kindness, respect and compassion.
- Patients were actively involved in the planning of their transport, including when discussing routes and journey times.
- Drivers ensured patients understood the nature of the service and their eligibility to use it.
- Staff and drivers used the guidance of healthcare organisations to understand the potential emotional needs of patients, including in adapting communication styles.

Compassionate care

- We observed staff in the control centre speak with patients and their relatives with kindness and compassion. For example, when a patient called the control centre to cancel a booking, staff offered to also let the hospital department know and checked if there was anything else they could do to help. When one patient called who staff recognised, they had friendly conversation with them and made the patient feel at ease about booking their next transport.
- Drivers discussed with us how they ensured patient dignity during each journey, such as by asking how each person would like be addressed and being sensitive about conversation relating to medical care.
- The service had received five letters and cards in the previous six months from patients to thank drivers for their kind and compassionate service, including their caring attitude during journeys.
- A provider who used this patient transport service (PTS) told us they found drivers to be consistent in their positive attitude and said they felt drivers treated vulnerable patients with kindness and dignity.

Understanding and involvement of patients and those close to them

- We observed staff in the control centre check transport needs with each patient or escort when they called. This included specifics about levels of mobility and the type of support they would need during the journey.
- The control centre involved patients when there was service disruption as a result of unavoidable traffic delays. For example, drivers contacted the control centre who then liaised between the patient and the hospital to ensure their appointment could still go ahead.
- We spoke with two patients who had used the patient transport service. In both cases, we were told drivers had been friendly and polite and given information about the journey such as expected time of arrival and the route they planned to take. In both cases, patients told us drivers had helped them carry bags and had escorted them directly into the hospital department.
- Staff and drivers ensured patients understood their eligibility for the PTS. For example, if a patient asked for another person to be transported with them, drivers explained that only pre-booked patients and their escorts could be carried.

Emotional support

- Staff and drivers had received guidance from the healthcare organisations they provided PTS for. This meant they understood the needs of each patient group and were prepared for some patients to be anxious or upset.
- Drivers demonstrated skills in adapting their communication technique to each individual patient, which enabled them to provide conversational support during journeys.

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

- The control centre team managed the driver fleet flexibly to meet changes in demand. This included moving drivers between contracts and reallocating tasks to mitigate potential traffic delays.

- Drivers and control centre staff had undertaken dementia awareness training and those we spoke with demonstrated how they adapted the service.
- Control centre staff monitored on-scene and turnaround times and ensured journeys were planned to reduce the risk of delays.
- A complaints procedure was in place and we saw evidence of learning and service improvements as a result of complaint investigations.

Service planning and delivery to meet the needs of local people

- Control centre staff could plan to match patients to drivers based on previous experiences and feedback. This included positive and negative experiences. In addition, control centre staff tried to match patients who were transported regularly with the same drivers. This was to improve their overall experience as they would visit the centre a number of times for treatment.
- Coordinators monitored traffic problems in London live and were able to reroute drivers or reallocate drivers based on delays and anticipated problems. In addition, the organisation had access to live transport and travel updates from the London travel authority, which meant they could anticipate problems and reroute or reallocate drivers as needed.
- Each driver carried an electronic device that meant messages from the control centre were received instantly and drivers could use these to change their route plan.
- At the time of our inspection, the provider did not have any female drivers. This meant they could not accommodate the requests of patients who requested a female driver. However, the organisation was proactively promoting the recruitment of female drivers on its website and an established equal opportunities policy was in place.

Meeting people's individual needs

- The organisation demonstrated a proactive approach to tailoring services and staff training to meet individual needs and improve the patient journey experience. For example, the senior team had engaged with the Kidney Patient Association to discuss how they could provide a safer and more individualised service to patients who were transported for kidney dialysis or transplant. This meant drivers had access to more detailed information on the types of symptoms and needs patients were likely to have and how they could make the journey more comfortable.
- Staff and drivers had all undertaken dementia awareness training and individuals we spoke with understood how to provide safe services to patients living with the condition. For example, drivers recognised the signs and symptoms of dementia and were able to adapt their communication style to help patients understand them. In addition, there were additional safety processes in place for transporting patients including strict instructions on where they were to be picked up and dropped off with a known carer or member of staff.
- The service demonstrated the ability to provide flexible and individualised services based on patient need. For example, where a patient with mental health needs wanted to wait for their driver in the grounds of a hospital's garden, the provider was able to coordinate this with the hospital so the patient could be safely collected.
- Where drivers completed long-distance journeys, they discussed planned comfort stops with patients. Drivers also stopped on-demand for rest breaks. Although the electronic booking system included an option for hospital staff to request drivers carry bottled water for patients, operations staff told us this happened inconsistently and could not always be guaranteed.
- Control centre staff had access to which languages were spoken by drivers and used this to match patients who had limited English language skills. At the time of our inspection, drivers were available who spoke Greek, Romanian, Turkish and Somali. In addition staff had access to a telephone interpreting service.
- The service was able to accommodate requests to carry a guide dog with a patient as well as supply extra padded cushions and newspapers and to carry luggage after an inpatient stay.

Access and flow

- In the 12 months prior to our inspection there had been no cancelled clinical appointments as a result of PTS delays.
- Control centre staff managed resources based on the individual service level agreement of each healthcare

organisation's service contract. The electronic booking and satellite navigation systems meant needs could be accommodated flexibly, including long-term and short-notice bookings.

- A named member of staff acted as a manager for each contract and planned journeys according to the nature of it. For example, patients who were booked into a follow-up clinic months in advance had their journeys booked in advance. Patients who attended outpatient departments often needed short notice changes, which the service was able to accommodate.
- The organisation operated a fleet of private hire vehicles in addition to patient transport services. Operations staff were able to increase the number of vehicles for PTS during periods of high demand by moving drivers between contracts. This happened only where private hire drivers with PTS training and the appropriate safety and background checks were available. This enabled the service to operate without interruption and without the need to sub-contract PTS work.

Learning from complaints and concerns

- There was a formal complaints procedure in place, which was readily available on the provider's website. NHS hospitals that used the provider's PTS services had access to this as part of their service level agreement.
- Between March 2017 and July 2017, the provider received seven written complaints. These related to journey time or the behaviour or actions of a driver. In each case, the general manager had provided an initial written acknowledgment and then completed an investigation. We looked at the investigation of all seven complaints and found in each case the manager used data from the electronic monitoring of transport journeys as well as interviews with staff and drivers to come to a resolution. For example, following a complaint regarding an uncomfortable car journey during hot weather, the manager found the air conditioning had been broken but the driver had not informed the control centre. As a result, the driver received additional training. Another complaint related to the speed one driver drove at during a long-distance journey. The general manager identified the driver had broken the speed limit during the journey from looking at tracking data. As a result, they were suspended from long-distance driving and senior staff conducted spot checks on the driver to monitor safe driving.
- Where patients or escorts had made complaints to both the provider and the hospital department treating them, we saw evidence the general manager liaised with the hospital department's senior team. For example, the information needed by the provider for PTS patients involved in clinical trials was increased following a missed appointment. The general manager worked with an outpatient administration manager to ensure this was implemented.
- We spoke with a manager of an NHS provider about the complaints process. They told us they received no more than one complaint about the PTS per quarter and that they had found the senior management team to be proactive and responsive in each case. For example, they said a driver had been retrained when a patient complained they had not offered conversation and another had been given guidance on the appropriate volume of music following negative patient feedback. Another provider manager told us, "The number of complaints is well below what we'd expect from the volume of patients they carry," and said this amounted to an average of one complaint per month with between 750 to 1200 individual patient journeys per month.

Are patient transport services well-led?

- The leadership structure was well established and staff, drivers and partner organisations spoke highly of managers.
- There was a demonstrably positive work ethos, supported by managers who encouraged high standards of performance and offered ongoing support.
- The general manager used a series of risk assessments to monitor risks, however, there was no centralised risk register to track and address these.
- Corporate governance structures addressed clinical risk and partner organisations told us they were happy with these. However, there was room for improvement in some governance processes, including in staff meeting arrangements.

Leadership / culture of service related to this core service

- A director of operations and personnel led the organisation and was the registered manager. The senior leadership team included a general manager of client services and staff training, a head of control, a

fleet and driver training manager, a credit control manager and a head of sales and marketing. The senior team told us they operated a 'walkabout' leadership model adapted from an accredited international business management school. This enabled them to build informal relationships with staff to encourage self-development.

- A fleet manager post and driver services manager post were both vacant at the time of our inspection and the fleet coordinator's post was vacant due to sickness. This meant the general manager was fulfilling all three roles.
- The senior team promoted a working ethos amongst salaried staff and drivers that enabled each individual to be empowered and take responsibility for their own performance. This approach included a 'devolved power' system, which meant in practice that the senior team provided support and guidance as necessary but encouraged staff and drivers to make their own decisions on a day to day basis. In addition staff and drivers worked towards a 'PRIDE' ('Progress, Respect, Integrity, Drive and Excellence') set of values that outlined the standards of care and support individuals could expect from working in the organisation.
- Staff and drivers we spoke with were positive about the organisation and said they appreciated the flexibility afforded to them, including through shift patterns and achieving a good work-life balance.
- The senior team told us they held monthly control centre meetings. However, six control centre staff we spoke with said they had never attended a meeting and although managers were readily accessible, communication was always on an unplanned basis.

Vision and strategy for this core service

- The service operated with a 'no room for variance' strategy, which aimed to ensure every patient journey was successful and on time.
- A key vision of the senior team was the service offered bespoke instead of a standardised approach. To achieve this, the team ensured drivers and staff were recruited who held a work ethos of seeking a dedicated career rather than a job. There was evidence of the success of this approach from the positive feedback we received when speaking with them.

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

- The director and general manager held an operational status meeting daily, Monday to Friday, to discuss the fleet performance the previous day. They also used the meeting to address any staffing, governance or risk-related issues.
- At the time of our inspection, the senior team used a series of individual risk assessments to monitor risks to staff, drivers and patients. We looked at all current risk assessments and found each was linked to a safe system of work (SSOW). For example, the key risks identified were patient falls, car accidents and incorrect instructions received from a hospital. In each case, the senior team had implemented a SSOW to reduce the risk of each. This included moving and handling training and instructions for drivers, although there was evidence training was not always comprehensive. The senior team had worked with hospital colleagues to improve the quality of patient information received ahead of a journey. We saw in practice this was detailed and included information relating to patient safety, including mobility risks.
- SSOWs we looked at did not always have completed control measures listed. For example, potential risks identified included drivers under the influence of alcohol or drugs and drivers not taking sufficient rest periods. The SSOW indicated their was no control measure in place for either. However, the licensing authority undertook drug and alcohol spot checks of drivers as well as unannounced roadside vehicle safety checks as part of the provider's risk management responsibilities.
- After our inspection, the provider implemented a centralised risk register, which would enable them to monitor and track all risks and implement risk response plans.
- As part of the organisation's licensing requirements, Transport for London regularly audited drivers and vehicles for compliance with safe operating standards.
- The organisation held ISO 9001-2008 and ISO 14001-2004. ISO standards are internationally-recognised measures of quality management and indicate an organisation has effective quality strategies and processes in place.
- Drivers owned their own vehicles and were responsible for holding up to date insurance. The provider kept a record of each driver's insurance status and they were

only able to work if this was valid and in date. An electronic system alerted the general manager if a driver's insurance was due to expire so they could contact them to make sure it was renewed on time.
- Corporate governance systems were in place to ensure continual compliance with service level agreements with NHS providers. This included a quarterly meeting between senior teams and a quarterly performance report of each contract.

Public and staff engagement (local and service level if this is the main core service)

- All of the staff and drivers we spoke with said they felt able to offer feedback on the service operation and said managers listened to them. They also told us how their feedback led to improvements. For example, one member of staff said the control centre team regularly discussed ways to improve things. Recently this had included the bookings process, which meant patients ready to leave one outpatient department had just a 15 minute wait to be picked up.
- Senior staff did not hold scheduled or regular meetings for the control centre team or for drivers. Instead, managers communicated with shift teams or with individuals at the start of their shift when they needed to pass on information. Although this was not a formal or established process, staff and drivers we spoke with said they felt consistently well informed and were happy with standards of communication.

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

- The senior team aimed to ensure the business was environmentally sustainable and prioritised the use of hybrid vehicles wherever possible. A provider who used this PTS service told us they provided a CO2 emissions summary with every invoice as part of their environmental policy.
- The provider demonstrated a significant degree of flexibility in providing additional or unplanned services. This included during major incidents in London and when implementing an immediate recovery plan for patients who had been affected by the failure of another patient transport services.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

The provider should ensure that all staff have adequate safeguarding training and that the safeguarding lead is trained to the correct level for the services provided.

The provider should ensure that incidents and risks are recorded in an effective system to allow for learning and trends to be identified.