Exora Medical Limited

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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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Exora Medical Limited

Detailed findings

Services we looked at:
Patient transport services (PTS)

Detailed findings

Contents

Our inspection team

Our inspection team comprised of:

An inspector from the CQC and an advanced paramedic practitioner.

How we carried out this inspection

We visited the patient transport service (PTS) for two announced inspection days on 12 and 17 October 2016. We also reviewed data provided by the service.

During the inspection, we spoke with 12 members of staff including the leadership team, patient transport crews and paramedics. We also spoke with patients and relatives, as well as healthcare staff whose patients used the PTS service. We inspected four of the vehicles used by the service and observed staff transporting patients.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Exora Medical Limited is based in Watford, in North West London. The service offers a patient transport service and a high dependency transport service. A specialist bariatric patient transport service was also available. The service provides transportation between community care provider locations, hospitals and patients' home addresses for children and adults.

The service has nine vehicles, including six patient transport vehicles and three high dependency vehicles. There are 26 staff members employed, which includes three office staff and 23 drivers. The service provided 4553 patient transport journeys between September 2015 and August 2016.

The service provides a mainly ad hoc patient transport service, with bookings made frequently on the same day, or sometimes the day before. The service reported that 90% of their workload was patient transport or bariatric transfer bookings, with the remaining 10% comprised of high dependency transfers.

Summary of findings

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Our key findings were:

- Vehicle and equipment was well maintained and we saw documented evidence of servicing and upkeep at appropriate intervals.
- Cleanliness and infection prevention and control procedures were appropriate and adhered to by staff within the service.
- The service provided was flexible and could modify various aspects of its provision in order to meet patient needs. For example the service could transport patients outside of their regular working hours, with sufficient notice.
- Technology in the form of electronic tabs was fully utilised to enhance the planning and delivery of effective care.
- The service consistently completed more than 95% of immediate pick up patient transport jobs within one hour, which was a key performance indicator.
- There was a clear vision for the service and staff were aware that quality of care and reliability of the service were clear focuses for the organisation.
- Patient feedback, our observation of care, and examples from staff demonstrated that crews provided a caring and individualised service.

Patient transport services (PTS)

However:

- Staff knowledge about types of situations which should be reported as incidents was variable, as some staff only identified vehicle accidents as reportable incidents.
- Staff safeguarding training was not sufficient to meet recommendations from the Intercollegiate Document for Healthcare Staff (2014).
- Medicines management was not always appropriate. We saw gas cylinders and glucagon stored incorrectly, as well as a box of medicines in the staff food fridge.
- The service did not have an arrangement for formal clinical leadership. Crews relied upon clinical support from one another, and peers from outside the service, to provide advice when needed. Additionally no clinical supervision was completed within the service, which meant senior staff could not be assured of staffs' clinical competence.
- A clinical governance committee was in place; however minutes showed key governance issues, such incidents, were not formally discussed.
- The service did not have a risk register with evidence of frequent risk reviews and mitigating actions. Risk assessments had been completed but did not demonstrate full risk mitigation.

Are patient transport services safe?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- Vehicle and equipment was well maintained and we saw documented evidence of servicing and upkeep at appropriate intervals.
- Cleanliness and infection prevention and control procedures were appropriate and adhered to by staff within the service.
- Staffing was appropriate for the capacity of patient transport jobs accepted by the service, and all jobs were allocated a minimum of a two person crew.
- Compliance with mandatory training across a range of topics was good and uptake was 100% for all but one subject.

However:

- Staff knowledge about types of situations which should be reported as incidents was variable, as some staff only identified vehicle accidents as reportable incidents.
- Staff safeguarding training was not sufficient to meet recommendations from the Intercollegiate Document for Healthcare Staff (2014).
- Medicines management was not always appropriate. We saw gas cylinders and glucagon stored incorrectly, as well as a box of medicines in the staff food fridge.

Incidents

- Staff reported incidents via electronic pads which automatically transferred data through to the head office. Staff were also able to record incidents on paper based forms in the event that the electronic tab failed.
- Staff knowledge of what types of incidents should be reported was variable. Some staff only identified vehicle accidents as incidents which should be reported, whereas other staff could identify a range of situations which would trigger incident form completion.

Patient transport services (PTS)

- We saw examples of incidents which had been reported. However these largely involved vehicle issues rather than patient related situations. There were no serious incidents reported in the 12 months prior to our inspection.
- When incidents were reported, senior staff investigated the situation, including obtaining witness statements from staff and patients if required, and took any actions needed, such as organising for a piece of equipment to be replaced.
- Staff meeting minutes showed that staff received learning from incidents which occurred, including incidents that occurred in other organisations. We saw evidence that a group training session was delivered in response to a cardiac arrest situation which occurred to a crew in a different organisation. However, some crew members we spoke to told us they did not receive incident feedback.
- From April 2015, all registered providers of health and social care services are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- There was no duty of candour training for crews, although senior staff told us this was covered during one to one supervision sessions with staff. We did not see evidence of this in the one to one documentation we reviewed.
- Staff knowledge of duty of candour was variable, although most staff we spoke with were aware that they needed to be honest and open with patients if there were any incidents during their transport.

Mandatory training

- All staff were required to complete mandatory training upon commencement of employment at the service. Mandatory training was completed through online learning modules which could be accessed from any computer with internet access.
- Topics covered by mandatory training included moving and handling, infection control, mental health awareness and risk assessment.
- Records we reviewed showed that all mandatory training topics had been completed by 100% of staff other than training in mental health awareness, which had been completed by 54.5% of staff.

Safeguarding

- Safeguarding vulnerable adults and children was part of the mandatory training programme and was completed through online learning modules. Training records we reviewed showed that 100% of staff within the service had completed the relevant online learning.
- The safeguarding training provided in the mandatory training was equivalent to level 1. There was no additional level 2 training for staff available. National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that all ambulance staff should be trained to level 2, therefore the training provided was not sufficient to meet this guidance.
- The director of the service was the designated safeguarding lead. The director had completed a comprehensive safeguarding course run by the local authority, which was the equivalent of level 4 training.
- The service had a safeguarding of children and vulnerable adults policy in place, with a review date of January 2017. The policy identified that any suspected safeguarding issue should be referred to the local authority safeguarding team for investigation.
- Senior staff told us there had been one safeguarding concern raised in the previous two years and we saw evidence a safeguarding report form had been completed. We also saw evidence the patient had been referred to the local authority, in line with the local policy.
- Staff provided examples of circumstances when they would be concerned a patient was at risk, such as if they arrived at a patient's home and there was no food available. Staff advised they would never leave a patient at home alone in this situation, and would ensure that help from a relative or carer had been organised prior to leaving the patient.

Cleanliness, infection control and hygiene

- Day to day cleaning of the vehicles was completed by the crew assigned to the vehicle each day. Additionally, crews were required to mop the floors of their vehicle on a daily basis. Crews were aware of their responsibility to ensure sufficiently clean and presentable at all times.
- We saw colour coded cleaning equipment stored in a cupboard within the staff break room at the office base. We noted that one mop head was extremely discoloured and dirty, although was still being used to clean vehicles.
- Crews used appropriate wipes to clean vehicles in between patients, including seats and other on board equipment.
- After transporting patients colonised with certain infections, such as meticillin-resistant Staphylococcus Aureus (MRSA), crews returned to the vehicle base to complete a deep clean. A specialist deep clean company was contracted to provide a thorough deep on a six monthly basis and we saw documented evidence that this took place.
- Any linen or blankets used on the vehicles were changed between each patient. An arrangement was in place with the local hospitals so that crew could exchange any linen used on the vehicles for clean linen when picking up or dropping off patients. During our inspection, we saw that used linen was exchanged whenever possible and that used linen was not routinely transported on the vehicles.
- Basic personal protective equipment (PPE), including gloves and aprons, was available on each vehicle and we observed staff wearing and disposing of these items correctly.
- Staff adhered with bare below the elbow policies when transporting patients and used alcohol gel to clean their hands when on board the vehicles. We also observed crews washing their hands with soap and water when opportunities arose.
- Clinical waste bags were available on each vehicle and we observed crews disposing of items in these bags appropriately.
- Clinical waste was appropriately stored at the base office. There was a service level agreement in place which meant clinical waste was collected from the base office every month; although senior staff told us there were only small amounts of clinical waste generated due to the nature of the service. Crews were also able to dispose of clinical waste when collecting or dropping off patients from hospitals or other care providers.

Environment and equipment

- Two different types of vehicles were used by the service, one for high dependency transfers and one for generic or bariatric patient transport. In the previous two years, the service had replaced a number of vehicles due to increasing maintenance costs for those vehicles as they got older.
- Full records of vehicle maintenance including servicing and MOT details were maintained by office staff on a fleet management system. Documents we reviewed showed that all vehicles underwent regular servicing and had in date MOTs. A log of invoice numbers against any work completed meant there was a full audit trail of work completed on each vehicle.
- Vehicles were serviced quarterly or after completing 10,000 miles, whichever came first. A log of the vehicles miles completed was maintained through data which was entered onto the system each time a vehicle was refuelled.
- A vehicle daily inspection (VDI) was completed by the crew on each vehicle, and covered a range of key safety and cleanliness checks. The completion of the VDI was recorded on their electronic tab and communicated to the head office when completed.
- We reviewed records of completed VDIs which showed variation in how long each crew took to complete their inspection. VDIs we reviewed showed the checks took from 23 seconds to over five minutes. We asked senior staff if they were confident that the checks displayed as lasting for short periods of time were being completed correctly. They told us they were confident as staff sometimes completed the checks and then ticked the boxes on the electronic tab afterwards.
- Spot checks of vehicle cleanliness and upkeep were completed by a senior member of staff on a random basis when the vehicles were at the service premises. Records we reviewed showed 92 spot checks were completed on the full range of patient transport vehicles

between October 2015 and September 2016. Of these spot checks, 89% scored 10/10. Where a perfect score was not achieved, actions were identified to rectify the issue and it was highlighted to the crew responsible.

- Some specific equipment was only available on certain vehicles, for example the stair climber. A whiteboard within the base office kept track of which vehicle contained which specific items. Crews liaised with the head office and each other to change equipment onto different vehicles if it was known to be needed by another crew. Staff told us the system was effective and they always knew where equipment was located.
- A contracted company was responsible for equipment maintenance and items were serviced and calibrated as recommended by the manufacturers. We saw evidence equipment was regularly and appropriate maintained.
- Vehicles were usually parked at the office base overnight and when not in use, with keys suitably locked away. There were some occasions where crew members parked the vehicles outside their own homes, after a late finish or prior to an early start the following morning. Staff told us the keys were not securely stored in crew member's own homes.
- Basic resuscitation equipment, such as masks and emergency oxygen administration equipment, was available on each vehicle and staff checked this as part of their VDI.
- Automated external defibrillator (AED) machines were available on each vehicle and we saw that machines had been serviced within the required time frame.
- Some vehicles had on-board wheelchairs available for patient use and these were safely secured with fasteners onto the vehicle interior.
- Staff were responsible for checking stock levels and replenishing anything needed at the start of each check, as part of their vehicle checks. Overall stock management was completed by office staff, who were responsible for monitoring stock levels at the office and ordering additional items when needed.

Medicines

- A medicines management policy was in place. This policy outlined key details of how medicines should be stored, administered and disposed of, as well as how crews should report any adverse incidents related to medicines. Crews were aware of this policy.
- Paramedic crews carried snap locked emergency medicines bag on their vehicles. The medicines bag was stored in a keypad locked cupboard at the base office and was signed in and out at the start and end of each shift. Only the qualified paramedics and senior management had access to the code for the cupboard.
- Stock medicines were stored in a locked cupboard inside a locked storage room at the base office. This was only accessible to the registered manager and clinical lead paramedic. We reviewed the contents of the medicines cupboard and noted that it was neatly stored and all medicines were seen to be in date.
- We saw that glucagon was not managed correctly. Glucagon should be stored in a medicines fridge or if not stored in a fridge, a new expiry date should be identified (18 months following the date of removal from fridge storage). Glucagon we observed was not stored in a fridge and there was no indication when it had been removed from fridge storage.
- We saw a box of medicines stored in the staff food fridge. This was not appropriate storage as the medicine could be accessed by anyone with access to the break room.
- A spreadsheet documenting medicines expiry dates was maintained by the registered manager. We saw documented evidence that out of date stock medicines were appropriately disposed of via a local pharmacy.
- No controlled drugs were stored or used by the service.
- Oxygen was available on each vehicle and the level of oxygen in each canister was checked as part of the vehicle daily inspection. We saw crews completing this check during our inspection.
- Oxygen canisters were suitably stored in designated racks on each vehicle.
- Entonox was available at the base office and could be carried on the vehicles, for patients who use Entonox for pain relief.

- Spare oxygen and Entonox cylinders were stored in a suitable metal cage, out of direct sunlight and with appropriate ventilation. However the cage was not secured and it was possible to access canisters, which could pose a health and safety risk. Additionally, cylinders within the storage cage were a mixture of empty and full cylinders, which could mean staff mistakenly selecting an empty cylinder to be taken on their vehicle.
- Following our inspection, the service made changes to how oxygen was stored. Cages were secured with padlocks and empty and full cylinders were stored separately.
- Patients' own medicines were stored alongside their personal belongings on each vehicle and staff told us patient property would not be left unattended at any time.

Records

- The service was registered with the information commissioner's office, which is the organisation responsible for the enforcement of the Data Protection Act 1998.
- Electronic tabs, which connected directly with the head office, were used to communicate all patient details, as well as incidents, vehicle issues and equipment malfunctions or breakages. In the event that the electronic tabs failed to work, paper based forms were available in folders on board the vehicles.
- In the event that the electronic tabs failed, staff were required to use paper based forms, which were available on each vehicle and remain in contact with the head office via mobile phones. Senior staff and crews told us the electronic tabs failed rarely and so paper based forms were almost ever used.
- Paper records, if used, were stored appropriately in the head office.

Assessing and responding to patient risk

- Patients' needs were communicated to the service based on information provided at the time of booking. Staff throughout the service, including senior staff and crews, identified that full and accurate patient details were not always communicated to the crews.
- There were specific criteria when patients would be streamed for a high dependency journey, rather than for standard transport. Issues such as how much oxygen the patient required and what observations were needed determined which type of transport they were allocated to.
- To mitigate the risks associated with incorrect information being passed on at the time of booking, the crews checked specific details with each patient and/or the staff caring for the patient. For example, patients' medical history and location of drop off, including any access issues were confirmed.
- Crews told us they completed informal and dynamic risk assessments throughout their pick-ups and drop offs, to ensure patients were only transported safely. One crew described reviewing a patient prior to pick up at a hospital and finding the patient was not suitable to be transported by a non-qualified transport crew. The crew communicated to the office that it was not an appropriate allocation due to information lacking at the time of booking and the transport was reallocated to a qualified paramedic crew.
- Staff told us inappropriate job allocation happened infrequently but that the senior staff in the service were supportive of the crews assessment and would not apply any pressure to take the patient when the crew was concerned.
- Patient observations were completed on an 'as needed' basis while patients were being transported. Staff told us patients on supplementary oxygen of five litres or more had their oxygen levels checked during their journey. We saw evidence that patient observations were completed and recorded appropriately.
- If patients became unwell during a journey, the approach taken by staff would depend upon the level of staff completing the job. Paramedics would transfer patients by blue light to the nearest hospital and other crews would call for a 999 ambulance. There were no records that either of these actions had needed to be taken.
- Patients transported with a "do not attempt cardiopulmonary resuscitation" (DNACPR) order were highlighted to crews at the time of booking. Crews were required to confirm the DNACPR with staff at the pick-up location and to take the original DNACPR

documentation with them at the time of transporting the patient. Any patients who died during transportation would be taken to the drop of location, unless an alternative plan had been communicated to staff at the time of pick-up. Crews we spoke with were aware of the service policy regarding transporting patients with a DNACPR order.

Staffing

- All crews were made of two staff. High dependency transfers were completed by a team of two paramedics and patient transport journeys were completed by two staff members with First Person On Scene (FPOS) training. The requirements for bariatric journeys were assessed on a case by case basis, to ensure a suitable number of staff to safely meet the patient's needs.
- Staff usually worked with the same partner, although senior staff identified the benefits of mixing up working pairs to ensure standards of safety and reduce the risk of complacency. They told us staff occasionally worked with other people.
- All crew were on zero hours contracts and alerted the office with regards to their availability. Shifts were then allocated. The number of crews available at any one time varied according to service need. Senior staff told us there were certain times which were quiet periods for them, such as Monday mornings, and so less crews were planned to work.
- In the event of staff sickness, the office team called the staff who were not rostered to work that day to find cover. If cover was not available, the crew member without a partner worked with another pair as a three man crew on one vehicle.
- Office based staff worked in shifts, to ensure a member of staff was available for crews on the road to contact during their shifts. Outside of these times, senior staff held an emergency phone for other issues.
- Although crews sometimes worked as subcontracted staff for other transport providers, senior staff told us crews worked according to the service's policies and procedures at all times, not the policies of the organisation who initiated the subcontracted work. Crews we spoke to were clear of their obligations in this regard.

Anticipated resource and capacity risks

- There were no anticipated resource or capacity risks and senior staff explained that the capacity and activity levels of the service were variable day to day. This was due to the type of ad hoc service provided.
- Senior staff told us there was often one vehicle unused at the base office on most days. They told us this could be because a full complement of crews was not needed on that day, or because the vehicle was undergoing maintenance.
- Senior staff told us they would only accept transport jobs they were confident they had capacity to complete; therefore having a vehicle off the road or a crew member unwell would not affect any planned journeys.

Response to major incidents

- There was no plan for responding to major incidents in place at the service. Senior staff explained that this was not necessary due to the type of service provided.
- Senior staff acknowledged that they would provide vehicles and crews to the best of their ability and assist the local NHS ambulance service if possible in the event of a major incident.

Are patient transport services effective?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- The service was provided by competent staff, who had been suitably inducted and were supported to complete addition training outside of the organisation.
- Technology in the form of electronic tabs was fully utilised to enhance the planning and delivery of effective care.
- The service consistently completed more than 95% of immediate pick up patient transport jobs within one hour, which was a key performance indicator.
- We observed good liaison with other services, including effective handovers in care settings and efficient communication during bookings.

However:

- No clinical supervision was completed within the service which meant senior staff could not be directly and personally assured of staffs' clinical competence.

Evidence-based care and treatment

- We reviewed a range of policies and procedures relating to the service during our inspection. All policies we reviewed were seen to be in date, with an identified review date on each document.
- We saw that policies were referenced to a range of national and international guidance, as well as journal articles and best practice recommendations. For example, the handover policy was referenced to the Journal of Paramedic Practice and the Resuscitation Council (UK).
- The paramedic who provided clinical leadership for the service was responsible for monitoring best practice guidance and ensuring this was reflected in the policies and procedures used by staff.
- Crews were able to identify best practice recommendations which would guide their actions during transfers. For example, one crew member identified the British Thoracic Society (BTS) guideline for emergency oxygen use in adult patients (2008).
- There were no specific guidelines in place to determine which patients would and would not be accepted by the service. Senior staff told us each job request was assessed on its own merits and would be accepted or rejected as indicated. Staff told us the type of work that could be accepted often depended upon the availability of certain crews. For example if the only paramedic crew was on a job in south east London, jobs in north or west London which required a paramedic crew would not be accepted.
- Due to the ad hoc nature of work completed by the service, there were no service level agreements in place outlining the provision of transport services to or from specific care giving organisations.

Assessment and planning of care

- Staff received training in mental health awareness. However, the service did not accept booking for patients travelling under a mental health section as they did not have suitable vehicles for this purpose. If patients had specific mental health needs, these requirements were handed over to the crew through the booking process or when picking up the patient.
- All communication of jobs to the crews was completed via an electronic tab which was carried in each vehicle. Data regarding pick up times, patient details and drop off locations was all sent through to the crew in this way. The completion of the vehicle daily inspection was also recorded on the electronic tabs and communicated to the head office when completed.
- All vehicles were tracked and the tracking system, along with information entered on the electronic tabs, allowed senior staff to review many aspects of each journey. For example, the speed driven, time with engine in idle and waiting times at pick up destinations.
- Senior staff told us this high level of monitoring was useful for service planning and reviewing journeys retrospectively. For example if a patient required more than a two person crew, the office liaised with other staff close by to ensure an appropriate number of crew members were present. Additionally, if a patient complained that a crew member drove too quickly, the journey data could be reviewed to disprove or substantiate the patients' complaint.
- Crews had no specific responsibilities for managing patients' pain, although some patients were transported using Entonox for pain relief. Staff told us they tried to ensure patient comfort throughout the transport process, by careful positioning and driving without harsh acceleration or braking. One crew member described using a blanket to cushion a patient's shoulder underneath the seatbelt.

Nutrition and hydration

- The service did not routinely provide food or drink to patients being transported, although water was available on board the vehicles. Staff told us they offered patients water on long journeys or if the weather was particularly warm.

Response times and patient outcomes

- The main key performance indicator for the service was that vehicles should arrive at the pick-up location no later than 15 minutes after the booking time. Staff told us crews were rarely late as sufficient time was allowed between each job.
- For immediate pick-up jobs, which usually came from local hospitals that were discharging patients to the community, crews were expected to arrive within one hour of booking. Staff told us this was monitored through the electronic tab tracking system and the service consistently achieved more than 95% compliance with this target.

Competent staff

- All new starters were required to undergo an induction to the service, and we saw that an induction checklist was in place. The checklist covered all key points on how to perform the staff member's role, such as an orientation to the vehicles and equipment. We saw evidence this checklist was completed with new staff.
- Staff who were relatively new to working in patient transport had the opportunity to shadow colleagues prior to undertaking jobs as a crew member. Staff told us new starters were usually paired with an experienced colleague to help induct them into their role.
- All staff were qualified to a minimum level of First Person On Scene (FPOS) training, as provided by the Institute of Health Care Development (IHCD).
- Paramedics were appropriately registered with the Health and Care Professions Council (HCPC), and staff records prompted senior staff to review professional registration against specified renewal dates.
- Disclosure and barring service (DBS) checks were completed for all staff. We saw evidence of these checks during our inspection.
- Staff completed a driving assessment when they started working for the service. This involved an assessment by a senior member of staff, who also reviewed the crew member's driving licence and status.
- Staff received annual appraisals from their line manager and all staff had an up to date appraisal at the time of our inspection. Staff also received quarterly one to one supervision sessions where a general overview of the staff member's performance was discussed and issues addressed. Staff were positive about the appraisal and one to one supervision processes. They felt the sessions were beneficial and helped to guide their performance and development.
- Clinical supervision was not provided, however senior staff told us that most of staff worked in other organisations where this was provided. Senior staff acknowledged that where staff did not receive clinical supervision in other organisations, they could not be assured of the individual's competence. This meant that senior staff did not satisfy themselves personally and directly about the clinical competence of the staff they employed.
- No development training was offered in house within the service, although staff were supported to complete additional training outside of the organisation. Some staff told us they had been supported to complete emergency medical technician training, through assisted funding and flexible shift patterns. Staff had also been supported to complete blue light driving training.

Coordination with other providers

- Some work completed by the service was subcontracted by other transport providers. When this occurred, the other organisation contacted the service with a booking request and liaised with regards to timings required and patient needs.
- Bookings were usually confirmed or declined within a matter of minutes, which meant people making bookings knew whether alternative arrangements needed to be organised.
- When patients were attending outpatient appointments, crews sometimes completed both aspects of a patient's journey to and from the hospital. Crews told us they liaised with hospital staff to ensure they contacted the crew when the patient required picking up to minimise the patient's wait and optimise the efficiency of the service.
- We noted a good working relationship with other transport providers and with organised who made bookings directly through the service. Feedback from staff at other organisations was positive and the service was generally thought to be reliable and efficient.

Access to information

Patient transport services (PTS)

- All patient information, including past medical history and home access information, was provided by the organisation booking transport. Staff told us this meant they were not always informed about key aspects of the patients' needs or certain access related issues. Senior staff told us that a series of questions were asked when bookings were taken on the telephone to ensure as much information as needed was obtained, but emailed forms did not always include all the information required, such as access information at patient homes.
- To address this issue, crews asked patients about access difficulties at their homes when collecting patients and ensured they were satisfied they would be able to get patients safely into their home before leaving the pick up location.
- Crews received handovers from hospital staff when collecting patients from ward environments. This meant they had an opportunity to confirm key details about each patient. Crews also handed over to staff at drop off locations, to ensure staff there were aware of the patient's needed. We observed such handovers taking place and noted that they contained all key information and were communicated in a polite and professional manner.
- Staff accessed policies in the base office and had no access to policies whilst out in their vehicles. Crews told us this was not an issue as they would contact staff at the head office to confirm any policy related queries over the telephone.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service offered mental health awareness training, which had been completed by 54.5% of staff at the time of our inspection. This included information about the Mental Capacity Act and helping people to make decisions. Staff told us the low training uptake was because this was a new mandatory training topic and a completion plan was in place for the remaining staff.
- Crews were clear that consent should be obtained before transporting the patient. Crews also knew they should ask patients' permission before assisting them or completing any interventions, such as routine observations.
- We observed staff asking patients for consent during the pick-up process.

Are patient transport services caring?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- Patient feedback was positive about their experiences of being transported by crews working for the service.
- Our observations of care demonstrated the crews' compassionate and friendly approach to patients.
- Staff from the service provided examples where they had delivered good individualised and person centred care whilst transporting patients.

Compassionate care

- One crew member travelled in the back of the vehicle with the patient at all times. We observed staff taking time to chat to patients and ask them about their interests and families. Patients told us this put them at ease during the journey.
- We reviewed a number of emails the service had received praising the care provided by crews during transport. Crews were described as "amazing" and "professional, caring, dependable and friendly". Patients also described feeling "comfortable and safe" during their transport with crews.
- Staff maintained patient dignity at all times. We observed a crew who covered a patient's legs with a blanket when they were being transferred to ensure they were suitably covered.
- Crews told us it was important to act with sensitivity when assisting patients and told us they ensured they were empathetic and kind during their interactions.

Understanding and involvement of patients and those close to them

- Crews chatted to patients about the route they were taking and explained the cause of any delays, such as bad traffic or roadworks.

Patient transport services (PTS)

- Staff offered patients the opportunity to be as independent as they wished, including offering the choice between using a wheelchair or walking to and from the vehicle.
- Patients had the opportunity to complete a feedback questionnaire at the end of their journey. If they did not wish to complete the questionnaire with the crew, they could answer a paper based version and return it to the office.
- It was clear that direct bookings made by patients were chargeable to the patient and patients we spoke to were aware of this.

Emotional support

- Staff told us they were encouraging when returning patients to their home, particularly after a hospital admission. They told us it helped to make patients feel more confident in a circumstance which otherwise could be intimidating, particularly if the patient lived alone.
- Crews told us they had some patients which they had transported several times and described developing an on-going rapport with these patients. They told us it was nice to get to know people and be able to ask questions about aspects of their life they had previously discussed with the crew.

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

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- The service provided was flexible and could modify various aspects of its provision in order to meet patient needs. For example the service could transport patients outside of their regular working hours, with sufficient notice.
- A specialist bariatric patient transport service was provided by the organisation and we saw evidence that feedback about this service was positive.
- Patients could access the service through their local care provider when the usual provider was unable to meet patients' needs. Patients could also book directly with the service, although this would have to be paid for privately.
- We saw evidence the service collected complaint data and made changes to their practice in response to feedback received.

Service planning and delivery to meet the needs of local people

- The patient transport service was available from 6am until 9pm, seven days per week. It was possible for bookings to be made outside of these times, with advance warning.
- The service provided a primarily ad hoc patient transport service, with bookings made frequently on the same day, or sometimes the day before. The service reported that 90% of their workload was patient transport or bariatric transfer bookings, with the remaining 10% comprised of high dependency transfers.
- Senior staff acknowledged a good relationship with the organisations which book the service for patient transport, and told us these organisations often warned them of busy periods approaching.
- The service covered hospitals and care organisations across London and the home counties. Some jobs which took crews further afield were also accepted and these were usually booked in advance, to accommodate different start and finish times for the crew involved. Senior staff told us crews shift times were flexible to meet the needs of each individual booking, and we saw evidence of this during our inspection.
- All communication of jobs to the crews was completed via an electronic tab which was carried in each vehicle. Data regarding pick up times, patient details and drop off locations was all sent through to the crew in this way.
- Staff were required to confirm receipt of the job on the electronic tab and check in at various stages of their journey, including when they arrived at the pick-up destination, when they had collected the patient and when they had completed the journey.

Patient transport services (PTS)

- Crews utilised satellite navigation systems to make their journeys along the most efficient route, taking into account traffic jams and roadworks delays.

Meeting people's individual needs

- The service completed a high number of bariatric patient transport jobs and six of their vehicles were able to transport patients with specialist bariatric needs. Crews had received special training for completed transfers with these patients and we saw evidence that the organisation received positive feedback about their bariatric patient transport service.
- All vehicles could accommodate patients on stretchers, although the HDU vehicles were unable to transport patients in electric wheelchairs.
- The service transported children and young people, other than neonatal babies and infants. Staff told us transporting children formed a very small aspect of their caseload and that parents always escorted the children.
- Translation services, where needed, would be provided by the organisation making the transport booking. Staff told us translators were rarely used because a patient escort or family members were used instead.
- As part of the booking process, organisations booking transport were asked if the patient had a learning disability or was living with dementia. If the needs of the patient were deemed outside of the crew's competence, an escort from the booking organisation was requested.
- Crews did not identify any specific techniques or support methods for patients living with dementia or those with a learning disability. However we observed a crew transporting a patient living with dementia and noted that they were extremely patient and reassuring during their communication with the patient.
- The service did not accept booking for patients travelling under a mental health section, as they did not have suitable vehicles for this purpose.

Access and flow

- Patients accessed the service through bookings made by local NHS hospitals, where their usual transport provider was unable to fulfil their transport request. Some bookings were also subcontracted directly by transport providers who referred jobs to the service, rather than refusing bookings from their contracted organisations. This was particularly the case for transportation of bariatric patients.
- A range of organisations, including both NHS and private providers were served by the service.
- Patients could contact the organisation directly to make transport bookings, if they were not entitled to free transport from the hospital or care provider. Senior staff told us this type of booking was taken relatively rarely.
- Ad hoc bookings were frequently made at short notice and the service aimed to arrive at the pick-up location within one hour. The service consistently picked up more than 95% of these patients within one hour.
- Staffing was flexible to meet service demand and senior staff told us there were predictably quiet periods, as well as times when they knew more jobs would be booked.
- Senior staff told us the flexible system worked well and there were few jobs they were unable to accept. They told us they would only refuse one or two jobs on a busy day, and that this occurred rarely. Any occasions where jobs could not be accepted were documented and reviewed for future planning reference.
- Staff were required to be within five minutes of their vehicle at all times during their shift, including during breaks. This was to ensure they would be available at short notice to respond to any last minute bookings.

Learning from complaints and concerns

- Posters located inside each vehicle advised patients how they could complain about the service they received. There were three complaints made about the service between November 2015 and September 2016.
- Patients were able to make informal complaints verbally to any of the staff within the service, or could complain formally in writing. Complaints were logged by the registered manager and the complaints a policy was then implemented, including an acknowledgement letter and an outcome letter.
- Complaint investigations were led by the registered manager and included an analysis of the vehicle tracking system when appropriate and obtaining staff statements.

Patient transport services (PTS)

- Anonymised learning points from complaints were disseminated to staff during staff meetings or more specific feedback would be given during one to one supervision sessions if this was more appropriate. We saw documented evidence that one to one feedback from complaints was given during supervision sessions and staff meetings.
- We saw evidence that practice was changed in response to patient complaints. For example, during one drop off, the crew mistakenly took the patient's house keys away with them. They were returned to the patient immediately once the crew realised their error. In response to this, an additional step when dropping the patient off was added to the electronic tab, which prompted crews to check they had given patients all of their belongings. We saw this additional step in use during our inspection.

Are patient transport services well-led?

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

Summary

- The service did not have an arrangement for formal clinical leadership. Crews relied upon clinical support from one another, as well as peers from outside the service, to provide advice when needed.
- A clinical governance committee was in place; however minutes showed that key governance issues, such incidents, were not formally discussed.
- The service did not have a risk register with evidence of frequent risk reviews and mitigating actions. Risk assessments had been completed but did not demonstrate full risk mitigation.

However:

- Feedback about the leadership team was positive and staff felt able to raise concerns or problems.
- There was a clear vision for the service and staff were aware that quality of care and reliable of the service were clear focuses for the organisation.
- We saw evidence of some patient and staff engagement, through patient feedback forms and encouragement to vocalise thoughts and ideas in staff meetings.

Leadership of service

- Leadership was provided by the director of the service, with support from an office based operations manager. The operations manager was responsible for overseeing the day to day running of the service and problem solving when needed.
- Crews gave us positive feedback about the leadership team and told us they felt able to approach the managers with any concerns or problems. Crews told us they were well supported and their views were respected.
- Clinical leadership was provided the most senior of the paramedics employed by the service. There was no dedicated time for providing this clinical leadership and senior staff told us it was available on an ad hoc basis, such as when audits needed to be completed.
- Staff we spoke with felt comfortable with the level of clinical leadership available and told us they would call on the expertise of their peers, including those outside of the service, if they were unsure about anything specific.

Vision and strategy for this service

- The leadership team were proud of the quality of the service provided and described the service very responsive to the needs of patients and care organisations. They described a positive reputation among the organisations they received work from and identified an aim of becoming "the organisation of choice for patient transport services".
- The senior staff within the service acknowledged that substantial growth and competing for contracted patient transport work would require a different model of delivery to ensure suitable governance arrangements and quality were maintained. For this reason, senior staff identified that "organic growth, with a new vehicle here and there" was a realistic vision for the service.
- Staff working within the service understood there were no plans for the service to compete for contracted transport work and knew that quality of care and reliability were key focuses for the service going forward.

Patient transport services (PTS)

Governance, risk management and quality measurement

- A clinical governance and risk management committee was in place and a terms of reference policy outlined the specific role of this committee. The terms of reference policy identified that the committee met on an ad hoc basis. Minutes we reviewed showed meetings were held quarterly in the twelve months leading up to our inspection.
- Discussion at the committee meeting covered a review of operational issues and regulatory compliance. We saw no evidence that incidents, infection control or safeguarding concerns were discussed during these meetings. Meeting minutes identified some issues to be fed back to staff during the regular staff meetings.
- Minuted staff meetings were held quarterly and we noted a good attendance at each meeting. Minutes we reviewed showed there were some occasions where meetings where held less frequently (for example there was no meeting between September 2015 and February 2016).
- Minutes we reviewed showed that staff received information about patient feedback, including complaints, and learning from incidents in other organisations.
- There was no formal risk register for the organisation, although we saw evidence of risk assessments for various aspects of the service, including patients, crews and vehicles.
- The risk assessments covered the key risks identified during our inspection however failed to demonstrate a process of regular reviews and full risk mitigation. There was also no evidence of regular reviews of risks within the service contained in the minutes from the clinical governance and risk management committee minutes.
- We were advised the paramedic with clinical leadership responsibility was involved in some incident investigations. However, this could be difficult as the paramedic could be partnered to work with the colleague involved. This meant some investigations would be completed without involvement from a clinician and could potentially fail to identify key issues.

Culture within the service

- There was low turnover of staff within the service and no members of staff had left in the 12 months prior to our inspection. Two members of staff had reduced their working hours to allow for additional training completion outside of work time.
- Senior staff told us they monitor sickness levels and manage any repeated or extended absences in line with their local policy. They advised that there were not any issues with staff sickness levels.
- Staff described a positive culture throughout the service and told us everyone got on well. They told us that any disagreements were raised between individuals, with support from the leadership team to mitigate any issues if required, and quickly forgotten about.
- Staff felt comfortable raising issues and concerns with the leadership team and told us there was an open door policy for any of the senior staff.

Public and staff engagement

- Crews were prompted to complete a patient satisfaction questionnaire on their electronic tab with patients when dropping them off. Senior staff advised that paper copies of the questionnaire were also available on vehicles if patients did not want to complete the questions with the crew member.
- We reviewed a number of electronic patient journey records randomly and none of the patient feedback questionnaires had been completed. Staff advised us that some patients were not able to answer feedback questions, such as those living with severe dementia.
- Senior staff advised us that any information received via the feedback questionnaire was reviewed periodically and any themes would be investigated and an action plan would be produced to address any issues. Staff told us feedback was overwhelmingly positive and so there were no examples of actions after negative feedback.
- Staff were encouraged to participate in staff meetings and raise any concerns or ideas they had. We saw evidence of discussion with staff during these meetings, rather than it being a one way information sharing structure.

- We saw evidence that the leadership responded to feedback provided by staff. For example staff members requested challenging behaviour training and this was organised in response to this request.

Innovation, improvement and sustainability

- The senior leadership team had a strong awareness of how developing the patient transfer service further would effect key aspects of their service, particularly if they bid for contracts. For example, they acknowledged that demands on administration staff would increase significantly and vehicle upkeep would become more demanding. Senior staff identified that the service was successful in its current format and expansion was not likely at present.
- Senior staff aimed to improve the service provided by further developing relationships with organisations who make bookings to put the right crews in the right places, at times of high demand. This would lead to an improvement in the service patients received.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve
Action the location SHOULD take. The service SHOULD ensure:

- Clinical supervision is in place to enable senior managers to directly and personally assure themselves of the clinical competence of relevant staff members.
- Suitable clinical governance arrangements are in place and are used to manage governance issues in a timely manner.
- Staff receive appropriate training in safeguarding vulnerable adults and children, to meet recommendations from
- Medicines, including medical gases, are managed and stored appropriately at all times.