Patient Transport (UK) Limited

Patient Transport, Colindale

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

Patient Transport Colindale is an independent ambulance service providing patient transport services as a subcontractor to main contractors (identified as commissioners in this report). The main contractors who commission services from Patient Transport Colindale liaise directly with NHS providers. Patient Transport Colindale provides services as a subcontractor to two main commissioners working with the NHS. The service also carries out private work. However, private work is limited as the priority is to fulfil their contracts. The service also transports patients detained under the Mental Health Act 1983. Patient Transport Colindale does not undertake emergency and urgent transfers such as high dependency transfers.

We visited the ambulance service for a two day announced inspection on 21 and 22 September 2016 as part of our comprehensive programme of inspections.

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.

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

- There was a lack of incident reporting and complaints monitoring within the service.
- The service did not carry out local audits as a way of monitoring performance and making improvements.
- We found expired oxygen cylinders in storage and on one of the vehicles we inspected. This vehicle was not in use.
- Staff did not always follow the service's infection control policies.
- Most staff had a limited understanding of the principles of duty of candour.
- There was minimal reference to best practice and national guidelines by staff.
- There was no monitoring of key performance indicators (KPIs) against the commissioners' contracts as a way of measuring performance in order to make necessary improvements. The operations manager told us the service was not given access to KPI information by their commissioners and could not measure their service's performance against this data.
- It was not always possible for staff to communicate with patients who did not speak English. While the service employed multilingual staff who control staff could allocate to patient journeys accordingly in order to aid communication, this was not always possible. The managing director told us staff used language translation applications on their mobile phones in order to aid communication but this was not reflected in our interviews with staff. There was no provision for patients who had other communication difficulties.
- There was a clear vision for the service but there was no formal strategy for achieving that vision.
- There was little staff engagement to obtain their views and experiences in order to improve the service.

However, we found the following areas of good practice:

- Disclosure and Barring Service (DBS) checks had been applied for in relation to all staff before staff commenced employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.
- Staff had a good understanding of safeguarding processes and there was evidence of safeguarding referrals being made.
- The completion rate for mandatory training was 100% and all staff we spoke with except one had been appraised.

Summary of findings

- All vehicles inspected were visibly clean.
- There was good coordination between the service and its commissioners in planning the delivery of the service.
- During our inspection, all observations of care provided by the ambulance service showed patient dignity being maintained. Patients were treated kindly and compassionately. We observed positive and courteous interactions between staff and patients.
- The same crews transported the same patients wherever possible in order to maintain a degree of continuity in patient care.
- Staff had received training around dementia, mental health, and learning disability.
- All staff we spoke with were happy to work for Patient Transport Colindale and spoke positively about the leadership of the service.

Information on our key findings and action we have asked the provider to take are listed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		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. We found: • There was a lack of incident reporting within the service. The service had an incident reporting policy and incident reporting forms but no incidents were reported between September 2015 and September 2016. Due to a lack of incident reporting we were not assured incident reporting was embedded in the culture of the organisation. There was no evidence of staff learning from incidents. • We found expired oxygen cylinders in storage and on a vehicle which was not in use. Also, four of the twelve oxygen containers in storage had expired. However we saw evidence of processes for checking vehicles which offered assurance that the expired oxygen cylinder would have been changed prior to the vehicle being used operationally. • Staff including the safeguarding lead were trained up to level two adult safeguarding. A safeguarding lead would normally have a level of knowledge relating to safeguarding which exceeds the level required for operational staff, enabling the provision of advice and access to support across a safeguarding network in the event of difficult cases. • Staff did not always follow the service's infection control policies in relation to single mop use and wearing protective gear when deep cleaning vehicles. • There was minimal reference to best practice and national guidelines. Policies made reference to an old version of The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines even though there had been two further versions of the guidelines.

Summary of findings

- The service did not carry out local audits as a way of monitoring performance and making improvements.
- Most staff had a limited understanding of the duty of candour.
- The service did not monitor key performance indicators against the commissioners' contracts as a way to measure performance in order to make necessary improvements. The operations manager told us they were not given access to KPI information by their commissioners and could not measure their service's performance against this data.
- It was not always possible for staff to communicate with patients who did not speak English. The service employed multilingual staff and control staff took this into account when allocating journeys where a second language would aid communication. The managing director told us staff used language translation applications on their mobile phones to aid communication but this was not reflected in our interviews with staff. There was no provision for patients who had other communication difficulties.
- There was a clear vision for the service. However there was no formal strategy for achieving that vision.
- There was a lack of complaints monitoring and carrying out of audits within the service.
- Staff were not formally engaged in order to obtain their views and experiences in order to improve the service.

However:

- Staff had a good understanding of safeguarding and there was evidence of safeguarding referrals being made.
- The completion rate for mandatory training was 100%. Staff were appraised annually and all staff we spoke with except one had been appraised.
- All vehicles inspected were visibly clean and free from dust.

Summary of findings

- Disclosure and Barring Service (DBS) checks had been applied for in relation to all staff. Staff whose DBS checks had expired had new checks applied for. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.
- There was good coordination between the service and its commissioners in planning the delivery of the service.
- During our inspection, all observations of care provided by the ambulance service showed patient dignity being maintained.
- Patients were treated kindly and compassionately. We observed positive and courteous interactions between staff and patients.
- The same crews transported the same patients wherever possible in order to maintain a degree of continuity in patient care.
- Staff had received training around dementia, mental health, and learning disability.
- All staff we spoke with were happy to work for Patient Transport Colindale and spoke positively about the leadership of the service.

Patient Transport, Colindale

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Detailed findings

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Background to Patient Transport, Colindale

Patient Transport Colindale is an independent ambulance service providing patient transport services as a subcontractor to main contractors (identified as commissioners in this report). The main contractors who commission services from Patient Transport Colindale liaise directly with NHS providers. Patient Transport Colindale provides services as a subcontractor to two main commissioners working with the NHS. The service also carries out private work. However, private work is limited as the priority is to fulfil their contracts. The service also transports patients detained under the Mental Health Act 1983 using cell vehicles. Cell vehicles are a secure vehicle with the option of accommodating escorts to travel with the service user. Patient Transport Colindale does not undertake emergency and urgent transfers such as high dependency transfers.

Journeys are made to numerous locations within London and longer journeys across the United Kingdom occur on a regular basis.

Our inspection team

Our inspection team was made up of a CQC inspector and a specialist advisor with patient transport and management experience in ambulance services.

How we carried out this inspection

We asked the service for some information prior to the inspection. We analysed that information in the planning stages of the inspection.

We visited the ambulance service for a two day announced inspection on 21 and 22 September 2016 and gathered further information from data provided by the service during this period.

During the inspection, we spoke with nine members of staff including the managing director, operations manager, and ambulance care assistants. We also spoke with five members of staff at hospitals for which services were provided including four transport managers for two commissioners stationed at the hospital.

We were unable to speak to patients being transported on both days of the inspection. However, we met with patients using the service at the hospital locations for which services were provided.

We inspected six vehicles over the two days we inspected.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Patient Transport Colindale is an independent ambulance service providing patient transport services as a subcontractor to main contractors (identified as commissioners in this report).The main contractors who commission services from Patient Transport Colindale liaise directly with NHS providers. Patient Transport Colindale provides services as a subcontractor to two main commissioners working with the NHS. They also undertake some discretionary private work but this is limited as the priority is to fulfil their contracts. The service also transports patients subject to the Mental Health Act 1983 in secure vehicles. All patients transferred in secure vehicles are escorted by healthcare staff from the transferring hospital or organisation. This service does not undertake urgent and emergency transfers such as high dependency transfers.

Journeys are made to various locations within London and longer journeys across the United Kingdom occur on a regular basis. The service carried out approximately 2400 secure journeys between 1 July 2015 and 31 July 2016. The service was unable to provide the exact number of unsecured journeys during the same period due to the subcontracted nature of the service. Where crews are dispatched to commissioners for the day it is the commissioners who allocate workload and Patient Transport Colindale are not informed of the number of journeys carried out by their crews for that day.

This was a two day announced inspection as part of our comprehensive programme of inspections. We visited the ambulance premises as well as hospital locations in order to speak to patients and staff about the ambulance service. During the inspection, we spoke with nine members of staff including the managing director, operations manager, and ambulance care assistants (ACAs). We also spoke with five members of staff at hospitals for which services were provided including four transport managers for commissioners stationed at the hospital. We were unable to speak to patients being transported. However, we met with patients using the service when we visited some of the hospitals for which services were provided. We inspected six vehicles over the course of the two days.

The service employs 38 staff and has 30 vehicles. The fleet is wholly owned by Patient Transport Colindale. Of these there are four cell vehicles. Cell vehicles are a secure vehicle with the option of accommodating escorts to travel with the service user. Patient Transport Colindale uses cell vehicles for the transportation of patients detained under the Mental Health Act 1983.

The office is manned between 8am and 7pm on each day of the week. During out of hours, a duty officer facilitates bookings and requests.

The service is registered for transport services, triage and medical advice provided remotely. The current registered manager has been in post since October 2016.

Patient transport services (PTS)

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:

- There was a lack of incident reporting within the service. The service had an incident reporting policy and incident reporting forms but no incidents were reported between September 2015 and September 2016. Due to a lack of incident reporting we were not assured incident reporting was embedded in the culture of the organisation. There was no evidence of staff learning from incidents.
- We found expired oxygen cylinders in storage and on a vehicle which was not in use. Also, four of the twelve oxygen containers in storage had expired. However we saw evidence of processes for checking vehicles which offered assurance that the expired oxygen cylinder would have been changed prior to the vehicle being used operationally.
- Staff including the safeguarding lead were trained up to level two adult safeguarding. A safeguarding lead would normally have a level of knowledge relating to safeguarding which exceeds the level required for operational staff, enabling the provision of advice and access to support across a safeguarding network in the event of difficult cases.
- Staff did not always follow the service's infection control policies in relation to single mop use and wearing protective gear when deep cleaning vehicles.
- There was minimal reference to best practice and national guidelines. Policies made reference to an old version of The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines even though there had been two further versions of the guidelines.
- The service did not carry out local audits as a way of monitoring performance and making improvements.
- Most staff we spoke with had a limited understanding of the duty of candour.
- The service did not monitor key performance indicators against the commissioners' contracts as a way to measure performance in order to make necessary improvements. The operations manager told us they were not given access to KPI information by their commissioners and could not measure their service's performance against this data.
- It was not always possible for staff to communicate with patients who did not speak English. While the service employed multilingual staff who control staff could allocate to patient journeys accordingly in order to aid communication, this was not always possible. The managing director told us staff used language translation applications on their mobile phones in order to aid communication but this was not reflected in our interviews with staff. There was no provision for patients who had other communication difficulties.
- There was a clear vision for the service. However there was no formal strategy for achieving that vision.
- There was a lack of complaints monitoring within the service.
- There was minimal engagement with staff to obtain their views and experiences in order to improve the service.

However:

- Staff had a good understanding of safeguarding and there was evidence of safeguarding referrals being made.
- The completion rate for mandatory training was 100%. Staff were appraised annually. All staff we spoke with except one had been appraised.
- All vehicles inspected were visibly clean and free from dust.
- Disclosure and Barring Service (DBS) checks had been applied for in relation to all staff. Staff whose

Patient transport services (PTS)

DBS checks had expired had new checks applied for. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

- There was good coordination between the service and its commissioners in planning the delivery of the service.
- During our inspection, all observations of care provided by the ambulance service showed patient dignity being maintained. Patients were treated kindly and compassionately. We observed positive and courteous interactions between staff and patients.
- The same crews transported the same patients wherever possible in order to maintain a degree of continuity in patient care.
- Staff had received training around dementia, mental health, and learning disability.
- All staff we spoke with were happy to work for Patient Transport Colindale and spoke positively about the leadership of the service.

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

- There was a lack of incident reporting within the service. There was no evidence that incidents had been reported within the organisation or to commissioners in the twelve months prior to our inspection, that is, between September 2015 and September 2016.
- Even though the provider had an incident reporting policy, no incidents had been reported and or recorded between September 2015 and September 2016.There were no effective systems and processes in place for incident reporting and there was no evidence of staff learning from incidents.
- Most staff had a limited understanding of the duty of candour.
- We found expired oxygen cylinders in storage and on one of the six vehicles we inspected. This vehicle was not in use. Four of the twelve oxygen containers in storage had expired.
- Staff, including the safeguarding lead, were trained up to level two adult safeguarding. A safeguarding lead would normally have a level of knowledge relating to safeguarding which exceeds the level required for operational staff, enabling the provision of advice and access to support across a safeguarding network in the event of difficult cases.

However:

- There was good understanding of safeguarding by staff and we saw evidence of safeguarding referrals being made.
- All staff had completed their mandatory training. All staff but one had been appraised.
- All vehicles inspected were visibly clean and free from dust.
- Staff using the cell (secure) vehicles had additional training relevant to the patient group they were involved with.

- Staff had been trained in mental capacity and showed awareness of consent issues.

Incidents

- We were not assured that incident reporting was embedded in the culture of the service. There were no effective systems in place for the recording of incidents within the service and there was no evidence of incidents being reported and recorded by the service.
- The service had an incident reporting policy and we saw incident report forms located in the office and in vehicles. However, none had been completed in the twelve months prior to our inspection. The managing director and the operations manager told us that no incidents had been reported between September 2015 and September 2016. Minutes for the service's service quality meetings for May, June and July 2016 revealed no incidents had been reported by staff in each preceding month.
- We found there was under reporting of incidents within the service. Staff did not have an understanding of what they should be reporting as incidents. In our discussions with some staff we found that some things which should have been reported as incidents had not been reported. For example, the service did not transport bariatric patients but staff reported that they sometimes failed to carry out journeys allocated to them by commissioners because they found out on arriving to collect the patient that the patient was bariatric. However, these incidents had not been recorded as incidents. We also found that staff did not know they should be reporting near misses.
- Following the inspection we received further information from the service in the form of emails from their commissioners. Those commissioners stated that Patient Transport Colindale "managed all aspects of incident reporting" correctly and in a timely manner in line with their policies. However, the service was unable to provide evidence of incidents that had been reported to commissioners.
- There was no evidence of learning from incidents due to the lack of incident reporting. Staff we spoke with could not give us examples of when they had learnt from incidents.
- 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. Duty of candour was part of the mandatory training. However, we found that when we questioned staff about the principles of duty of candour, this was not well understood by most of them.

Mandatory training

- All staff had completed mandatory training .Staff had been trained in moving and handling, first aid at work level three including oxygen control, automated external defibrillator (AED) training, infection control, health and safety at work, fire safety, safeguarding of vulnerable adults and children, information governance and capacity and consent.
- Staff using secure vehicles (cell vehicles) received additional training in management of violence and aggression, control and restraint, mental health awareness, and Mental Capacity Act including Deprivation of Liberty Safeguards. The managing director told us there were plans to roll out the additional courses to all staff. However, this had not been completed at the time of the inspection.
- The service had a dedicated training lead who had been trained as an instructor and assessor and was appropriately qualified to deliver training.
- Drivers were assessed on their driving on appointment. Expectations were conveyed to staff during the induction programme.
- Staff training was provided by an employee of Patient Transport Colindale but was based on a training package produced by an external training provider .Training was supported by on-line learning. We visited the website for the external training provider and sampled the syllabus which we found to be appropriate for the service offered by Patient Transport Colindale.
- Staff told us the training they received was adequate and equipped them to effectively carry out their roles.

Safeguarding

- Safeguarding adults and children was part of the mandatory training and all staff had completed this training. We found that staff had an understanding of what safeguarding was and were able to give examples

of what might constitute a safeguarding concern. Safeguarding concerns were escalated via the commissioners. Staff completed safeguarding forms provided by the commissioners and the managing director of the service would be informed that a safeguarding referral had been made. We saw evidence of appropriate safeguarding referrals being made by staff.

- Patient Transport Colindale had a safeguarding policy published in April 2016 and due for review in April 2018. The policy covered elements of level two training such as awareness of female genital mutilation and awareness of risk of radicalisation.
- A safeguarding lead would normally have a level of knowledge relating to safeguarding which exceeds the level required for operational staff, enabling the provision of advice and access to support across a safeguarding network in the event of difficult cases. The highest level of safeguarding training in the service was level two. The training lead delivering the safeguarding training had not received any additional training and was also trained to level two.

Cleanliness, infection control and hygiene

- All vehicles inspected were visibly clean and free from dust.
- All staff had received training in infection control. Ambulance staff were bare below the elbow in all our observations.
- There was variable understanding by staff of their roles with regard to infection control. Some staff had a good understanding of their role in infection control and prevention, however others did not. We found that staff did not always follow the service's infection control policies. For example, staff told us the service encouraged the single use of mops but we saw two mop heads had been used and left attached to mop handles. The evidence suggested that the single use of mops had not been embedded in the culture of the service.
- Vehicles were stocked with hand sanitiser, gloves, hard surface wipes, and labelled pump bottles of bacterial cleaner, spill kits, and clean linen. Sharps bins were closed and not overfull. However, we found that some of the vehicles did not have aprons in them.
- Staff were able to explain to us how a vehicle would be cleaned following exposure to infection. Staff were aware of the manufacturer's instructions for the use of the chemical they used to clean their vehicles. We were shown safety instructions for the use of the product used to deep clean vehicles. The advice was that goggles and face masks were to be worn during the deep clean of vehicles. However we were not assured that staff used goggles and face masks when deep cleaning vehicles which meant staff were putting themselves at risk.
- A clinical waste bin was available but staff did not complete the labels on clinical waste bags prior to disposal. This was not in line with the regulations for disposal of clinical waste which require such bags to be marked.
- Ambulances were subject to spot checks by the operations manager and the training manager. We found that the spot checks had only been taking place for three weeks prior to our inspection. There had been no formal audit of these spot checks or of cleaning of vehicles.

Environment and equipment

- Patient Transport Colindale operated a system where all vehicles were no more than two years old. Regular services were undertaken and crew members carried out daily vehicle checks. Faults were reported to vehicle manufacturers and tyre centres with which the service had contracts with. Ministry of Transport (MOT) checks were carried out by the service on their vehicles in accordance with the requirements of the law.
- An external company was contracted to maintain and service medical devices in accordance with manufacturer's guidelines and there was evidence that servicing had taken place. We also saw evidence that equipment such as the trolleys in the ambulances had been serviced by an external company.
- In one of the six vehicles we inspected the trolley mattress was torn. This meant that there was a risk of spread of infection between patients using the trolley. We raised this with the operations manager who immediately made arrangements for the mattress to be replaced.

- We inspected a storage area for the service where we saw staff uniforms and various consumable items. All items were in date. Consumables included personal protective equipment such as gloves, gowns and face masks.

Medicines

- Staff at Patient Transport Colindale did not store or administer controlled medicines. Oxygen cylinders were stored securely on the ambulances. Medical gases were stored in a secured wire cage located in the garage of the premises. We found large oxygen cylinders standing at one end of the cage which had not been secured. These cylinders were heavy and should have been secured to avoid the potential of injury to staff.
- We found an expired portable oxygen cylinder on one of the three vehicles we inspected. This vehicle was not in use. We saw evidence of processes for checking vehicles which offered assurance that this cylinder would have been changed prior to the vehicle being used operationally. Four of the twelve oxygen cylinders we sampled from storage were out of date. We raised this with the managing director and the operations manager. We were told there had been a reduction in fleet numbers and this had reduced the requirement for medical gases. Immediate steps were taken to return expired cylinders to the service's provider and to check all gases on vehicles. Following the inspection we received a medical gases stock checklist which had been prepared by the service as a way to help them identify oxygen that was about to expire.
- Staff had been trained in the administration of medical gases. All staff had received the oxygen therapy training. Patients were expected to have paperwork stating how much oxygen they were on when they travelled on the ambulances.
- The service's policy on medicines management referenced The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. However, the references were from an older version of the guidance (2009 update) .The current version of the guidance is 2016.

Records

- Documents with patient information were securely stored in folders in the office. Staff returned booking forms and patient report forms to the office at the end of each day. Staff were aware of the need to protect patient data.
- Staff told us they were made aware by hospital staff if a patient they were transporting had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place. The service had a policy on DNACPR which set out the protocol on patients with DNACPR orders and recommended that the order should travel with the patient whenever possible.
- Policies were located in the staff area in the office and were easily accessible to staff. Policies included safeguarding, infection control, DNACPR, incident reporting and medicines management.

Assessing and responding to patient risk

- Staff told us they maintained constant dialogue with and observations of patients as a way of assessing risk. Staff were unable to tell us who they would contact within the organisation if they needed clinical advice on a patient during a journey. If a patient became distressed or if their condition deteriorated staff told us they dialled 999 or took the patient to the nearest accident and emergency department (A&E) department.

Staffing

- The service consisted of the managing director, an operations manager and a training manager. The remainder of staff were ambulance care assistants. We saw one member of staff who handled clerical and financial aspects of the business. There was a total of 38 employees employed by the service. There was no use of bank or agency staff.
- Staff reported they had adequate breaks during the working day.
- All staff we spoke with told us they were always able to get hold of the managing director out of hours.
- Between September 2015 and September 2016, the service had a staff turnover rate of between 4% and 5%. The managing director told us that they had enough staff to meet demand. Sickness absence levels were low. The service reported 23 sick days across 38 crew staff in the twelve months prior to the inspection.

- Staff were allocated ambulances depending on their skills and training. For example, only staff who had received additional training specific to secure vehicles would drive them and carry out the secure journeys.
- We found that some staff were working over 48 hours a week. However, evidence of these staff having signed opt out forms was inconsistent .One of the two employee files we looked at did not have a signed opt out form in it.

Anticipated resource and capacity risks

- Patient Transport Colindale operated in two separate buildings. One building was used as the staff office, control room, training room and staff kitchen and toilets. The other building was a garage, where the oxygen storage, store room and vehicle deep clean area were located. The managing director told us the garage could be used as an office in the event of a loss of the office building. Computer systems would be transferred and telephones diverted.
- The business continuity plan for the service covered loss of information systems, building security, staff and vehicles. The service had identified the risks in relation to these aspects of the service and set out what the potential impact on the organisation would be and identified what resources would be needed for the recovery of each aspect of the business.

Response to major incidents

- The service did not have any plans for responding major incidents and was not required to have any.

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

- Disclosure and Barring Service (DBS) checks had been applied for in relation to all staff prior to commencing employment. Staff whose DBS checks had expired had new checks applied for.
- Staff using the cell vehicles had additional training relevant to the patient group they were involved with.
- All staff we spoke with except one had been appraised.
- Staff had been trained in mental capacity and showed awareness of consent issues.
- There was good coordination between the service and its commissioners in planning the delivery of the service.

However:

- There was minimal reference to best practice and national guidelines. Policies made reference to an old version of The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines even though there had been two further versions of the guidelines.
- The service did not carry out local audits as a way of monitoring performance and making improvements.
- We found that employee references in staff employment files were inconsistent.
- The service did not carry out local audits to monitor the service and make improvements.

Evidence-based care and treatment

- There was minimal reference to best practice guidelines by staff. We asked a senior member of staff what they would reference to support reflection and learning following a query and they told us they had access to the First Person on Scene Intermediate (FPOS-I) training manual. Staff did not refer to best practice guidelines which would normally be referred to by patient transport services such as JRCALC guidelines, the National Institute for Health and Care Excellence (NICE) guidelines, or local protocols. Other staff we spoke with were unable to tell us what evidence based guidance they referred to in their work.
- The service's policy on Do Not Attempt Cardiopulmonary Resuscitation was based on and referred to the Resuscitation Council (UK) guidance.

Assessment and planning of care

- Patient Transport Colindale relied on the booking system to provide them with sufficient information to effectively plan for patients' care. Bookings for journeys from commissioners indicated information needed to plan care, for example, if a patient was a wheelchair user this was indicated on the booking form. The booking

form, which could be downloaded online, allowed for the recording of any special notes such as whether a medical professional or family would accompany a patient and this assisted in the planning of care.

- Staff were made aware of any patients suffering with mental health or patients subject to detention under the Mental Health Act 1983 through the booking system in advance of accepting a booking so they could plan accordingly. Bookings for patients suffering from mental health were separate from other bookings to ensure that only mental health-trained staff responded to these bookings.
- The service had cell (secure) vehicles for transporting patients detained under the Mental Health Act 1983. All staff who used these vehicles had been trained in mental health awareness and restraint techniques and training was up to date.
- Staff reported they were not always given adequate information by commissioners to enable them to appropriately plan care. An example was staff arriving at a hospital site to collect a patient then finding out the patient was bariatric. The service was not equipped to transport bariatric patients and when this happened staff were unable to complete the journey. Staff contacted control back at Patient Transport Colindale who would advise the commissioners to identify an alternative service provider.

Nutrition and hydration

- The service did not provide food to patients during journeys. However, vehicles were stocked with water. Patients were able to bring their own food or drink onto the vehicles. In the case of long journeys, scheduled stops were given to allow consumption of food and drink if required.
- Staff we spoke with told us long journeys were usually secure transfers with hospital staff as escorts and escorts were responsible for making sure patients had food and drink.

Patient outcomes

- There was no monitoring of key performance indicators (KPIs) by the service. The managing director told us there were no formal or regular meetings with commissioners to discuss their performance however his understanding from informal discussions with the commissioners was that they were happy with the service's performance. There were no minutes of the informal contract review meetings which took place and there were no logs of when these meetings took place.
- We asked the service about the lack of monitoring of KPI data and the operations manager told us they were not given access to KPI information by their commissioners and were therefore unable to measure the service's performance against that data.
- The service did not undertake local audits in order to monitor the service and make improvements.

Competent staff

- We spoke with staff about the induction programme and training provided at Patient Transport Colindale and they told us it had prepared them well for the job.
- There was formal appraisal of staff within the service. Only one of the staff we spoke with had not received their appraisal. They had been with the service for less than a year.
- Patient Transport Colindale carried out scheduled driving licence checks on all employees driving their vehicles. This check involved accessing the Driver and Vehicle Licensing Agency database to obtain up to date information on driver records and any endorsements that may have existed. Licences were also checked manually during the induction process to ensure they were valid. Driver license checks had last been done in June 2016.
- Staff transporting patients on secure vehicles had received training in management of violence and aggression, and control and restraint.
- All staff were subject to a Disclosure and Barring Service (DBS) check as part of the service's recruitment process. We found that DBS checks were either in place or had been applied for in relation to all staff. Staff whose DBS checks had expired had new checks applied for and worked with another crew member pending the completion of DBS check.
- A DBS risk assessment process existed for staff whose DBS checks indicated an offence. The service requested details and circumstances of the offence. In forming an assessment and decision to employ, the managing director and the operations manager discussed the

application to determine whether that person should be employed with support or without conditions. The risk assessment and the decision were clearly documented on the risk assessment form.

- We checked two employee files for employment references. References had been obtained for both employees but the quality was inconsistent. In one file the employee had references from a previous employer and from a peer. The second employee only had one personal reference.

Coordination with other providers

- We spoke with three transport managers at three different hospital locations. They all told us there was good and effective coordination between themselves and Patient Transport Colindale. Any concerns they had were escalated to the managing director and the transport managers felt these were addressed effectively.
- Commissioners contacted the service with details of the journeys they needed completed. The information was captured on booking forms and crews were allocated accordingly. Commissioners also communicated to Patient Transport Colindale if they wanted crews for the day. In these instances Patient Transport Colindale provided crews and it was the commissioners who allocated journeys for the day.
- Ambulance crews told us they had good coordination with the various transport managers based at the hospitals they transported patients to.
- The majority of the service's work was in London under contracts with commissioners who worked directly with NHS hospital trusts. The exact proportions of work carried out for each commissioner were variable due to the fluctuating nature of the 'ad hoc' work. The service also carried out private work. However this was limited as the priority was to fulfil their contracts with commissioners.
- There were no formal meetings with commissioners to assess and discuss Patient Transport Colindale's performance in relation to key performance indicators. Senior staff informed us they believed these were being met. We were informed informal discussions with commissioners indicated that they were happy with the work being done by the service.

Multidisciplinary working

- There was coordination between Patient Transport Colindale staff and hospital staff where a patient was known to have a Do Not Attempt Cardiopulmonary Resuscitation order. Staff liaised with hospital staff to obtain the order or a copy prior to transporting the patient.
- Staff told us there were effective handovers between themselves and hospital staff when they collected patients from and dropped them off at hospital locations.

Access to information

- Special notes for patient journeys were recorded on booking forms which ambulance crews had access to.
- Staff told us both hospital staff and control staff made them aware of any special requirements. For example, they were notified if a patient was living with dementia.
- We found that staff had access to the service's policies which were stored in the staff information area of the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training on the Mental Capacity Act 2005. The training had covered Deprivation of Liberty Safeguards and the crossover between the Mental Health Act 1983 and Mental Capacity Act 2005.
- Staff understood the need to have valid consent when supporting patients, for example, when moving a patient or placing them in a wheelchair.

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

- We were unable to speak to patients being transported on both days of the inspection. However, we met with patients using the service at the hospital locations for which services were provided.

- During our inspection, all observations of care provided by the ambulance service showed patient dignity being maintained.
- Patients were treated kindly and compassionately. We observed positive and courteous interactions between staff and patients.
- There was evidence Patient Transport Colindale sent the same ambulance crews to collect the same patients wherever possible in order to maintain continuity of care.

Compassionate care

- A patient described staff as "so nice" and "so kind".
- There was evidence Patient Transport Colindale sent the same ambulance crews to collect the same patients wherever possible. Staff we spoke with told us they were allocated the same patients wherever possible in order to maintain a degree of continuity. However, this was not always possible due to annual leave or sickness.

Understanding and involvement of patients and those close to them

- Patient eligibility for services was assessed by commissioners who were aware of the nature of the service provided by Patient Transport Colindale. For work that was carried out outside the contacts with commissioners it was the service who assessed whether patient was eligible for the patient transport service.

Emotional support

- We asked staff how they emotionally supported patients and they told us they constantly reassured patients during the journey.

Supporting people to manage their own health

- Staff told us that they encouraged patients to be as independent as possible and provided support where required. Staff told us that they made an assessment of whether encouraging independence was appropriate as each patient's situation was different.

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 utilised its vehicles and resources effectively to meet patients' needs. Commissioners were provided with crews and vehicles as required and as part of the contract with Patient Transport Colindale.
- Staff were able to plan appropriately for patient journeys using the information provided through the booking system.
- Staff were aware of what information to provide to patients or carers that wished to complain.
- Ambulance crew staff had training to support people with dementia, mental health, and learning disability.

However:

- It was not always possible for staff to communicate with patients who did not speak English and there was no provision for patients who had other communication difficulties.
- Staff had no access to communication specialist equipment, pictorial guides, and language services to meet patients' individual needs.

Service planning and delivery to meet the needs of local people

- The service had two core elements, pre-planned patient transport services, and 'ad hoc' services to meet the needs of their contracts. Commissioners planned journeys in advance, for example what time a patient had to be collected and dropped off. This was communicated to Patient Transport Colindale who delivered the service in line with their contracts with commissioners. The 'ad hoc' services allowed the service the flexibility to expand or retract this element of its service based on contract demands.
- On the day bookings were responded to quickly via both telephone and email. For the ad hoc on the day

bookings control staff identified which drivers were free or had finished jobs and were nearest for the next transfer pickup. We observed effective communication between drivers and office staff as part of service planning.

- The service had four cell (secure) vehicles and any secure transfers were planned dependant on the availability of the cell vehicles.

Meeting people's individual needs

- Patient journeys were accompanied by a booking form which highlighted any specific conditions such as dementia, learning disability or physical disability. Staff used this information to ensure the comfort of such patients. Mobilisation equipment was available for physical injury and disability.
- Staff told us their training had covered learning disability and dementia and they felt confident transporting such patients. Staff supporting patients with mental health conditions were offered training around mental health. Staff using the cell vehicles had been trained in physical intervention and restraint techniques.
- It was not always possible for staff to communicate with patients who did not speak or understand English. Patient Transport Colindale employed several multilingual crew members and control room allocated resources accordingly if translation was required. The managing director told us crews also used a translation application on their mobile phones to assist in communicating with patients who did not speak or understand English. However, staff we spoke with during the inspection told us they used their knowledge of other languages to communicate with patients who did not speak English. Staff did not mention the use of a translation application to aid communication with patients. No provision was made for patients with other communication difficulties.

Access and flow

- Commissioners assessed patients' eligibility for the service. The service delivery was based on journeys (pre booked and ad hoc) given as part of the contract with commissioners. For journeys outside contracted work, the service assessed patients' eligibility for the service taking into account capacity in light of contracted work.
- Vehicles were allocated by the service depending on which crews were free or were completing journeys close to the area where the service was required.
- The service could be accessed 24 hours a day seven days a week via telephone as the control line was always manned.

Learning from complaints and concerns

- There were posters at the back of ambulances with information on how to make a complaint.
- There was no evidence of monitoring of complaints by the service .The service had a complaints policy which stated all customer complaints were to be recorded in a complaints log. However there was no evidence of complaints having been logged by the service between September 2015 and September 2016. We questioned the lack of complaints and the managing director told us that the priority for the service had been to address any concerns and complaints swiftly by involving staff and commissioners at the earliest opportunity in order to resolve complaints .However, there was no record of the complaints which had been received and dealt with in this manner.
- Minutes of the service and quality meetings for May, June and July 2016 showed no complaints had been received at the time of those meetings.
- We were unable to assess the service's response to complaints as none had been recorded .We were also unable to assess how staff learnt from complaints and concerns.

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

- There was a clear vision for the service. However there was no formal strategy for achieving that vision.
- There were limited governance structures within the service including a lack on incident reporting, complaints monitoring, and carrying out of audits.

- There was minimal formal engagement with staff to obtain their views and experiences in order to improve the service.

However:

- Staff were positive about working for the service.
- Staff spoke highly of the managing director who they said was visible and available for them to speak to.

Vision and strategy for this service

- The managing director told us the vision for the service was to sustain profitability and explore opportunities. There was a focus on creating an environment where staff were happy. The managing director also spoke about creating an environment where staff were able to express their views freely. There were no plans to expand the service but to maintain size and maximise on the quality of the service offered before focussing on growth.
- Part of the strategy for maintaining a happy workforce was providing staff with reliable vehicles. Vehicles at Patient Transport Colindale were not used beyond two years. However, there was no strategy for achieving the priorities and delivering good quality care. For example, there was no clear strategy in relation to how the service planned to remain profitable or how they would explore opportunities. The vision and strategy were not written down and there was no evidence progress against delivering the strategy was monitored and reviewed. Following the inspection, Patient Transport Colindale sent a copy of their formal vision statement.
- Staff were not aware of the vision of the organisation or their role in achieving it.

Governance, risk management and quality measurement

- There were limited governance structures within the service. There was a lack of effective systems and processes around incident reporting, complaints monitoring, carrying out of audits and the monitoring of key performance indicators (KPIs). We asked the service about the lack of monitoring of KPI data and the operations manager told us they were not given access to KPI information by their commissioners and were therefore unable to measure their service against this data. The managing director told us he believed KPIs were being met. He told us that the service did not meet with commissioners regularly to discuss KPIs but there had been informal discussions to confirm that the commissioners were happy with the service's performance.
- Service quality meetings occurred monthly and were attended by the managing director, the operations manager, and the training manager. Agenda items included patient feedback, incidents, complaints, staff morale, service issues, training, and trends in demand. Minutes of these meetings had limited detail and information recorded as evidence of what had been discussed. There was no evidence of the discussions of these meetings being communicated to other staff.
- The service did not hold staff meetings apart from the service quality meetings which were attended by the managing director, operations manager and training manager.
- The service had two risk registers, one for premises and another for the service. Risks were identified and control measures put in place to mitigate the risk. However we found that there were no dates on the risk registers and it was not possible to tell when a risk had first been identified or when it had been reviewed.

Leadership of service

- The leadership of the service was made up of the managing director, the operations manager and the training manager.
- Staff spoke highly of the leadership of the service. They used words such as ''very fair", "fantastic", "very approachable" and "the best". All staff we spoke with told us they saw senior staff including the managing director on a regular basis.

Culture within the service

- Staff described the service as a friendly and open environment. All staff we spoke with without exception were happy to work for the service with some staff describing it as "a big family".
- Most staff did not understand the principles of the duty of candour and we were not assured that this duty had been carried out in practice due to the lack of incident reporting in the organisation.

Public and staff engagement

Patient transport services (PTS)

- Patient Transport Colindale provided patients with questionnaires in order to obtain their feedback on the quality of the service received. Patient feedback was discussed in the service quality meetings. Meeting minutes for May and June 2016 indicted that patients had complimented staff on their conduct and patients liked the fact that vehicles were new and clean. The service planned to have an online feedback questionnaire added to their website. This was discussed in the service and quality meeting in June 2016 but this had not been achieved at the time of our inspection in September 2016.
- There was evidence of informal discussions of patient feedback between the service and commissioners. For example, a transport manager from one of the hospital locations told us if patients gave feedback (verbal or otherwise) about the service directly to them as commissioners they always passed this feedback on to the managing director at Patient Transport Colindale. The service found this helpful as not all patients were willing or able to complete questionnaires.
- The service did not hold any staff meetings due to shift patterns worked and staff availability. Staff were unable to tell us how they were engaged by the service for the purposes of gathering their views and experiences in order to improve the service. However, staff told us the organisation had an open door policy which allowed them to approach and speak to the managing director to discuss any issues or concerns.

Innovation, improvement and sustainability

- We saw evidence of the service exploring new ways of working. For example, the renewal of company vehicles every two years to ensure efficient vehicles with minimum breakdowns and in turn improve the quality of the service.
- The managing director told us the service was stable and sustainable and the focus was to sustain profitability and explore new opportunities. Data received from the service prior to the inspection stated the service maintained consistent investment in finance, time and resources into all areas of service provision in order to guarantee improvements.
- The operations manager told us the service's online booking portal allowed them to safely and securely arrange transport, take payments and allocate resources in a very short space of time allowing them to provide an effective service to patients and commissioners.
- Recent improvements within the service included the introduction of a brand new training centre located on the first floor of the premises.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must record and monitor incidents.
- The service must conduct local audits in order to monitor the quality of the service and make necessary improvements.

Action the hospital SHOULD take to improve

- The service should ensure risk registers show that risks are continually reviewed.
- The service should ensure expired oxygen cylinders are not left on vehicles or kept in storage.
- The safeguarding lead for the service should be trained to a level higher than level two in adult safeguarding.
- The service should take steps to monitor key performance indicators and obtain KPI data from the commissioners.
- The service should record and monitor complaints in line with their complaints policy.
- The service should have a strategy in place for how they plan to achieve the vision of the organisation.
- Staff should be engaged in order to obtain their views and experiences and use the information to inform improvements.
- The service should check mattresses on vehicle trolleys for wear and tear.
- The service should have a consistent system for obtaining employee references as part of the recruitment process.
- Staff should follow the services infection control policies including in relation to single mop use and wearing appropriate protective equipment when cleaning vehicles.
- The service should make more provisions to enable staff to effectively communicate with patients with communication difficulties and patients who do not speak or understand English and make staff aware of the provisions already available.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on Good Governance 17.— Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to — assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); Your systems and processes were not operated effectively to allow the service to assess, monitor and improve the quality and safety of the services provided because: • Your systems and processes in relation to incident reporting were not operated effectively to ensure that all incidents which staff should have been reporting were being reported to able the service to assess, monitor and improve the quality and safety of the services provided. • There was a lack of incident reporting and there was evidence staff lacked knowledge around what they should be reporting as incidents or near misses despite an incident reporting policy being in place. •There was a lack of audits within the service which would have allowed the service to assess, monitor and improve the quality and safety of the services provided.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 17 (1) and 17 (2) (a).