DHL Supply Chain Limited

DHL PTS Ponders End

Quality Report

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

Ratings

Overall rating for this ambulance location	Good
Patient transport services (PTS)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

DHL PTS Ponders End is operated by DHL Supply Chain Limited. The service provides a patient transport service to NHS patients.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 11 and 12 June 2019.

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.

Services we rate

We rated this service as **Good** overall.

We found good areas of practice:

- Staff had 100% training compliance in all mandatory training modules, with refresher training for all modules
- Induction training was thorough, and staff were not allowed on PTS duties without completing induction training.
- All vehicles had in date MOT certificates, road tax and insurance.
- There was a strong visible patient centred culture amongst all staff that had contact with patients, either face to face or on the telephone.
- Staff built good rapport with healthcare professionals outside of the provider.
- We observed good application of infection prevention control. Deep cleaning of ambulances was scheduled every six weeks.
- We found a strong evidence-based care practice and good understanding by staff of national guidelines.
- Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity.
- There was an appeal team available to deal with complaints as well as the clinical support from the registered nurses.
- We saw there was opportunity for career progression at the provider.
- Staff at DHL patients transport service had access to an employee assistance programme.

However,

- Staff did not follow the guidelines set out in the safeguarding policy to report a safeguarding concern.
- All staff in the organisation including senior staff were unsure of who the safeguarding lead was, including the safeguarding lead listed in the policy.
- There were no formalised documented daily cleaning lists for staff to follow.
- Staff did not have an adequate supply of personal protective equipment to do their job.
- All staff reported being unhappy with the Personal Digital Assistant (PDA) equipment used for navigation. Staff reported that they needed to use their own equipment for navigation. This practice is not in compliance with the General Data Protection Regulation 2016, a regulation in European Union law.

Summary of findings

- There was no formalised paperwork for mental capacity assessments on the ambulances.
- On inspection we found unsafe storage of fire extinguishers and footplates within the ambulances on 10 ambulance vehicles.
- Ambulance Care Assistants (ACA) we spoke with reported no lessons learnt and little feedback from senior management team in regard to incidents.
- All signs and posters within the reception area of the provider regarding patient transport services referred to the ACAs as 'drivers'.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with two requirement notices that affected patient transport services. Details are at the end of the report.

Professor Edward Baker
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)	Good 	The main service was patient transport services. High dependency transfers were contracted to a third-party provider.

DHL PTS Ponders End

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Background to DHL PTS Ponders End

DHL PTS Ponders End is operated by DHL Supply Chain Limited. The service opened in August 2016. It is an independent ambulance service in Enfield, London. The service primarily serves communities in North London.

The service has had a registered manager in post since November 2017. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in August 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors with expertise in patient transport.The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Facts and data about DHL PTS Ponders End

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the ambulance depot and the trust with which the provider has a contract. We spoke with 25 staff including; patient transport drivers, control staff, staff at the trust and management. We spoke with three patients and one relative.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (April 2018 to May 2019)

- In the reporting period April 2018 to May there were 170,936 patient transport journeys undertaken.

127 patient transport drivers worked at the service.

Track record on safety

- There were no never events reported in the last 12 months.
- There were 20 clinical incidents reported, 13 no harm, seven low harm, 0 moderate harm, 0 severe harm, 0 death
- There were 0 serious injuries
- There were 511 complaints in the reporting period April 2108 to May 2019.

Detailed findings

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Patient transport services (PTS)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Ambulance service providing a patient transport service between a patients home, local medical centres and hospitals. All patient transport was pre-booked in advanced.

Summary of findings

Are services safe?

We rated safe as **Requires improvement** because:

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

- Staff did not follow the guidelines set out in the safeguarding policy to report a safeguarding concern.
- All staff in the organisation including senior staff were unsure of who the safeguarding lead was, including the safeguarding lead listed in the policy.
- There were no formalised documented daily cleaning lists for staff to follow.
- Staff did not have an adequate supply of personal protective equipment to do their job.
- All staff reported being unhappy with the Personal Digital Assistant (PDA) equipment used for navigation. Staff reported that they needed to use their own equipment for navigation. This practice is not in compliance with the General Data Protection Regulation 2016, a regulation in European Union law.
- There was no log of piped medical gases in the ambulances, such as oxygen.
- On inspection we found unsafe storage of fire extinguishers and footplates within the ambulances on 10 ambulance vehicles.

Patient transport services (PTS)

However, we found the following areas of good practice:

- Staff had 100% training compliance in all mandatory training modules, with refresher training for all modules.
- Induction training was thorough, and staff were not allowed on PTS duties without completing induction training.
- We observed good application of infection prevention control. Deep cleaning of ambulances was scheduled every six weeks.
- All vehicles had in date MOT certificates, road tax and insurance.
- Staff knew how to correctly and effectively respond to a deteriorating patient, despite the provider not having a separate policy on this.
- The provider was understaffed but was recruiting new staff to fill the staffing gaps.

Are services effective?

We rated effective as **Good** because:

- We found a strong evidence-based care practice and good understanding by staff of national guidelines.
- The majority of polices we looked out were in date.
- Patients had access to water whilst being transported on the ambulances.
- The provider met 24 out of 26 key performance indicators (KPI's) in April 2019, which was an improvement from March 2019.
- The overall number of aborted journeys for all patients was decreasing and was recorded at 3.87% which was an all-time low.
- All ACA's were required to complete their two-week induction prior to starting their job.
- Staff built good rapport with healthcare professionals outside of the provider.

However, we found the following areas of practice that requires improvement:

- There was no formalised paperwork for mental capacity assessments on the ambulances.

Are services caring?

We rated caring as **Good** because:

- There was a strong visible patient centred culture amongst all staff that had contact with patients, either face to face or on the telephone.
- Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity.
- ACA's communicated well with patients throughout their patients' journey.
- We observed staff in the control centre went through the eligibility criteria with excellence, clarity, speed and support for the patient.

Are services responsive?

We rated it as **Good** because:

- Staff used the same eligibility criteria to assess a patient's suitability for patient transport services.
- There were11 staff members at the contracted trust site to do various jobs such as discharge coordination, attend bed meetings and staff the discharge lounges.
- The provider had a partnership with a national dementia charity and the dementia friends programme was being rolled out to all staff. A dementia friend is somebody that learns about dementia, so they can help their community.
- There was an appeal team available to deal with complaints as well as the clinical support from the registered nurses.

However, we found the following areas of practice that require improvement:

- A defective seat in an ambulance had been reported but had not been fixed since Christmas 2018. This had been causing issues with patient flow.
- We witnessed controllers cancelling a job at the last minute when ACAs had already arrived at a patient's house.

Are services well-led?

We rated well-led as **Good** because:

Patient transport services (PTS)

- Leaders had the right skills and qualifications required for the job.
- Leaders without a clinical background did not shy away from clinical training and attended training at every opportunity, such as dementia training.
- We observed a strong leadership team within the call control office.
- ACA's and control room staff we spoke with said that senior staff were visible.
- The provider had a staff association representative and staff were able to share ideas and concerns via a suggestions board in the control area office.
- The provider had clear methods in place for checking and updating essential and legal vehicle requirements such as MOT and insurance.
- We saw there was opportunity for career progression at the provider.
- Staff at DHL patients transport service had access to an employee assistance programme.
- There were online anonymous opportunities to provide feedback for patients and service users, details of this were found in all discharge lounges.

However,

- The service vision was not embedded within the organisation and many staff members could not recall the vision.
- There was a mixed opinion about the culture within the provider.
- ACAs we spoke with reported no lessons learnt and little feedback from senior management team in regard to incidents.
- ACAs we spoke to were more aware of the one-hour notification method of reporting incidents in comparison to the other methods of reporting. Such as the reporting methods for a safeguarding concern that included completing paperwork.
- The provider did not have a complete asset tracking system in place, though most assets were tracked.
- Staff we spoke to were unhappy with the delays in ordering new uniforms.
- All signs and posters within the reception area of the provider regarding patient transport services referred to the ACAs as 'drivers'.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.**
- The service kept a training matrix to assess how much training had been completed and what training was outstanding. We went through the training matrix with senior staff at the organisation. All training had 100% compliance such as infection prevention control (IPC), safeguarding, and first aid training.
- The provider provided a mandatory 2-week induction training for all new members of staff. Training included general information regarding health and safety in the organisation such as, the safety management structure and employees' responsibilities. Local health and safety information such as local fire and emergency arrangements and first-aid and accident reporting procedures. Information was relayed to staff via lectures, discussions, DVDs, computer-based training, tours, documents and literature. Staff we spoke with said they had enjoyed their induction training and that the training provided was of a good standard.
- Refresher training was available for staff for General Data Protection Regulation (GDPR), infection prevention control (IPC), manual handling including wheelchair and stretcher use, oxygen, and dementia training every two years. First aid training was refreshed every three years.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so, complying with notifying the Care Quality Commission with safeguarding notifications.** Staff had training on how to recognise and report abuse but did not follow the policy on how to report their concerns.
- The provider aimed to keep patients safe from abuse and highlighted specific requirements for staff to follow in the adult and children safeguarding policy and procedures.
- We reviewed the safeguarding adult policy in place and found it to be comprehensive and in date. The policy covered topics dealing with staff duties and responsibilities, types of abuse and contact numbers for local authorities. The policy highlighted modern slavery, and female genital mutation as types of abuse. The policy did not identify the government's 2011 PREVENT strategy as a means to prevent people from being radicalised.
- There was a flowchart to follow if staff suspected a safeguarding concern and an incident safeguarding form to complete to report these concerns.
- However, despite the clear information on the safeguarding flowchart Ambulance Care Assistants (ACAs) were not following the correct procedures to report a safeguarding concern. Instead of completing the incident safeguarding form staff were calling the control team to share concerns and were then made to write a statement once they had returned to the depot.
- Also, staff were not contacting the designated safeguarding lead to pass on their concerns as mentioned in the flowchart. This meant that staff were not following the correct procedures and we were unsure if the right staff members were contacted in the event of a safeguarding concern.
- The policy informed staff who the designated safeguarding officer was, and their contact number. The designated safeguarding officer was trained for safeguarding for adult and children level four but was currently on sabbatical leave. There was an additional person to contact; listed on the safeguarding flowchart and their contact number. However, when we asked ACAs who the safeguarding lead was, no one could provide the two names that were listed in the safeguarding flowchart. Furthermore, when we questioned the senior management team who the safeguarding lead was, staff pointed at each other, including the staff member listed on the flowchart.
- Staff could not recall the last reported safeguarding, they thought that it was around March or April 2018. We asked to see the last reported documentation of a

safeguarding concern, but electronic computer systems were down at the time of inspection, and we were unable to review this data. Post inspection we were told that the last safeguarding concern was reported in January 2019 and we were provided with a log extract as evidence.

- Since the inspection the policy has been changed to correctly record safeguarding concerns.
- All staff involved in the care of adult and children patients were trained to safeguarding Level one and two. The Safeguarding Children and young people: Roles and Competencies for Healthcare Staff Fourth Edition: January 2019 Intercollegiate Document states that level two was an acceptable level of training for non-clinical and clinical ambulance staff. All paediatric patients were accompanied by a parent, carer or professional escort. There was no specific policy on transporting children. There was no set age range of patients that were transported by the service.
- Three senior members of staff currently trained at level three safeguarding were booked onto level four adult and children safeguarding training at the end of June.
- Employees were not permitted to commence training without a valid Disclosure and Barring Service (DBS) check. Employees were required to bring in their DBS certificates on the first day of their training which was validated by the trainer. The provider did not keep employees' certificates due to GDPR requirements. Human resources had an automatic tracker for keeping on top of renewal dates for DBS checks, which alerted managers three months in advance of the expiry date. We spoke to human resources staff and were assured that they had adequate process in place to ensure that all employees had in date DBS checks.

Cleanliness, infection control and hygiene

- **The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- Staff wore clean uniforms, which were cleaned by staff at home. However, staff we spoke to were unsure of any washing instructions for uniforms such as the temperatures uniforms should be washed to kill bacteria. There was no guidance available for staff on uniform maintenance. Senior staff we spoke with said that there would be a uniform policy coming soon stipulating ideal washing instructions.
- We saw that ambulances were clean. However, we did not observe a daily cleaning checklist for staff to follow, nor was one in place. This meant that we could not be assured that all ambulances were consistently cleaned daily in the same way. We saw that mops were being used to clean the floors of the ambulance. The area used for cleaning in the yard had a separate waste connection and sluice. We saw records of deep cleaning of ambulances which were scheduled every six weeks by an external provider. There was also a hygiene clean once a week. A hygiene clean consisted of an outside clean and a hoover and mop out of the vehicle bay area and a wipe down of all interior surfaces and equipment. A deep clean involved the outside clean and then a full equipment and supplies removal and clean of the entire patient vehicle bay area and equipment, using the specified chemicals steamer.
- We saw staff wiping down equipment with cleaning antiseptic wipes after being in contact with patients and washing their hands in between patient contact.
- We saw staff using the alcohol gel to clean their hands after patient contact.
- We saw staff use appropriate Personal Protective Equipment (PPE) whilst handling patients such as gloves and blue tissue roll. However, some staff we spoke with told us that they were required to use gloves from hospitals as the ambulances were low on PPE stocks. This was despite requesting stock in advance. ACA staff we spoke to were unsure who was responsible for ordering more stock.
- We spoke to staff in regard to soiled blankets and contaminated items. We had mixed responses from staff and it seemed that individual staff members did different things. Some staff members kept soiled and contaminated items in orange bags and left them at hospitals laundry areas. Other members of staff brought the orange bags back to the depot to be disposed of. Some orange bags were brought back to the depot

overnight and returned to the hospital in the morning. We observed that the orange bags were not secured in the vehicles and posed an infection control and hygiene risk which was not documented on the risk register.

- There were no mandated immunisations required to work for DHL.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The provider delivered services from its dedicated ambulance station in Enfield, where our inspection was held.
- All vehicles were hired from a third-party contractor with scheduled servicing, that included vehicle ramps servicing. Equipment within the vehicles such as the chairs had scheduled servicing with their manufacturer. Day to day maintenance was handled -in-house such as tyre replacements.
- Ambulance staff used a personal digital assistant (PDA) to receive bookings and transport details from the control centre teams. This included all details relevant to the journey, including destinations, time of departure, arrival and drop off. All staff we spoke to were unhappy with the equipment and said that the navigation system on the PDA often stopped working which caused stress, delays and missed turnings whilst driving. As a result of this some staff members brought their own satellite navigation system or used their own personal phones to provide directions to patients addresses. This practice is not in compliance with the General Data Protection Regulation 2016, a regulation in EU law on data protection and privacy for all individuals' citizens of the European Union.
- There is a requirement to ensure that all medical devices are serviced, and best practice is that this information is contained in an asset register that enables the operator to identify when the asset was purchased, its service records and when the equipment is next due for a service. We looked at the providers asset register and saw that most assets were logged along with last service dates and the service due date. However; carry cots and carry chairs did not have asset tracking. Therefore, the provider could not track these items and were unable to track which asset was on which vehicle.
- There was no log of piped medical gases in the ambulances, such as oxygen. This was done by an outside contractor, but during the inspection the provider could not provide assurance through records that this was done. However, post inspection we were shown evidence that these records were kept on site.
- Daily vehicle checks were undertaken by ACA's via check lists on the PDA. Yard people also known as Stock and Quality team leaders performed their own check lists before and after vehicles left and entered the depot. These included checking serviceable items, stock levels and damage to the vehicles. There were also checks for ambulances arriving back to the depot where the fuel level was checked. Despite the provider's checking of vehicles, we found fire extinguishers and footplates stored in door bins. We found this on three separate ambulances on the first day of inspection. We raised this with senior managers and were told that this had been rectified. However, on the second day of the inspection we found this on seven more ambulances. Fire extinguishers should be mounted securely on the wall of an ambulance and footplates should be stored correctly to prevent injury to patients and drivers. Again, we informed the provider of our findings and they took action to remedy this; and this time the provider removed all fire extinguishers from all of the ambulances. This was because the brackets used to hold the fire extinguishers were broken. There is currently no legal requirement for these vehicles to carry fire extinguishers.
- All vehicles were on a replacement programme, so that newer vehicles could be used for transportation, and to accommodate bariatric patients. There were 38 vehicles that could transport a bariatric wheelchair and 12 vehicles equipped with bariatric stretchers.
- On the second day of our inspection we went out on an ambulance and noticed that there was tape on the windows to secure the window in place. This had been reported but not yet fixed.
- We looked at a random sample of 20 ambulances and found that all ambulances had in date MOT certification

and road tax. The transport manager had a wall planner of all the vehicle MOT dates and the expiry dates for easy tracking. Also, there was an electronic system portal which provided alerts when vehicles were due to expire their MOT or road tax. This portal had the ability to pay the ultra-low emission zone payments and congestion charges automatically.

- We looked at the provider's insurance documents and saw that all vehicles had up to date insurance.
- We asked senior staff what the weight limit was per vehicle after all the equipment inside was taken account of. The total weight that the vehicle could withstand was three tonnes, and the provider allocated one ton for patients, patients wheelchairs and their belongings. We were not assured that this information was available for the ACAs, which could lead to an overload of an ambulance. Senior staff informed us post inspection that this information was known by the controllers in the planning team and planned accordingly for the ambulance and therefore ensured that ambulances were not overloaded.
- On the second day of the inspection we went out on the road to observe patient care. We were in a vehicle that had one broken seat out of eight. ACA staff we spoke with told us that this seat had been broken for a few months and they were constantly reporting this broken seat.
- We were informed that the provider occasionally transported children, however there was no specific equipment used for children transportation kept at the service. We not provided with the evidence that equipment was supplied to transport children from elsewhere. The service transported one to two children per month on average.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks.** Staff identified and quickly acted upon patients at risk of deterioration.
- There was 100% training compliance for all ACAs for first aid.
- There was not a separate policy for the deterioration of patients. We looked at the safe system of work policy which stated that if a patient became unwell on route, the driver must stop, conduct a primary survey and call emergency assistance. Should a patient go into cardiac arrest, the crew should immediately call the emergency services and commence Cardiopulmonary Resuscitation (CPR). The policy went on to further state that the only expectation not to perform CPR was where the crew had a valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. There was a flag on the booking system for patients with valid DNACPR forms.
- Policies such as incident reporting and road traffic accidents often required staff to report to the control centre including when responding to patient risks. ACAs we spoke with told us that there was always someone available when calling the control staff, including out of hours.
- ACA's we spoke with were clear on what to do should a patient deteriorate whilst being transported. Staff we spoke to had successfully performed CPR on a patient after suffering a cardiac arrest. We asked to look at a policy for a patient death in the ambulance, but we were referred to the safe system of work policy and the patient injuries and incident reporting policy. Neither policy stated what to do in the event of a patient death.
- There was a third-party contract for all high dependency patients. This was performed by another provider.

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**. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction
- In total there was 178 staff members that worked for this provider. This included various roles such as transport managers, transport team leaders, ACAs, complaints advisors and call centre agents.
- The provider had various staff groups starting at different times across its location based on the needs of the service and operated 24 hours a day 365 days a year.
- Staff were assigned to vehicles by the providers control and planning staff team, as either single or double crew dependent on the needs of the patient.

- Staff had access to on call duty managers out of hours for escalation and management support in case of staffing issues.
- The provider had 12-16 staff inductions going on at the time of inspection, with more inductions booked in before the end of the month. The serviced employed 127 ACAs but had a target headcount of 132 ACAs. The provider filled vacant shifts through a combination of overtime and through authorised service partners.
- Staff turnover was recorded at 7% for 2018, the management team recognised that this was an issue and were looking at changing the pay to the London living wage to help with staff retention.

Records

- **Staff kept records of patients' details.** Records were up-to-date, stored securely and easily available to all staff providing care.
- Staff accessed patient information securely via the PDA's this included patients name, address, date of birth and mobility constraints. DNACPR status was included in the information provided on the PDA's. All PDAs were pin protected, and each driver had a unique pin.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Patients own medicines were transported with the patient. The ambulance staff did not take any responsibility for controlled drugs (CDs) carried by patients. If CDs accompanied a patient, they were the responsibility of the patient or carer.
- We found oxygen canisters being stored correctly, upright in a lockable cage in the depot.
- Some patients required and travelled with oxygen. However, there was no method of recording this information on PDA's. Oxygen is a medicine and ACAs should have recorded how many litres of oxygen was required and who administered this medicine. This was raised with the provider, and senior staff were looking into this.

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, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. However, some staff we spoke with reported little feedback from senior management teams.
- All incidents were reported within one hour of occurring, known as the one-hour notification, this was done via a phone call to the control team. All ACA's we spoke to were familiar with the procedure.
- There were 65 incidents reported between April 2019 and May 2019. 40 incidents were classified as vehicle collisions and 24 were classified as personal injury and one incident was left unclassified.
- The service had not reported any never events in the last 12 months. A never event is a serious incident that is wholly preventable because guidance or safety recommendations providing strong systematic protective barriers are available at national level and should have been implemented by all healthcare providers. They have the potential to cause serious patient harm or death, have occurred in the past and are easily recognisable and clearly defined.
- Duty of Candour (DoC) is a statutory (legal) duty to be open and honest with patient or (service users) or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with CQC. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The provider used other methods of reporting for vehicle accidents, such as bump cards for damage and Stop, Look, Assess and Manage (SLAM) alert forms for a near miss, a hazard, an unsafe act or a safety concern. When ACA's were involved in a road traffic collision the team leader tested for drugs and alcohol misuse via a urine test and a breathalyser.

Patient transport services (PTS)

- Staff at the provider had major incident training which was conducted by DHL. There was a service level agreement in place with another ambulance provider that staff from DHL could be resourced if a major incident occurred.

Are patient transport services effective?

Good

We rated effective 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. Staff protected the rights of patient's subject to the Mental Health Act 2005.
- The provider used the Department of Health, Patient Transport Services and National Institute for Health and Care Excellence guidelines when looking into eligibility appeals. Registered nurses looked at GP factor reports and the British National Formulary (BNF) to support or reject eligibility appeals.
- We looked at five policies on site and found one policy to be out of date. This was the patient care, duty of candour, dignity, privacy and equal access policy which had expired in November 2018. We raised this with the provider and the relevant staff groups were notified to rectify this.

Nutrition and hydration

- **Staff assessed patients' food and drink requirements to meet their needs during a journey. The service made adjustments for patients' religious, cultural and other needs.**
- ACA's we spoke with told us that there was water on the ambulances for patients. For longer journeys ACAs will stop and purchase food for patients if required.

Pain relief

- Staff did not administer pain relief to patients during transportations.

Response times / patient outcomes

- **The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.**
- Notice boards in the control centre displayed the essential gross Key Performance Indicators (KPIs). This included a daily performance dialog productivity that captured weekly data including average handling times, booking lines, query lines and planned staff on shift versus actual staff numbers.
- We looked at the latest performance KPI summary for April 2019, 24 out of 26 KPI's were met which was an improvement compared to performance figures from March 2019.
- The contracted trust had a performance standard of 95% of all patients receiving dialysis treatment to be picked up within 60 minutes of their booked ready time, the provider achieved this target for 88% of patients.
- The contracted trust had a performance standard of 100% of time spent on vehicles for emergency and urgent care outpatients that lived within 0-10 miles from the hospital to be within 90 minutes. The provider had 100% compliance. For outpatients within a 0-5 miles radius the performance standard was at 85% within 60 minutes and the provider achieved 92% in April 2019.
- The provider set a target of 90% of calls answered after 60 seconds, but only 37% of calls were answered after 60 seconds in April 2019. This had worsened from the March 2019 report which was recorded at 42%. The most successful month was May 2018 at 70%. The average speed to answer a call was 1 minute and 55 seconds in April 2019, the worse performing month was in December 2018 which took 3 minutes and 54 seconds.
- The overall number of aborted journeys for all patients was decreasing and was recorded at 3.87% which was an all-time low. This equated to 545 patients in April 2019. The number of cancelled journeys had decreased from 193 journeys in March 2019 to 187 journeys in April 2019.

Competent staff

Patient transport services (PTS)

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance.
- All ACAs went on a two-week induction training course, completed their mandatory training and had refresher training for mandatory training every two to three years.
- Competency assessments were completed for all staff once every two years and staff were rated against the required standard. The ratings were" far exceeds", "exceeds", "fully meets", "partially meets" or" does not meet" in five different areas. We looked at the competency assessment which was focused on customer relationships, organisational strategy, driving and development. We saw no focus on patient needs or care.
- Field trainers were available to accompany ACAs to provide extra support. ACAs could request a field trainer for themselves or request a field trainer for another staff member. Field trainers performed spot checks on vehicles, looked at IPC, uniforms and provided clinical information to ACAs.
- Team leaders performed appraisals once a year. ACAs and call control staff we spoke to confirmed that they had had an appraisal within the last year. Staff were required to complete a form independently before their appraisal and go through their answers with their appraiser.
- We asked ACAs what the last policy was that was issued to them, and staff were able to relay information from the mobile device policy which was effective in March 2019.
- Managers were given corporate general training for their job, training was not specific to patient transport services.

Multi-disciplinary 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.**
- ACAs built good rapport with nurses at hospitals and medical centres and demonstrated clear communication with staff they worked with. Nurses we spoke to at the contracted hospital sites spoke highly of the ACAs and described ACAs as great staff.
- Registered nurses at the provider worked with other clinical professionals such as GPs for eligibility appeals.

Health promotion

- **Staff did not give patients practical support and advice to lead healthier lives.**
- The service did not have relevant information promoting healthy lifestyles or support in patient areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment.** They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff we spoke with said that they would encourage patients to attend their medical appointments verbally but otherwise would not verbally or physically force a patient to do so. When a patient refused patient transport, ACA's contacted the control room.
- We looked at the policy for consent and mental capacity issued in October 2017 and up for review on in October 2019. The policy was detailed and provided relevance to patient transport services.
- However, there was no formalised paperwork for mental capacity assessment on the ambulances, and therefore nowhere to document how such decisions were made. The provider was looking into their training slides, the escort provided with patients living with mental health and records available of patient's condition.
- There was a third-party contract for mental health patients.

Are patient transport services caring?

Good

We rated caring as **good.**

Patient transport services (PTS)

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- There was a strong visible patient centred culture amongst all staff that had contact with patients, either face to face or on the telephone.
- Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity. We observed staff going the extra mile to preserve a patient's dignity when transporting a patient from the hospital to their home with a catheter bag. Staff immediately offered to cover the patient's catheter bag with a bag to conceal the patient's urine from other members of the public and from other patients.
- Relationships between patients that use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and supported smooth transition for patient transportation.
- We observed control staff taking the time to interact with patients who use the service in a respectful and considerate way.
- We observed ACA's supporting patients at hospitals.
- ACA's showed compassionate care, and a gentle approach, giving additional time and comfort to ensure the patient was comfortable.
- ACAs kept patients warm with blankets.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.** They understood patients' personal, cultural and religious needs.
- We observed ACA's focusing on patients care during transportation. Patients were reassured and carefully secured into the chairs. We observed ACA's talking with patients throughout their journey.
- Staff recognised and respected patients' needs. Patients emotional and social needs were seen as being as important as their physical needs.
- We observed staff in the control centre were empathetic, kind and patient went communicating with patients.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- We observed ACA's engaging with patients asking about specific needs and creating a plan to address any concerns raised by patients.
- We observed a telephone conversation between a patient and staff in the control centre. The patient was enquiring about a hospital patient transport service that was not covered by DHL, but staff did not dismiss the call. Instead staff assisted the patient by looking up the right information and contact details and shared this with the patient.
- We observed staff in the control centre went through the eligibility criteria with excellence clarity, speed and support for the patient.

Are patient transport services responsive to people's needs?

Good

We rated responsive as **good.**

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. It also worked with others in the wider system and local organisations to plan care.**
- Eligibility criteria for patient transport was set by local Clinical Commissioning Groups (CCG's) parameters. The criteria looked at alternative methods of transport, level of assistance requires and mobility constraints. A dedicated team at the provider assessed patient's eligibility for transport over the phone. Assessment of patients eligibility for transport was also undertaken on hospital wards using the same criteria.

Patient transport services (PTS)

- There were 11 staff members at the contracted trust site to do various jobs such as discharge coordination, attend bed meetings and staff the discharge lounges. This included five members of staff that were concierges to move patients from the wards to vehicles.
- There was an interpretation service available to use over the phone if staff required.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.**
- The provider had a partnership with a national dementia charity and the dementia friends programme was being rolled out to all staff. The dementia charity had provided advice on the design and layout of the discharge lounges and vehicle layouts.
- The provider employed two registered nurses to provide assistants on clinical matters. For example, if a patient showed to have no eligibility of patient transport but had a clinical or medical predisposition that may not have been picked up on an eligibility assessment the registered nurses were able to provide a better understanding of a patient's needs.

Access and flow

- **People could access the service when they needed it, in line with national standards, and received the right care in a timely way**.
- There were discharge co-ordinators employed by the provider at various discharge lounges at the contracted trust site. These discharge co-ordinators attended bed meetings and worked at making sure care packages were in place for patients who required transport.
- A defective seat which had been reported but had not been fixed since Christmas 2018 had been causing issues with patient flow. Controllers were still giving jobs not suitable for this particular ambulance due to the seating capacity. ACA's assigned to this vehicle were concerned that the controllers were not aware of this particular vehicle's limitation. This sometimes caused a conflict between the controllers and ACA's when transportation was booked but was not practicable.
- We witnessed controllers cancelling a job at the last minute when ACA's were at a patient's house. The cancellation occurred because an escort required for the patient had not been included in the booking, the job was still cancelled even though there was room to take the escort. The cancellation occurred because an escort required for the patient had not been included in the booking, the contractual agreement with the contracted trust stated that unauthorised escorts were not allowed to travel.

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, including those in partner organisations.**
- The majority of all complaints were for patients who fail the eligibility criteria set by the local CCGs and the trust. Other complaints arose from delays from both patients and the trust.
- There was an appeal team available to deal with these complaints as well as the clinical support from the registered nurses.
- 90% of all complaints were closed off within the 10-day target of receipt. Staff reported that information used to close complaints was easily accessible including statements from ACA's. Also, all calls within the control centre were kept for three months, this meant that if there was a complaint made within this time frame, calls could be listened to retrospectively to help deal with a complaint.
- Learning from complaints was directed to transport shift managers which was then passed on to ACA's. Some staff had received retraining as a direct result of a complaint.
- The PTS contract with the trust stipulated that on this contract DHL did not take direct complaints, and complaints must go through the trusts Patient Advice and Liaison Service (PALS). This allowed for openness and transparency.

- Incidents recorded at the trust regarding patient transport were sent to DHL. Complaints were overseen by the trust and updates were provided to the trust on completed investigations.

Are patient transport services well-led?

Good

We rated well-led as **good.**

Leadership of service

- **Leaders had the integrity, 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. They supported staff to develop their skills and take on more senior roles.**
- The management team within the organisation had the right skills to run the patient transport service. We looked at the organisational structure chart which listed all the senior positions within the patient transport service. However, the chart poorly illustrated the relationships and relative ranks of job positions within the organisation. For new members of staff, organisational charts are vital in helping learning names and titles and to better understand where they fit into the overall corporate structure.
- Leaders without a clinical background did not shy away from clinical training and attended training at every opportunity, such as dementia training. Senior management teams we spoke with were eager to learn and improve on their existing knowledge. Many senior management staff we spoke with had spent a day out on an ambulance with ACA's including the chief operating officer.
- DHL had a formal management training course set up for staff at all levels and provided corporate support to the provider. However, courses were general to the logistics business and not designed specifically for patient transport services.
- We observed a strong leadership team within the call control office.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- The vision and mission statement were displayed on a display board in the control area, the vision stated, 'customers trust DHL as the preferred Hospital Logistics partner that leads the industry in terms of a safe, effective, caring, responsive and well led service'. The vision was not embedded within the organisation and many staff members could not recall the vision. We saw that the vision was only displayed once within the depot and was not written on polices or on other notice boards in the staff room.
- We looked at the Strategy 2020 Hospital services document which was focused on patient transport services. The strategy outlined three pillars to accelerate future growth: focus, connect and grow. The strategy document listed a different vision. which was 'we want to be The Supply Chain Solutions Company for the world'. The strategy was described as short term and senior staff we spoke with all focused on short term gains rather than the direction and scope of the business over the long term.

Culture within the service

- **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 and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- There was a mixed opinion about the culture within the provider. Some ACA's staff we spoke with said that they are generally well supported by their direct line manager. Whereas others reported that they were treated as just a number.
- All control room staff we spoke with felt well supported and part of a team. Staff here reported having an open

and honest working relationship with their peers and their managers. We observed a positive environment with managers being open about the business KPI's and financial targets.

- ACA's and control room staff we spoke with said that senior staff were visible.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. 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 provider held monthly senior management meetings where clinical issues were discussed with the two registered nurses as well as the two trainers.
- Staff association meetings were held once a month and the minutes from the last meeting was displayed in the call control office. However, we saw that the last minutes displayed was from April 2019, May's meeting minutes had not been displayed. The provider had a staff association representative and staff were able to share ideas and concerns via a suggestions board in the control area office.
- The provider had appointed a manager with the sole responsibility of dealing with Key Performance Indicators (KPI's). KPI data including costs of the business was displayed in the control area office. This meant that staff were able to see how the business was performing and the costs of operations.
- The provider had automatic driving licence checks.
- ACAs we spoke with reported no lessons learnt and little feedback from senior management team regarding incidents. We found numerous methods of reporting different types of incidents, we found the process lengthy and ACA's we spoke to were more aware of the one-hour notification method of reporting incidents in comparison to the other methods of reporting.
- The provider did not have a complete asset tracking system in place to monitor which asset was in which vehicle. Staff we spoke with said that some of the assets were still in the process of being transferred from a previous contract. Equipment was often moved around to different vehicles and this could cause a problem when servicing of equipment was due and scheduled. However, the provider had clear methods in place for checking and updating essential and legal vehicle requirements such as MOT and insurance.
- Senior management teams were not aware of their own policies on how to report a safeguarding concern or who the safeguarding lead was.
- Front line staff were not reporting safeguarding concerns through the method stated in the safeguarding policy. Staff were using the one-hour notification and not completing a safeguarding form and contacting the designated safeguarding officer. This was not being picked up on or corrected by senior management teams in the organisation.

Management of risk, issues and performance

- **Leaders and teams 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- We spoke to the health and safety manager who was assigned all health and safety risks the manager kept a tracker of all risks regarding health and safety.
- We spoke to senior management staff regarding the risks within the organisation. Staff stated that risks included seatbelt use by patients, IPC and driver retention.
- We identified that the orange bags containing clinical waste posed an infection prevention control risk as they did not have a fixed position in the ambulances. This had not been documented in the risk register. We raised this with senior staff who were looking into this.
- The provider informed staff of issues via red alerts, town hall meetings and via alerts on the PDA. New policies in place had a sign off sheet for staff to sign once they had read the policy.

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. Data or notifications were consistently submitted to external organisations as required.

- We observed there to be a holistic understanding of performance which covered and integrated staffs views on operations and finances for control staff. Control staff were able to visually see their own weekly performance on notice boards. Financial information regarding the costs of contracts were also made public to control staff and displayed on notice boards too.
- ACA's did not have access to this information daily, ACA's relied on information being passed to them via their PDA's or via notice boards in the reception area and staff room. Information received on PDA's included updates to policies and traffic alerts. Information on notice boards were a lot more detailed and included updates on health and safety.
- The staff room held information leaflets such as general use of a wheelchair, personal safety, staff updates and dementia. Staff were able to leave an anonymous suggestion of improvement on cards called 'we want your idea!'.
- The provider was ISO 9001 accredited in January 2019 for the control centre. ISO 9001 is defined as the international standard that specifies requirement for a quality management system. Organisations use the standard to demonstrate the ability to consistently provide products and services that meet customer and regulatory requirements.

Public and staff engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Senior management teams communicated with staff via notice boards, red alerts (tool to share feedback from incidents), PDA messages staff meetings and appraisals. We saw that procedural changes were shared via red alerts; the last red alert was on the non-use of phones at the wheel even via Bluetooth. There were sign off sheets for this red alert.
- We saw there was opportunity for career progression at the provider. Staff we spoke with in the control room had started off at the company as ACA'S and progressed into control room staff. Senior staff we spoke with told us that they had submitted a level two career framework which had a National Vocational Qualification (NVQ) for ambulance care assistants to progress into emergency medical technicians (EMT).
- There was no formal recognition of a staff union, but union representatives were allowed on site if staff wished.
- Notice boards in the control call centre had an 'every voice counts' section where staff improvement suggestions were listed and where the provider could respond to these suggestions. There was also a nomination section, whereby colleagues would nominate each other for an award. The notice board listed the date for the next meeting.
- The staff room had an anonymous feedback box for staff to provide suggestions for improvement.
- Staff at DHL patient transport service had access to an employee assistance programme. Through this programme staff could access counselling that was funded by DHL. Signs and posters for this were displayed on the back of toilet cubicles so that staff who wanted their contact information could access so in confidence.
- Senior management staff we spoke with told us that staff were involved in the new equipment selection in order to help facilitate the requirements of the job.
- Staff we spoke to were unhappy with the delays in ordering new uniforms and as a result some staff members bought items of uniforms themselves, this included high visibility jackets, trousers and boots. We noticed that even though all uniforms were the same colour in green some uniforms had the DHL logo whereas others did not.
- We witnessed an example of poor communication within the organisation whilst on inspection. On the second day of the inspection ACA's we were out on the road with, were unsure of who a new member of staff was and their role.
- All signs and posters within the reception area of the provider regarding patient transport services referred to

the ACA's as ''drivers''. ACA's we spoke with said the term 'drivers' takes a lot away from the job that they actually do. Staff we spoke with said there was a lot more to it than driving. They said they were actively looking after patients as well.

- There were online anonymous opportunities to provide feedback for patients and service users, details of this were found in all discharge lounges. There were also survey electronic pads for digital feedback located in the discharge lounge for patients and escorts.

Innovation, improvement and sustainability

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
- Senior management staff were quite clear that the aim of the provider was to expand the number of ACA's they had and the number of vehicles they deployed. The had clear means of doing so and were already working on expanding the number of contracts they have.
- The provider had successfully maintained a partnership with a national dementia charity. This relationship helped designed discharge lounges and ambulances to aid patients living with dementia.
- The provider understood that assessing patient needs was not as simple as a tick box exercise and employed two registered nurses to aid in clinical assessments for patients requiring transportation.
- Senior staff we spoke with had plans on using secret shopper escorts to assess patient care and transportation for learning and improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding. The provider must make sure that staff are following the guidelines as stated in the safeguarding policy to report safeguarding concerns.

Action the hospital SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should document and keep logs of daily cleaning of ambulances.
- The provider should ensure that an adequate supply of PPE is always available for ACA's .
- The provider should ensure that all equipment used for transporting patients are fit for the job at hand, in particular the PDA's.
- The provider should ensure that equipment for children is available when transporting children, to be either kept at the service or included in service level agreements.
- The provider should ascertain a method of documenting mental capacity assessments on ambulances when required.
- The provider should document vehicle capacity and report to this to the control staff to ensure that patient flow is not affected.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. (1) service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and process must be established and operated effectively to prevent abuse of service users. •Potential under reporting of safeguarding concerns, senior managers were unable to recall latest safeguarding concern. •Staff were not adhering to the safeguarding policy. Policy stated that staff must report safeguarding concerns via completion of safeguarding forms that should be on all vehicles. •Safeguarding forms could not be located on PTS vehicles.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance (1) Systems or processes must be established and operated effectively to ensure compliance.

This section is primarily information for the provider

Requirement notices

•Senior management team were not aware of their own policies on how to report a safeguarding concern.

•Front line staff were reporting safeguarding concerns through a method not stated in guidance, but this was not being picked up on or corrected by senior management teams in the organisation.

•Senior management team were unaware of who the safeguarding lead was – and pointed to each other.