

Exora International Limited

Exora International Limited

Inspection report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Insufficient evidence to rate 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff were now trained to the appropriate level of safeguarding for children and adult safeguarding and the service's safeguarding policy had been updated to reflect the latest national guidance. The registered manager was also now trained to level 4 safeguarding.
- Policies we reviewed now reflected the service's provision. There were now clear policies outlining when staff were required to use oxygen.
- Medical gases were now stored appropriately, and the relevant authorities had been notified of the presence of the medical gases at the property.
- The service now carried out infection prevention and control audits, and risks to the service had been documented.
- Equipment servicing logs were comprehensive and no longer had gaps within the record.
- There was also now a formal record of incidents and incidents were now being discussed at regular governance meetings.
- At our last inspection we found the service did not collect or monitor key information such as response times. At this inspection, the provider did collect and monitor response times as part of their key performance indicators (KPIs). Compliance was consistently above 95% for picks-ups that were on time.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Most staff understood the service's vision, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.

However:

- We found some consumables in the emergency grab bag such as bandages, oxygen masks, defibrillator pads, a tourniquet and nasal cannulas did not have expiry dates on them which meant the service was not monitoring how long these pieces of equipment should be kept on vehicles and did not have a stock rotation document. Crew would therefore not know how old the consumables were and if they needed replacing.
- Some staff we spoke with had variable knowledge around oxygen saturation monitoring.
- Although staff we spoke with had a good understanding of the protocol on how to manage a deteriorating patient, the protocol for managing a deteriorating patient was within the service's incident reporting policy and was not a standalone policy. This meant that the protocol could not be easily found among the policies of the service.
- The service should ensure the disinfectant sprays on ambulances have Control of Substances Hazardous to Health (COSHH) risk assessments in place.
- We did not see any communication aids within ambulances to support patients who are non-verbal or have learning disabilities.

Summary of findings

Our judgements about each of the main services

Service

Patient transport services

Rating

Good



Summary of each main service

Patient transport services (PTS) were the sole service provided by Exora International Limited. The service transports non-emergency patients to and from community care locations, airports, hospitals and patients' home addresses. The service transports both adults and children.

Summary of findings

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Summary of this inspection

Background to Exora International Limited

Exora International Limited is operated by Exora International Limited. The service was registered with the Care Quality Commission (CQC) on 23 August 2017. The service provides a patient transport service (PTS). The provider is registered for the regulated activities: transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury. The service transports non-emergency patients to and from community care locations, airports, hospitals and patients' home addresses. The service transports both adults and children. Exora International operates as an ad hoc subcontractor to main contractors (identified as commissioners in this report).

Exora International Limited does not have fixed contracts with any providers. In the last 12 months, the service carried out 3790 journeys. All jobs the service undertakes are ad-hoc and short notice bookings. 98% of the bookings are made on the same day.

The service has five ambulances equipped for patient transport only.

The service was last inspected in April 2019 and rated requires improvement overall. We carried out a short notice announced inspection on 11 April 2022. We inspected this service using our comprehensive inspection methodology and we checked to see if the provider had complied with the Requirement Notice issued in July 2019.

The provider had made improvements in relation to their management of medical gases. There were now clear policies outlining when staff were required to use oxygen. Medical gases were now stored appropriately and the relevant authorities had been notified of the presence of the medical gases at the property. Staff were now trained to the appropriate level of safeguarding for children and adult safeguarding and the service's safeguarding policy had been updated to reflect the latest national guidance. The registered manager was also now trained to level four safeguarding. The service now carried out infection prevention and control audits, and risks to the service had been documented. Equipment servicing logs were comprehensive and no longer had gaps within the record. There was also now a formal record of incidents and incidents were now being discussed at regular governance meetings.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

How we carried out this inspection

We carried out a short notice announced comprehensive inspection on 11 April 2022 using our comprehensive methodology.

The inspection team comprised a lead CQC inspector, a second CQC inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

During this inspection, the inspection team spoke with the registered manager and patient transport crew. We reviewed patient bookings and eight staff records. Due to COVID-19 restrictions we were not able to observe care within ambulances but we were able to review patient feedback information.

Summary of this inspection

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service SHOULD take to improve:

Patient Transport Services:

- The service should ensure consumables have expiry dates and that there is a system in place to monitor the expiry dates on consumables on the ambulance.
- The service should ensure that all staff have good knowledge and understanding of oxygen saturation monitoring
- The service should consider a standalone deteriorating patient policy.
- The service should ensure that disinfectant sprays on ambulances have a Control of Substances Hazardous to Health (COSHH) risk assessment in place.
- The service should consider having communication aids within ambulances to support patients who are non-verbal or have learning disabilities.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Insufficient evidence to rate	Good	Good	Good
Overall	Good	Good	Insufficient evidence to rate	Good	Good	Good

Patient transport services

Safe	Good 
Effective	Good 
Caring	Insufficient evidence to rate 
Responsive	Good 
Well-led	Good 

Are Patient transport services safe?

Good 

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included safeguarding adults and children, mental health awareness and assessing capacity, learning disability awareness, dementia awareness, equality, diversity and inclusion, basic life support, COVID-19, infection, prevention and control, moving and handling and information governance. Refresher training was provided annually. We were shown a training matrix which showed 100% of staff had completed their mandatory training modules.

The modules were a mixture of face to face and online training. At our last inspection, the service did not have formal training on information governance. At this inspection, the provider was able to show that staff undertook a module in information governance as part of mandatory training.

Crews also undertook driving assessments prior to starting their role at the service.

In addition to mandatory training, the service used an external provider to provide staff with first response emergency care level three (FREC3) training. This course was attended by staff every three years.

The registered manager was able to monitor training compliance via the online training system. When training was due, the registered manager emailed staff with reminders and we also saw that the registered manager reminded staff at team meetings when certain training modules were due. The provider offered protected time to staff to complete mandatory training and we saw that this was reiterated to staff at team meetings.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Patient transport services

The service transported adults and children. Staff received online training by an external provider for safeguarding adults and children training. At our last inspection, staff had not been trained to level 2 safeguarding adults and children and the safeguarding lead did not have level 4 safeguarding training which was not in line with national guidance.

At this inspection, we saw that all staff had been trained to level 2 safeguarding children and adults. The registered manager was now trained to safeguarding level 4 which was in line with the national guidance from the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

We viewed the service's safeguarding policy which was up to date and now contained relevant national guidance including referencing the Working Together to Safeguard Children 2018 guidelines.

The service's booking form captured information about safeguarding concerns so crew could be made aware. There was also a section where staff could input any safeguarding concerns they came across on jobs. The information would be automatically sent through to the registered manager who could then make a safeguarding referral. We saw examples where this had been done and the registered manager had contacted the local authority when crew had concerns that a patients' home was without heating.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the office premises visibly clean.

Vehicles were visibly clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. The service audited cleanliness of equipment on the ambulances on a monthly basis and undertook swab tests of high touch surfaces such as handrails, passenger seats and the steering wheel to assess the levels of cleanliness of these areas. Results we reviewed showed readings of 25 or less which was categorised as 'exceptionally clean'. The audit had a notes sections for each area that was assessed where actions could be recorded if there were any issues.

The service had also introduced a sterilising fogger which produces a fine mist of disinfectant to kill microorganisms into the ambulance to further ensure cleanliness of the vehicles.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service had an up to date infection prevention and control policy. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff told us they had access to personal protective equipment and cleaning equipment could be replenished at the office base. Staff cleaned equipment after patient contact. Staff demonstrated to us how disinfectant wipes would be used. They explained that the ambulance would be wiped down after every patient and cleaned at the start and end of every shift. However, we saw a bottle of disinfectant spray on an ambulance which did not have Control of Substances Hazardous to Health (COSHH) risk assessment in place.

Patient transport services

Infection, prevention and control training was an online module provided by an external provider and was part of mandatory training. Compliance was 100%. The service also provided face to face training in hand hygiene and hand washing techniques and had invested in a training kit whereby staff could wash their hands having applied a liquid which would show under ultraviolet light. This would then give a visual demonstration of effective hand washing techniques to help improve infection control and hand hygiene compliance.

Staff completed daily cleaning checks for each vehicle before starting a shift. A job would not be released to the crew until the cleaning checks had been complete and logged on the application on the crew's mobile devices. Within the checks, the mobile application also required crew to take their temperature and confirm they were not exhibiting symptoms of COVID-19. A thermometer was kept on the ambulances so staff could take their temperature at the start of each shift.

The data would be sent to the office once complete and the registered manager audit the daily checks. The registered manager also complete spot checks at random to ensure that crew were completing the vehicle daily checklist effectively. Any issues would be raised with the individual at the time and monitored.

Deep cleans of the vehicles were undertaken once a month by an external company. At our last inspection, records we reviewed showed gaps for some vehicles where it was not clear if vehicles were deep cleaned monthly as per company policy. At this inspection there were no gaps in records and we saw that all vehicles had had monthly deep cleans as per policy of the provider.

Environment and equipment

The design, maintenance and use of premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. Equipment servicing logs were now in date and equipment and matched the dates we found on equipment on the vehicles. However, some consumables did not have expiry dates and the service did not have a process around monitoring stock rotation.

The service had enough suitable equipment to help them to safely care for patients. The service had five ambulances which were multi-purpose which meant that a range of patient transfers could be undertaken with suitable equipment. The equipment we inspected on the ambulances were suitable for the patient groups the service transported. For example, there were bariatric wheelchairs, stair climber and a paediatric harness for the transportation of children. Staff had been issued with high visibility jackets to keep staff safe when collecting patients in the dark.

Vehicles we observed were in a good state of repair. All fixtures and fittings were fully functional and equipment was appropriate for the service provision. Vehicles were kept either at the office base or with the crew to enable crews to start shifts without needing to travel to the office base.

We checked records for the five ambulances and saw that servicing and MOT were up to date. Crews had access to up to date satellite navigation systems and the control office could track vehicles in real time.

Staff used the mobile application on their phones to complete and submit their temperature checks and confirm they did not have any COVID-19 symptoms and vehicle daily inspection checklists. Checks included equipment such as wheelchairs, stretchers, carry chairs and cleanliness of the vehicle as well as general vehicle safety checks. Staff could escalate any faults or issues through the mobile application and by calling the office. A job was not released to the crew until the daily vehicle equipment check had been recorded and submitted. The checks were audited monthly by the

Patient transport services

registered manager who also completed spot checks and joined drivers on jobs to make sure the checks were being conducted comprehensively. We viewed audits of the spot checks which showed good compliance. At our last inspection it was not clear how the actions from these audits were followed up but at this inspection we saw minutes from team meetings and within staff personnel files where issues had been picked up from the audits and discussed.

Equipment on ambulances were serviced yearly by an external company. Where equipment was damaged or needed replacing the provider was able to get replacement from the external company as and when required. At our last inspection several pieces of equipment had stickers with servicing dates that did not match the dates recorded within the servicing log. At this inspection equipment stickers matched the dates recorded within the servicing log we reviewed.

We found some consumables in the emergency grab bag such as bandages, oxygen masks, defibrillator pads, a tourniquet and nasal cannulas did not have expiry dates on them. The provider told us that the supplier did not provide expiry dates on these consumables. The provider was able to provide purchase orders of the consumables but the service was not monitoring how long these pieces of equipment should be kept on vehicles and did not have a stock rotation document. Crew would therefore not know how old the consumables were and if they needed replacing. It would not be possible to identify if a piece of equipment had degraded over time if an expiry date is not indicated. All consumables were however, sealed and in good condition. Following the inspection, the registered manager told us they had ordered a new set of consumables with clear expiry dates in order to begin monitoring these pieces of equipment more effectively.

We found a defibrillator pad in the emergency grab bag which stated that it had been reconditioned. We were unable to find assurance documentation around what checks had been done on it to confirm that it was safe to use. When we raised this with the registered manager, they immediately ordered new defibrillator pads which were not reconditioned and had a clear expiry date indicated.

Some staff we spoke with had variable knowledge around oxygen saturation monitoring.

Staff disposed of clinical waste safely. Clinical waste was disposed of at hospitals or at the office base. The service used an external company to collect waste that was left at the office.

Crews used phones which contained a mobile application where information about a job was securely relayed from the office. After a job was completed, the information would automatically be removed from the device and replaced with information of the next job.

At our last inspection we found equipment such as electrocardiogram dots on ambulances which were not used by the crew. At this inspection all equipment we found on the ambulances were necessary for the type of transfers the provider undertook.

The service had a cleaning cupboard and store cupboard at the office base where crew could access to restock their vehicles with consumables and any equipment which needed replacing. Spare uniforms were kept at the office should the crew require them.

The medical gases store was based at the office where bookings were taken. There was an office space for staff to attend for staff meetings and to access policies which were kept on site.

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We found that there was no separate first aid kit on the ambulances for staff use. We raised this with the registered manager who took action to order the kits for the vehicles.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

The service used an electronic booking system to book patients for transfers and assess their suitability for a transfer. The booking system contained a detailed checklist to assess patient risk and ensure a patient could be transferred safely. The booking form included details of a patient's specific needs such as mobility, COVID-19 status, if there was a do not attempt cardiopulmonary resuscitation order (DNACPR) in place and whether there were for example, steps at the patient's home address which required additional equipment or staff to transfer the patient. The service did not transfer patients with COVID-19.

If crew were unsure if a patient was medically unstable or not fit to travel, they would call the office to escalate this where a decision would be made to call emergency services and/or abort the transfer depending on the situation. The provider also had access to the service's medical director who could provide clinical advice over the phone.

Although the service only transported patients who were medically stable and not considered to be at risk of deterioration by the referring commissioner, care home or hospital, all staff were FREC3 (First Response Emergency Care (Level 3) trained and had emergency first aid at work training which meant that there was always a member of staff on board trained in basic life support.

Staff had a good awareness and understanding of how to manage a deteriorating patient; they explained they would call an NHS ambulance or transport a patient to the nearest emergency department if they were nearby. However, the protocol for managing a deteriorating patient was within the service's incident reporting policy and was not a standalone policy. This meant that the protocol could not be easily found among the policies of the service.

The service did not carry out emergency transfers and therefore did not use blue lights which are installed within the ambulances. At our last inspection we found that the blue light function had not been deactivated on the vehicles to prevent misuse. At this inspection they had been deactivated.

The service did not transport patients with mental health needs. The service did transport children although they had not done so in the last 12 months. The registered manager told us that children would always be accompanied by their parents or carers.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service employed six members of operational staff. The registered manager and the control office staff member were also available to attend transfers if required. There were no staff vacancies at the time of our inspection and the service had put a pause on recruitment.

All staff had FREC3 (First Response Emergency Care (Level 3) training. All patient journeys were carried out by a minimum of two members of staff.

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Due to the nature of the service whereby bookings were made on an ad hoc basis, the registered manager reported that they did not experience staffing issues as the service only accepted jobs which they could fulfil with the staff they had. In exceptional circumstances if a staff member had to take a day off, the registered manager was able to provide cover.

All staff had the same qualifications and could be allocated to any jobs that the service undertook. For long distance jobs, the two person crew would take turns in driving and were offered hotel stays the night before if necessary. The registered manager told us they would ensure that staff who had undertaken long distance jobs were not immediately allocated to another job so as to allow them to rest. Staff could request days where they preferred to work and this was accommodated as far as possible.

Staff told us they were able to take adequate breaks as jobs were booked on an ad hoc basis so they could fit their breaks around this. On average, a crew would do two to three jobs a day and would therefore have enough time to take breaks in between.

Records

Staff kept detailed records of patients' care. Booking forms were detailed, clear and appropriately managed.

Control office staff took bookings at the office base. Booking information was recorded on an electronic system which prompted the control team staff to complete the required fields to assess the patient's eligibility for the service. This included information such as mobility requirements. The form did not allow the staff member to move on to the next stage and complete the booking until all areas of the form had been filled in.

Crew received job information through a mobile application on their mobile phones which required a login and password. The information relayed to crew included the patient's name, address and transfer location, if the patient required any equipment and if they had any additional needs. Once a job had been completed, the booking information would no longer be stored on the application and would be replaced by a new job allocated to the crew.

Records maintained by the provider consisted only of electronic booking forms and were stored securely on a cloud based system which was password protected and accessible only by the registered manager after a job had been completed.

We viewed booking forms in the control office and saw that they were clear, detailed and contained information relevant to the journey to aid a safe transfer by the crew. For example, we viewed a booking form which made clear that the patient required a bariatric transfer, with two crew and that there were steps into the property. We saw that the transfer was carried out with the crew allocated, with the appropriate equipment to transfer the patient.

Staff told us if crew felt there was not enough detail included in the booking or if they had arrived at the destination and found the patient had additional needs, they would call the control office to discuss whether the transfer could go ahead. This would then be recorded in the booking form. We saw an example of this where the needs of a patient had changed since their appointment which was escalated by crew and recorded on the booking form. We saw that learning from this booking was shared with the team at the team meeting around the importance of capturing any changes to needs even for regular patients.

Medicines

The service did not store or administer medicines. The service had made improvements around the storage of medical gases such as oxygen.

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The service did not carry or store medicines. Staff did not prescribe, dispense or administer any medicines to patients. The service did transport patients who carried their own medicines. The registered manager told us in these cases, crew would log this within the booking form held on the mobile application on crew phones. There was a section on the booking form on the mobile application which ensured that crew could not 'complete' the journey without logging that the patient had left with their medicines and any other personal belongings. This ensured that no medicines or belongings were left on board.

At our last inspection, when we reviewed the medicines management policy we found that it included information on the ordering and receipt of medicines and stock of medicinal products which did not match the service's provision. At this inspection, we saw that this had been replaced by a medical gases policy which had been updated to reflect the service provision. It made clear that the service did not keep medicines apart from medical gases (oxygen).

At our last inspection the service did not have a medicines administration protocol on the safe and effective use of medical gases. At this inspection, we saw that the medical gases policy explained the safe and effective use of oxygen. At this inspection the service was able to confirm that staff who had been FREC3 trained had competencies in the administration of oxygen. The registered manager also undertook audits of oxygen usage and administration for each job undertaken requiring oxygen.

The service no longer kept nitrous oxide with oxygen. The registered manager told us they did not transfer patients requiring nitrous oxide with oxygen.

At our last inspection we found that medical gases such as oxygen was stored in an external cage which was not locked which meant that cylinders could be tampered with. We found that large cylinders were not chained securely as recommended in the Health Technical Memorandum (HTM) 02 guidance. Oxygen cylinders were leaned against each other within the cage which could fall onto anyone who opened the cage.

At this inspection, we found that the provider had made improvements around the storage of medical gases. The external cage was locked and large cylinders were secured with a belt. Small cylinders were stored horizontally in slots within the cage. The provider had also put signage on the cage to indicate its contents.

At our last inspection we raised the concern that the location of the external cage containing the gas cylinders had not been shared with the local fire service as per HTM-02 guidance. At this inspection we viewed documentation confirming that the local fire service had been notified of the location of the external gas cage and had completed an assessment of the cage to ensure that it was safe. Risk assessments by the local fire service would then be undertaken every five years.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

At our last inspection we found that the service did not have an incident reporting policy and we were not assured that incidents were being reported.

At this inspection, we found the service now had an incident reporting policy.

There had 14 incidents in the last 12 months, all of which were categorised as low harm. The service had no never events.

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We saw incident reporting forms which were filled out by the registered manager once reported by crew through the mobile application. We were shown the incident reporting form on the mobile application which allowed staff to input the details of the incident and submit to the office where managers could pick this up immediately and taken the necessary actions.

The registered manager would then investigate the incident and share learning at monthly staff meetings. Staff received feedback from investigation of incidents. We saw examples from team meeting minutes where we saw discussion around learning from an incident and how to further improve patient care. We viewed completed incident reporting form and saw that staff raised concerns and reported incidents and near misses in line with the service's policy. Staff we spoke with knew what incidents to report and how to report them.

Staff generally understood the duty of candour. They knew about being open and transparent, and giving patients and families a full explanation if and when things went wrong.

Are Patient transport services effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

At our last inspection we found that not all policies were tailored to the service provision. For example, the medicines management policy went into detail about the ordering of medicines when the service did not order or store medicines. We also found that the safeguarding policy did not reflect up to date national guidance. At this inspection, we saw that the service had replaced the medicines management policy with a medical gases policy which reflected their service provision. At this inspection we viewed the service's safeguarding policy which was up to date and now contained relevant national guidance including referencing the Working Together to Safeguard Children 2018 guidelines.

We saw that all policies were in date and had review dates in place and version controls to show when the policy had been last updated. All policies we viewed had equality and environmental impact assessments included within them.

Policies were accessible from the computers in the base office and in paper form. When staff started at the service, they had to sign that they had read and understood the policies as part of their induction. We saw this checklist which had been signed by staff when they started at the service.

The service did have eligibility criteria which ensured that only patients suitable for the service could be booked for transport by the provider. The electronic booking system ensured that all questions had to be answered before control staff could move on to the next step of the booking and complete the process.

At our last inspection we noted that the service had very few audits and had not conducted an infection prevention and control audit. At this inspection, the service had a more comprehensive audit schedule which included audits of

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infection prevention and control, hand hygiene, vehicle daily checks, equipment checks, vehicle and equipment spot check audits, oxygen administration audits, bookings audit, key performance indicators, DBS check audits, driving license audits, and deep cleaning. We saw that results from the audits were discussed at the team meetings and at clinical governance and risk management meetings.

Nutrition and hydration

Staff gave patients opportunities to obtain food and drink during patient journeys.

Staff told us they would carry water bottles for patients on long distance journeys. Prior to a long distance journey, staff would ensure patients had their own food or snacks to take with them.

If a patient required food for a journey for medical reasons, this would be recorded within the booking form and would be provided by the carer or provider who made the booking.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

At our last inspection we found the service did not collect or monitor key information such as response times. At this inspection, the provider did collect and monitor response times as part of their key performance indicators (KPIs). The service's target was to achieve 98% of 'on time' pick ups. We reviewed the service's KPI monitoring report which broke data down into on time pick ups, and those exceeding 30 minutes. Comments were made at the bottom of the report in relation to the reasons for delays. These were then discussed at the team meetings and clinical governance and risk meetings.

Compliance was consistently above 95% for picks-ups that were on time. The service had undertaken 3790 journeys in the last 12 months. The service had not needed to cancel any jobs in the last 12 months. Between January and March 2022, compliance was 97% where pick ups were on time. Reasons around delays were due to traffic or if a job received from a commissioner still recorded the original pick up time before it had been allocated to the service. The provider did not have any contracts and all bookings were made on an ad hoc basis and only if the service had the capacity to fulfil the job. All bookings were made with specific pick up times agreed at the point of booking and pick up and drop off times were recorded for each job. As a result, the service rarely reported any delays.

If there was a delay in a pick-up for example due to traffic, the control office staff would call the patient and the hospital awaiting the patient to let them know about the delay.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Although the service only provided a patient transport service for medically stable patients, all staff were FREC3 (First Response Emergency Care (Level 3) trained and had emergency first aid at work training which meant that there was always a member of staff on board trained in basic life support.

Managers gave all new staff a full induction tailored to their role before they started work. The induction process included: driving checks, online and face to face mandatory training and staff were also expected to read the service's

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policies. An induction sheet was given to new starters to ensure they had read the service's policies and were signed off by the registered manager confirming that they had completed training modules and training on the use of equipment such as stair climbers and carry chairs. All personnel files contained this information and a checklist to show that mandatory training modules had been completed. Upon completion of the induction, staff would then be able to shadow a more experienced member of staff on jobs. Staff we spoke with told us that the induction programme was comprehensive and included familiarisation with the ambulance and equipment.

We viewed staff yearly appraisals which were up to date and showed discussion around development, skills, quality of work, teamwork, general conduct, discipline and absence records. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The registered manager continued to carry out informal supervision sessions with crew and went on some jobs with crew as part of this to assess staff competencies.

Mandatory training was a mixture of face to face and online training. There was regular refresher training built into the training matrix for some modules such as manual handling and use of equipment such as paediatric harnesses to ensure staff maintained their competencies. The registered manager monitored the mandatory training matrix to ensure staff compliance and sent out reminder emails to those who needed to complete modules.

At our last inspection, the service did not provide driving assessments however at this inspection, the service was conducting driving assessments for new starters and this would form part of the induction programme. Driving license checks were still being conducted every six months. The service also had a computer programme which was connected to all of the ambulances to enable the registered manager to monitor staff driving in real time. This meant that the registered manager could monitor the speeds at which a driver was driving. The registered manager also carried out spot checks whereby they would accompany crew on jobs to assess elements such as infection, prevention and control, driving, patient care. Any concerns would then be brought up with individuals.

The provider carried out disclosure and barring service checks for each member of staff as part of the service's recruitment process in line with service policy. The registered manager used an online update service to check staff members' certificates when they were due for renewal. We reviewed these documents and found them all to be up to date.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff held regular and effective meetings to discuss patients and improve their care. Staff told us that the regular team meetings were a good opportunity to feed back any issues and share learning from incidents.

We spoke with staff who told us there was good team working with fellow crew members and control staff.

The service had a handover policy which they shared with commissioners and receiving hospitals and care homes to explain how crew were required to get a comprehensive handover from hospitals and care homes before transferring a patient. If crew had any concerns about a patient when they arrived for a transfer, they were able to call the control office staff for advice.

We saw on booking forms a free text area where staff could write in any details about the handover.

Patient transport services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff generally understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice.

The Mental Capacity Act and consent formed part of mandatory training and staff we spoke with showed a good understanding of the mental capacity act. All staff were up to date with mental capacity act training.

The service did not transport patients detained under the Mental Health Act 1983 or patients experiencing a mental health crisis. The service did not use restraints.

Are Patient transport services caring?

Insufficient evidence to rate 

We did not rate caring at this inspection as due to restrictions during the pandemic, we were unable to accompany staff on the ambulance to see care first-hand.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We were provided with examples of patient feedback that demonstrated staff treated patients with compassion and kindness, took account of individual needs and respected patients' privacy and dignity. Patients and their families could give feedback on the service and feedback we viewed was overwhelmingly positive:

Comments from the past 12 months included: "...my sincere thanks to the crew for the care and compassion they gave us"... "This is to thank you and your extraordinary crew for their care and kindness to us both. They made a very difficult journey to the hospital a little less difficult to bear"... "they were very patient and spoke with me also to make suggestions on how they could support us; please do pass on my appreciation for this level of professionalism"... "an amazing service. Please pass on to your staff how much I appreciated what they did."

Are Patient transport services responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Patient transport services

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised the service, so they met the needs of the local population. The service also undertook long distance journeys across the United Kingdom which meant that they also served areas outside the immediate local population. The service provided was non-emergency patient transport for patients who were unable to use public or other means of transport. The service did not transport COVID-19 positive patients. All patients eligible for the transport were medically stable and transport was provided to patients attending hospital appointment, being discharged from hospital or going to care homes. The service also provided a repatriation service however had not received any of these types of jobs in the last 12 months.

The service took non-emergency ad-hoc bookings from private customers and commissioners through a service level agreement. The control team risk assessed referrals against the service's eligibility criteria to ensure individual requirements could be met such as the type of equipment required.

The service did not have any contracts and therefore only accepted bookings they knew they had the capacity to fulfil.

The service also had a customer information pack which was sent out to private customers who enquired about the provider's services.

The service operated seven days a week from 7am to 11pm and were able to receive bookings by telephone and email.

Control office staff could track vehicles' locations so that they could effectively allocate crew who were nearer to pick up locations. They were also able to monitor traffic delays and communicate this to crew and patients awaiting pick up.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

All ambulances had equipment to transport bariatric patients. The service also had paediatric harnesses available for transporting children.

The service only took bookings that they had the capacity to fulfil. Therefore they were able to give precise pick up times and provide a flexible service for patients. The service could also accommodate short notice bookings as all vehicles were equipped with specialist equipment such as bariatric wheelchairs.

The booking system ensured that information about a patient's individual needs could be recorded including details about the pick up location such as whether there were steps at the address.

The booking form also included details of patients' additional needs including medical conditions, if the patient had any infections, their COVID-19 status, whether they required an escort and their mobility needs. Control staff could then decide whether the job could be fulfilled and then allocated to crew. Control staff would also phone the crew ahead of the job to make sure the information about the job had been successfully relayed and answer any questions the crew had.

Patient transport services

At our last inspection, the service did not have a translation services for patients whose first language was not English. The service now had a service level agreement with an external translation provider should translation be required. The translation service would be booked by the control team at the time of booking to ensure it was in place for the journey. The translation provider was also able to translate leaflets and documentation if required.

We also saw posters on the ambulances informing patients on how to make a complaint and if they required information on this in a different language, this could be requested.

The provider told us that they would ensure that patients requiring British Sign Language would travel with an escort. Staff received training in dementia awareness but patients who were living with severe dementia would require a carer to travel with them however some staff said they had transported a patient with dementia who did not have a carer or escort with them.

Staff had received training in supporting patients with learning disabilities however we did not see any communication aids within ambulances to help support patients who are non-verbal or have learning disabilities.

Where possible, the same crew were allocated to patients who regularly used the service to ensure continuity of care.

Access and flow

People could access the service when they needed it.

Managers monitored response times and made sure patients could access the service when needed. Patients could access the service in a timely way as the service only booked jobs they could fulfil with their staff and ambulances.

The registered manager told us they rarely experienced delays in pick up times but when there was a delay for example due to traffic, control staff would call the patient to keep them updated. The service was consistently achieving over 95% for on time pick ups and the service submitted their response times to commissioners for whom they carried out jobs. At our last inspection they told us they did not receive feedback from commissioners. At this inspection the provider told us they had regular calls with commissioners to discuss response times and any other issues.

Control staff could track vehicles so they were able to allocate bookings to crew effectively matching the proximity of the vehicles to the pick up locations.

The service had not cancelled any journeys in the last 12 months.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service had an up to date complaints policy. All complaints were acknowledged within 48 hours and the registered manager responded in full within 25 days of receiving the complaint. The registered manager told us that any concerns would be handled as soon as they were received.

The service had received one complaint in the last year. We saw that the complaint had been addressed by the registered manager within the timeframe as per the service's complaint policy and investigated. Learning from the complaint had been shared with staff at the team meeting

Patient transport services

Ambulances had posters on how to make a complaint which detailed that patients could make a complaint by telephone or in writing. The posters also indicated that if a patient required the information in a different language this could be requested.

At the end of every journey, the mobile application prompted crew to ask for feedback from patients where they could rate their journey and whether they would recommend the service.

Are Patient transport services well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The registered manager was the managing director and provided the overall leadership of the provider. They were supported by a medical director and an accountant who was also part of the control office staff.

Day to day operations was coordinated by the registered manager. They also carried out supervision and appraisals of staff. The registered manager understood and managed the priorities and challenges the service faced.

Governance and risk management committee meetings were led by the registered manager and took place every three months. The medical director provided clinical support and attended clinical governance and risk management committee meetings remotely. The meetings were minuted and covered discussion around clinical and operational governance, audit results, incidents, complaints, risk register, recruitment, fleet, COVID-19 updates, and actions to be taken forward and by whom.

Team meetings were held at the office base every two months. Staff told us this was a good opportunity to feedback any concerns and make suggestions to improve practice.

Staff were complimentary about the management and spoke highly of the support provided by the leadership team. They told us that managers listened to their suggestions and ask for staff's opinion in these meetings. They said that the managers were visible and joined them on some jobs occasionally.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The service had a documented five-year strategic plan whereby the provider had divided plans into short term and long-term goals with challenges clearly defined.

Plans included to expand the service by increasing the number of ambulances and crew. There was also a plan to move to commercial premises and gain direct contracts from commissioners. Progress against the strategy would be assessed yearly and also discussed at the clinical risk and governance meetings.

Patient transport services

The values of the service were 'responsibility in action, excellence in service and difference in delivery'. At our last inspection staff were unaware of the vision and values of the service. At this inspection not all staff could recall the values of the service but they were aware of where they could find these (on posters within the office and in the ambulance). Staff were aware of the service's strategy and vision around plans to expand.

The registered manager told us that they wanted to continue to be able to provide a flexible service and fulfil journeys with multipurpose vehicles that will be able to meet the different needs of all patients in the community and further afield.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

Due to restrictions during the pandemic, we were unable to accompany staff on the ambulances and were therefore limited to how many staff we could speak with. Staff we spoke to told us there was an open, honest and patient centred culture within the organisation. They spoke of good teamwork and felt able to raise concerns with the leadership.

Staff told us they felt supported by the registered manager and felt valued by the organisation.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had systems in place to monitor the quality and safety of the service. There was now a comprehensive audit schedule which monitored infection prevention and control, vehicle and equipment checks as well as audits to monitor the booking process and administration of oxygen.

There was now a formal clinical governance and risk management meeting schedule which took place every three months. We reviewed minutes of these meetings and found that there was now more detail recorded within the documents to show what was discussed, actions taken and who was responsible for taking other actions forward.

The service now had an incident reporting policy and kept a formal record of incidents which they then used to share learning with the team. We viewed the incident reporting folder containing the 14 incidents that had been reported in the last 12 months and saw that they had been investigated, follow up and any learning had been shared with staff members.

Team meetings occurred every two months and minutes from these meetings showed that topics such as learning from incidents, audit results, infection control, training reminders and the provider's strategy were discussed. These minutes were also circulated to staff by email so that those staff members who were not able to attend would still receive the relevant messages.

Management of risk, issues and performance

Leaders used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Patient transport services

At our last inspection we found that the service did not routinely record risks and the risk register did not reflect the risks the registered manager had described. At this inspection we viewed the risk register which contained the risks the registered manager described to us. We viewed the risk register which contained a list of risks which were graded low, medium, high, very high. The risk was listed with a responsible lead, actions taken to mitigate the risk and the next review date if the risk was still ongoing.

Risks were discussed and reviewed at the clinical governance and risk management governance meetings and we saw these discussions in minutes we reviewed.

The registered manager described the main risks to the service currently were an older fleet and staffing due to illness or testing positive for COVID-19. They described that both of these risks had mitigations in place for example, there was always an ambulance kept at the base to replace an ambulance if it were to break down. In terms of staffing, the service did not have any contracts and could therefore only accept bookings they had the capacity to fulfil.

The service had a business continuity plan. Within the document we saw that there were plans in place in the event of loss of communications with the office or crew, damage or loss of vehicles or loss of utilities at the office. At our last inspection the plan referred to the service's old address but at this inspection we saw that this had been amended and reflected the correct address.

Patient information and bookings were stored within secure cloud-based software which meant these would not be lost. During the height of the pandemic, the service adapted the control office to ensure that control staff could work safely and securely from home.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Information relayed to crew was through a mobile application which could only be accessed with a personal login and password which crew held. This meant that patient information could be kept secure and only accessible to authorised staff. Once a job had been completed the information would automatically be removed from the application and replaced with the details of the next job.

The service used up to date satellite navigation systems and vehicles could also be tracked and monitored at all times by control office staff.

The service now collected key performance indicator (KPI) data and produced quarterly reports from the computer system. The booking forms could also be analysed and filtered using the computer system to help the service understand the types of patient transfers they were undertaking each month to ensure effective service provision; for example forms could be filtered to show how many bariatric transfers the service was doing or how many repatriations they had completed within a specific period.

At our last inspection we saw leaflets that reflected services that the provider no longer provided. At this inspection we saw that these leaflets had been removed.

Patient transport services

At our last inspection, we found that not all Disclosure and Barring Service (DBS) certificates had been processed in line with data protection legislation as we had found hard copies of certificates in some personnel files. At this inspection, we checked all personnel files and found that this was no longer the case for staff. Certificate numbers were kept and the service had signed up to an automatic DBS update service to ensure that these were checked yearly.

Engagement

Leaders and staff actively and openly engaged with patients and staff.

Booking forms on the mobile applications had a feedback section where staff could ask a patient about their journey. Staff told us it was not easy to receive feedback from patients after a journey. However, the service did receive feedback by email which were overwhelmingly positive. These comments were shared with staff at team meetings.

The service had further built on their engagement with staff since our last inspection. We saw discussions involving staff to get to know the service's strategy and staff were actively encouraged to make suggestions at team meetings to improve practice. Staff who had completed training were congratulated on team meetings.

The service had previously arranged Christmas lunches and social events but this had been put on hold due to the pandemic. We saw the service was planning on a team building day when it was safe to do so. Staff were also given shopping vouchers at the end of the year as a token of appreciation for their hard work.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff we spoke with reported that they enjoyed working for the service. Team meeting minutes showed discussion of different topics such as learning from incidents to the understanding of the duty of candour and showed an active discussion around improving the service.

To help improve infection control and hand hygiene compliance, the provider had added extra training around effective hand washing using a training kit that gave a visual demonstration of effective hand washing under ultraviolet light. They had also implemented an audit whereby the high touch surfaces of ambulances were swabbed to check that they had been effectively cleaned. The service had also trained staff in the use of a fogger to further clean the inside of ambulances.