

Olympic (South) Limited

HATS @ Weir Road

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected this service on 14 and 15 March 2017 as part of our programme of comprehensive inspections.

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 service understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service services need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Patient transport services (PTS) were managed in line with current standards and legislation, and staff had the skills to carry out their roles effectively, and in line with good practice.
- There were systems to communicate learning from incidents and complaint outcomes
- The service met the needs of patients it transported as was clear from their feedback.
- We saw staff treating and caring for patients with compassion, dignity and respect.
- Staff adhered to good infection prevention and control practice.
- Vehicles were maintained to a high level of cleanliness and servicing was seen to be effective, timely and accurately documented.
- PTS services were mainly pre booked to ensure sufficient resource could be allocated to each job, taking account of individual patient's needs.
- Patient booking forms were stored appropriately and audited to ensure good completion by staff.
- At booking stage, the dispatchers collected all relevant information on patient needs: mobility, the type of vehicle needed and any equipment required, as well as whether a nurse or carer would accompany the patient.
- The service was performing well against its contractual key performance indicators (KPIs).
- There was close and effective coordination with the hospitals that HATS worked for. The attendance of HATS staff at bed meetings was excellent practice.
- Staff feedback was collected and used in service development, and it was clear from staff comments that that the service valued their staff.

However, we also found some issues that the service needed to improve, all of which were corrected very soon after inspection:

- Safeguarding training had a bias towards child protection. Following the inspection the service revised their training to cover safeguarding vulnerable adults in greater depth and arranged for all staff to have this training by the end of April 2017.
- The vehicle daily checks did not include checking tyre inflation pressure. The service added tyre pressure monitoring caps to all their vehicles shortly after the inspection and had added this check to the daily vehicle checklist.
- We saw three small oxygen cylinders stored, unsecured, within the office area of at St Pancras hospital. The service responded promptly and provided secured storage for these within days of the inspection.

Professor Edward Baker

Deputy Chief Inspector of Hospitals

HATS @ Weir Road

Detailed findings

Services we looked at

Patient transport services (PTS);

Detailed findings

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Background to HATS @ Weir Road

- HATS@Weir Road is operated by Olympic (South) Limited. It was founded in 1995. It is a private ambulance service that provides non-emergency patient transport services for sick, injured or infirm patients eligible for patient transport.
- The service works for St Pancras hospital run by Central and North West London NHS Foundation Trust(CNWL) where it mainly takes patients to clinics and day centres, and for one hospital (Chelsea and Westminster) run by Chelsea and Westminster Hospital NHS Foundation Trust taking patients to and from hospital appointments and clinics, taking discharged patients to their homes and transferring patients between hospitals. This includes the transfer of high dependency patients, non-emergency transfers and repatriations of patients including babies to local hospitals. Patients are transported to various locations within London and longer journeys (over 25 miles) occur regularly because some patients are referred for specialist treatment at Chelsea and Westminster Hospital and are returned to other parts of England.
- The service has two blue light ambulances operated by emergency care assistants and ambulance care assistants, and other ambulances.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and another CQC inspector with specific expertise in ambulance services. The inspection was overseen by Roger James, inspection manager.

How we carried out this inspection

- We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 14 and 15 March 2017.
- To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?
- Throughout the inspection, we took account of what people told us and how the service understood and complied with the Mental Capacity Act 2005.
- During the inspection, we visited the two hospital bases from which calls were managed and drivers dispatched, and the office headquarters at Weir Road in Wimbledon. We spoke with 15 staff including patient transport drivers, emergency care assistants, fleet manager, despatch manager, call handlers and managers. We spoke with contract managers employed by both hospitals. We spoke with eight patients. We also received eight 'tell us about your care' comment cards which patients had completed during our inspection.

Detailed findings

- We observed drivers and dispatch staff, and the communication between patients and staff. We reviewed booking sheets for 10 patients as well as

electronic booking information. We looked at documentation including relevant monitoring tools for training, staffing, recruitment and analysed data provided by the service before the inspection.

Facts and data about HATS @ Weir Road

HATS@Weir Road manages patient transport services (PTS) for people who are unable to use public or other transport to and from hospitals, clinics or day centres due to their medical conditions. The hospitals are primarily responsible for assessing patients' eligibility for patient transport and making the bookings. PTS is free at the point of use for eligible patients. Journeys were pre-booked.

HATS also provides home to school transport for children with special educational needs and disabilities, staff transport between hospital sites and transport of samples and medical devices for Chelsea and Westminster hospital, but these were outside the scope of this inspection which focused on patient transport.

There are 6000 journeys a month on average between April 2016 and March 2017.

One ambulance station is based at St Pancras Hospital, the other at Chelsea and Westminster Hospital. At St Pancras there is one stretcher ambulance and four wheelchair accessible vehicles used mainly for community health services. At Chelsea and Westminster hospital there are two HDU/bariatric ambulances, two patient transport stretcher ambulances and four wheelchair accessible vehicles.

Twenty two staff are employed to provide transport services from the Chelsea and Westminster Hospital base and nine at Pancras Hospital, a community hospital run by Central and North West London NHS Foundation Trust. There were no vacancies at the time of the inspection.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once before in December 2012 and January 2013 and was found to meet the standards all standards of quality and safety it was inspected against.

Activity (April 2016 to March 2017)

- In the reporting period April 2016 to March 2017 there were about 30000 patient journeys undertaken at one site and 33800 at the other site.
- The service employs 21 patient transport drivers and four emergency care assistants at the Chelsea and Westminster site and nine at St Pancras.
- The service is able to provide transport services 24 hours a day seven days a week. Two drivers were on call at night.
- The ambulance control centre operates 24 hours to coordinate the transport services.
- The service has a fleet of 13 ambulances.

Track record on safety

- No never events reported
- No clinical incidents
- No serious injuries

The service could also draw on a bank of drivers who worked for the school transport service operated by the same service. The service occasionally used another CQC registered patient transport service to supplement specialist capacity for patient journeys.

Patient transport services (PTS)

Safe

Effective

Caring

Responsive

Well-led

Overall

Information about the service

HATS@Weir Road is a private ambulance service that provides non-emergency patient transport services. It mainly undertakes work at hospitals owned by two London NHS foundation trusts where it facilitates journeys for hospital appointments or patient transfers between hospitals. This includes the transfer of high dependency patients, non-emergency transfers, repatriations to local hospitals and taking patients home after treatment. Some journeys are outside London.

Summary of findings

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- There was a system for reporting incidents and for disseminating learning to staff.
- Vehicles and equipment used were clean, well maintained and appropriate.
- Staff understood and practiced good infection control.
- Ambulance crews were able to plan appropriately for journeys using the patient information provided to them by their managers.
- Crews were competent in carrying out their responsibilities and they received appropriate training and support for this.
- We observed staff communicating effectively with patients, and treating them with kindness, compassion, dignity and respect at all times
- Feedback from patients was unanimously positive about the care they had received from staff.
- Services were planned and delivered in a way which met the needs of the local population served by the respective hospitals.
- A vision and strategy had been developed and shared across the organisation.
- There was an ongoing audit plan with an audit topic nominated for each month to measure quality of the service, and we saw evidence of action on learning from audits.
- Staff we spoke with were proud of the care the frontline staff gave to the patients in their care.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had a system for recording and reporting incidents, and learning from them. Although few incidents had been reported – only 5 in the year to February 2017. All staff we spoke with knew about their responsibility to report incidents and how to do this. Examples of incidents reported were patients missing appointments or delay in transfer of a patient. Where incidents such as delays did occur they were usually investigated jointly with the hospital.
- An example of a recent incident related to the fitting of oxygen to an outlet in a High Dependency Unit (HDU) ambulance. The incident had led to additional training for Intensive Care Unit (ITU) staff at the hospital. The incidents we reviewed had been dealt with appropriately, and action taken to prevent recurrence.
- Each ambulance had a red folder on it that included guidelines for certain situations such as injury to a staff member of a patient. A clear flowchart was provided with actions of what to do, as well as a form that staff could complete as a record.
- Staff had access to a phone application called 'My HR Toolkit' on their work phones. Managers could upload news items and key information to this to cascade the information to staff. This could include learning from incidents. The toolkit had a function to show that a memo had been read. The service was able to monitor themes of incidents. For example they had identified a theme in vehicle incidents. There were seven minor vehicle incidents in 2016. 86% of incidents happened when there was no patient or passenger in the vehicle.
- Ambulances were already fitted with a tracker device to monitor the type of driving and would send an electronic alert to the manager in the event of poor driving such as harsh braking. In addition, as a result of this analysis, the service was installing forward-facing cameras to the dashboard of each vehicle to help review incidents visually and protect the driver from false claims in the case of an accident. A similar system used elsewhere in the organisation had reduced reportable incidents by 53%. The service's insurance company had approved the technology.
- There had been no liability claims between September 2014 and March 2017.

- Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. This regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the person in relation to the incident and offer an apology.
- The service had a designated duty of candour lead. Duty of candour was part of the incident reporting policy. Staff were clear about the need to apologise to a patient if something went wrong in transporting a patient. A duty of candour e-learning course for staff was in development and due for publication in April 2017.

Cleanliness, infection control and hygiene

- There was an infection prevention and control policy and system that addressed all relevant aspects including decontamination of medical devices, vehicles and workwear. All staff completed infection control training on induction.
- Personal protective equipment (PPE) such as gloves and aprons as well as hand sanitiser gel were available on three of the ambulances that we looked at; however the fourth had an empty gel container. We raised this at the time and were told they would replace this. We observed crews using hand sanitiser gel appropriately before and after patient contact.
- The booking sheet indicated whether the patient was an infection risk and staff checked with the ward on the need to use PPE.
- All staff that we observed were wearing clean uniform and were bare below the elbow. Staff were responsible for laundering their own uniforms. We observed a crew member using wipes and spray appropriately to clean a stretcher after a patient journey.
- We saw that training included how infections were spread through poor hygiene and good practice in handwashing.
- Vehicle deep cleans were scheduled in line with the regular maintenance checks every 56 days and were carried out by an external company. We reviewed records of this for three of the vehicles. In addition the same external company carried out an outside clean of the vehicle every two weeks. If a deep clean was needed outside the routine schedule because of an infection risk, this would be arranged as soon as possible.
- Cleaning equipment such as anti-bacterial wipes and sprays were available on all of the ambulances that we

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checked and there were spares located within the stores at each hospital site. Mops were provided at each hospital site for crews to carry out daily cleaning of the interior of the ambulance. We saw checklist prompts for daily cleaning as a reminder for crews on each ambulance.

- Linen, such as blankets, sheets and pillow cases were provided by agreement with the hospital where the service was based. Clean linen was stored in closed cupboards in ambulances and was also available for replenishment from the hospital. Used linen was returned to the hospital where arrangements were made for them to be laundered.
- Most chairs provided in the ambulances were covered with a washable cover that was able to be wiped down by the ambulance staff. We saw one chair in one vehicle that had some non-wipe fabric on, which could pose an infection risk. We asked about this and were told that the seat had been swapped in as a temporary basis because a seatbelt had not been working on another chair.
- Clinical waste was disposed of under agreement through the hospital waste disposal system.

Environment and equipment

- Drivers carried out daily vehicle safety checks to ensure the vehicle and equipment was safe to use. The daily inspection was set against the vehicle commissioner public service vehicle standards. Until recently drivers had completed this check on a written form; however the checklist form had been added to a personal electronic device that was signed out by each driver at the beginning of the day. In addition to completing the checklist, staff could note any faults or issues and if required take a photograph to demonstrate what the issue was. If a fault or issue was noted, this would flag as red on the supervisors electronic tracker which would mean that they could rectify the issue straight way or arrange for a repair.
- The service worked out of two hospital locations. At Chelsea and Westminster hospital there were offices for HATS staff at the back of the patient transport lounge. A ramp and stairs led from this site to the ambulance loading bay where ambulances could wait to collect patients. At St Pancras Hospital, a smaller external cabin provided the base for the ambulance crews who would collect patients directly from other buildings within the area served by the hospital.

- HATS had been involved with Chelsea and Westminster hospital in the design of the patient transport lounge where patients waited after discharged from wards, or following their outpatient appointments.
- The service had a total of 13 ambulances used for transporting patients. (They also provided taxis to transport car suitable patients, but this was not included in the inspection.) The ambulances were owned by the company, apart from two vehicles which were leased. All vehicles were under four years old. The ambulances could be configured differently for the requirements of patients, for example, they could have up to eight chairs on the back for ambulatory patients, be fitted with a stretcher for those that required it, or an infant incubator could be secured within the vehicle. All vehicles were compliant with the Low Emission Zone (LEZ) controls used in the London area.
- The service used an online forward planner to identify when each of the 13 ambulances were due for MOT, servicing, tail lift (LOLER) inspections as well as road fund licence and insurance due dates. All repairs and servicing were carried out by the manufacturers' approved service centres. All ambulances had a full service once a year, a mini service at the six month point and a periodic maintenance inspection that checks 78 items every 56 days. We reviewed servicing and MOT records for three ambulances at one of the operating centres. Records showed that servicing had been completed within the required dates. We also saw records of vehicle service reports and replacement and testing of parts in head office records.
- The ambulance ramps on each vehicle were serviced twice a year by a specialist tail lift company. This was the statutory check under the Operations and Lifting Equipment Regulations 1998 to ensure that all equipment used for lifting was fit for purpose and free of defects.
- The daily vehicle checks did not include the checks for tyre inflation pressure, only a visual check. Although tyre pressure checks were carried out on the periodic maintenance inspections every 56 days, and we saw written evidence of this, the Highway Code vehicle maintenance guide recommends that this should be carried out at least weekly. Soon after the inspection the service fitted all HATS vehicles with a tyre pressure

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monitoring cap system. This enables the crew to immediately identify the pressures of each individual tyre. This verifiable information then formed part of the crews daily defect sheets.

- At each hospital site where ambulances were based, a spare ambulance was provided so that, in the event of a vehicle being identified with a fault that meant it was not roadworthy, a replacement was available while a repair was arranged. In addition we were told that HATS had an agreement with a lease company if there was an urgent requirement for a spare vehicle.
- HATS had agreements with two breakdown companies and tyre companies for recovery and tyre replacement in the event of a vehicle breakdown. In each vehicle that we inspected, a red vehicle folder provided details of which company to call in the event that the driver could not contact the control room.
- HATS held replenishment stores at each site for regularly used items, such as disposable bowls, urine bottles, cups and drinking straws. The equipment checks were included on the electronic vehicle checklist so each driver could confirm that they had enough of each item at the beginning of the day. The crew were responsible for replenishing stocks.
- Although children were not often transported, the service had suitable child seats (held within the office of the acute hospital) in the event that a child required transportation. Babies were transported between hospitals, mainly after leaving special care.
- Each ambulance that we saw had both a wheelchair and a collapsible carry chair, used for moving patients up and down stairs. The service also had a number of 'stair climber' chairs that could be used to aid staff to move patients in and out of accommodation. These items were all serviced on a six monthly basis by the manufacturer. We saw stickers on each of the ambulances that we inspected to show that service had been carried out. Additional mobility aids, such as sliding boards and straps were also available on each of the ambulances that we saw.
- Medical equipment carried on each ambulance varied depending on the nursing needs of the patient being transported. As a minimum, ambulances carried a small basic first aid kit, including resuscitation face mask for journeys where the patient was assessed by an appropriate health professional that the patient as stable for the duration of the transport. For inter-hospital transfers a 'high-dependency' crew was

used and they would carry additional equipment including automatic suction, an automated defibrillator and basic monitoring equipment. We saw these on one vehicle. The items had stickers on to show that they had been serviced in line with manufacturer's guidance. Staff were able to demonstrate to us the daily checks that they would carry out to check equipment was working appropriately. Monitoring equipment held included sizes suitable for children and adults (for example different sizes of blood pressure cuff), although we were told that the acute hospital would usually provide their own equipment for monitoring children.

- High visibility jackets were provided on an individual issue basis to each member of staff to carry with them. We saw these being carried in each of the ambulances we inspected.
- Each ambulance was fitted with a tracking system which performed several different functions. When staff logged in, the system enabled managers and control staff to view the status of the ambulance, for example its location and whether it was driving or stationary. This meant work could be allocated efficiently. The system also monitored the performance of the driver.
- Fire extinguishers and hammers for breaking glass in an emergency were available on each of the vehicles that we inspected. We looked at two fire extinguishers and found that they were stored appropriately and were within their expiry dates.
- To ensure smooth operations in the event of electronic failure, the service used mobile phones supplied by three different operators. Internet was secured and provided by two different suppliers and GPS by yet another supplier. There was wireless internet at both sites. We observed the benefit of this arrangement during our inspection when there had been an internet failure at one site, but the service was able to continue with staff working on laptops. A local generator on site provided 36 hours of critical service supply. Telecommunications could transfer between sites with sufficient terminals at each site for seamless operation. Data was backed up on remote servers.

Medicines

- No medicines were stored on any of the vehicles or within the office buildings.

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- Staff were not permitted to handle medicines directly but had a role in reminding patients to carry their medication with them as necessary, and to take home their hospital-prescribed medicines.
- Small, portable oxygen cylinders were provided by the acute hospital for transfer use. We saw these secured appropriately on the stretchers in ambulances that we viewed. All cylinders that we saw were within expiry dates. The protocol was that the hospital replaced these when they were half full. Staff were able to administer oxygen to patients if it had been prescribed by a doctor, but this was usually done by a nurse accompanying the patient.
- We saw three small oxygen cylinders stored, unsecured, within the ambulance office area at St Pancras. The service responded promptly and provided secured storage for these.
- Large oxygen cylinders were stored outside in line with guidance from the British Compressed Gases Association. These were provided directly from the supplier and replaced by the supplier when requested

Records

- Ambulance crews reported that for inter-hospital transfers and journeys for patients who were being discharged from wards, they were able to view a discharge summary and receive a handover from a nurse on the ward. This meant that where patients required monitoring, they could check that observations stayed within required levels and report any changes to the receiving hospital. Information was also provided within these summaries if the patient had any additional requirements.
- Patient booking sheets were created from the control centre and received by the ambulance crew on the handheld electronic device associated with each vehicle. Control staff collected relevant information during the booking process recording information regarding the patient's health and circumstances. For example, any information regarding access to property. The process ensured crews were informed about any needs or requirements the patient may have during their journey. Details of any patients with do not attempt cardio pulmonary resuscitation (DNACPR) documentation in place were also recorded. A manager said the responsibility for ensuring the currency of DNACPR information rested with the NHS provider.

• We reviewed six booking sheets which demonstrated staff had had fully completed the documentation.

- Staff logged the pickup and set down times of all patients transported electronically. The vehicle journeys were tracked on computer.

Safeguarding

- Training on safeguarding was provided to all staff as part of induction and it was face to face training. Some staff we spoke with were initially unsure about what level of safeguarding training they had completed, although they were all able to report when they should raise a safeguarding alert. Staff reported that they would contact the control centre at the hospital to raise any concerns. Managers told us that if a concern was received by the office staff they would liaise with the hospital safeguarding team on whether to raise an alert.
- No safeguarding referrals had been made in 2016-17, although we saw that two safeguarding concerns had been raised in the previous year. Both managers and staff we spoke with reported that the most common concerns raised were often about the environment of a patient's house. Managers told us that they would often work with the occupational therapy teams who had often carried out an assessment of the home environment prior to discharge and were able to pass this information onto the crews. Staff we spoke with gave an example of where they had taken a patient back to the hospital, after gaining their consent, as the home environment had not been suitable on a discharge journey.
- We reviewed the safeguarding training materials which covered the different types of abuse of vulnerable people, reporting and the investigation process. We considered that the safeguarding training focused more on safeguarding children than vulnerable adults. This had arisen because the service also provided home to school transport for children with special educational needs and disabilities. The service immediately took this on board, and within a few weeks had developed a vulnerable adults training module on which all ambulance staff were to be trained by the end of April 2017.

Mandatory training

- Mandatory training for Ambulance Care Assistants (ACAs) included fire safety, moving and handling, infection control, passenger assistance training, basic

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oxygen therapy, first aid at work including basic life support, incident reporting and other health and safety such as station security, clinical waste and sharps disposal. Staff completed a competency workbook. We reviewed two of these and saw they had been fully completed and signed.

- All staff training was carried out within work time (five paid days were allowed for training) and training was mainly face to face. Staff had access to a phone application called 'My HR Toolkit' on their personal phones which had a log of training they had completed, so that they had a personal record.
- All operational staff undertook relevant mandatory training updates annually.
- Driving level qualifications and revalidation dates of driving level training were recorded on staff records.

Assessing and responding to patient risk

- Ambulance crews reported that for inter-hospital transfers and journeys for patients discharged from wards, the discharge summary and handover provided from a nurse on the ward ensured they were aware of risks.
- Patient assessments were primarily of a person's transport and mobility needs and ambulance crews were only concerned with clinical conditions that might affect transport. In cases where the patient was likely to require treatment, an escort from the hospital would be provided. Mobility types assessed were patients that could walk and those needing aids such as wheelchair, carry chair or stretcher, and HDU patients (cardiac patients and neonates) and patients over a certain weight.
- All staff working on the ambulances had been trained in basic first aid which gave them initial skills to notice if a patient was deteriorating. All staff we spoke with told us if a patient deteriorated they would call 999 for the emergency services to attend.
- The staff we spoke with could only recall two instances where the patients had deteriorated on route to a destination and in both those cases this had been expected. In both cases the patients had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order and the crew had received clear instructions about necessary action on the handover from hospital staff.
- One of the regular journeys undertaken at St Pancras hospital was providing transport for patients with

mental health needs to a day care centre. The service manager of this day centre told us that they undertook a risk assessment of the patients to assess their suitability for transport, for example the patient would not sit directly behind the driver. Some mental health patients were transported, with a registered mental health nurse. However, HATS did not provide secure transport.

- Booking forms identified patients with a disability so they could be transported safely and comfortably.

Staffing

- Most ambulance drivers were trained as Ambulance Care Assistants. Four staff were employed at an enhanced level as emergency care assistants (ECAs). These four staff operated the 'High dependency' inter-hospital transfers, although they could also be used for patient transport home when required. The ECAs mainly worked Monday to Friday between 7am and 4pm although they reported that they sometimes worked as overtime on weekends when they were available and it was requested.
- At the control centres at both sites there were administrative staff, at a minimum a supervisor and dispatch officer to coordinate the service during the working day. At the acute hospital site there were also a patient experience officer and support contract manager. The supervisors at the sites monitored quality and risk and dealt with day to day fleet issues and compliments and concerns.
- Staff driving licences were confirmed with the Driver and Vehicle Licensing Agency (DVLA) as being valid and appropriate for the class of vehicle they were driving when the staff member were appointed, and then checked bi-annually with the DVLA with the consent of the employee. All staff required Disclosure and Barring Service (DBS) checks and overseas applicants were checked with the UK Border Agency. We reviewed recruitment records and saw that appropriate pre-appointment checks were carried out.
- For long journeys, the service made sure that two members of staff were allocated so that there could be sufficient rest periods from driving. In addition hotels were provided for staff when required and we saw receipts of one journey where this had been arranged.
- There were enough staff to cover planned absences including annual leave and sickness at historical levels. The service was able to draw on staff within their Home

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to School transport service to cover some fluctuations such as a higher level of sickness. The rota was designed to reflect the variable patterns of demand across the day and week.

- At head office staff managed finance, IT and data analysis. The lead for Risk and Quality and the Fleet and Logistics lead were based there.
- No agency drivers were used.
- Volunteers worked in the transport lounge to provide refreshments to patients awaiting transport.

Response to major incidents

- The managers reported that they were part of Chelsea and Westminster hospital's major incident plan and had attended two training days with the hospital in order to plan the HATS' response in such an event. They would transport PTS suitable patients as required.
- The managers reported that their links with the hospital emergency preparedness team kept them up to date on large scale events affecting roads around the hospital that would impact on transport times. They reported that where required the hospital provided maps of road closures and crossing points for vehicles so they could circulate these to staff on duty that day.
- Ambulance staff had arrangements to call for urgent assistance if a patient became unwell during transport, calling either the contact centre or 999 as appropriate.
- The service had contingency fuel arrangements to cover four weeks of critical transfer. Spare vehicle capacity was accessible if needed
- In the event of adverse weather, such as heavy snow affecting travel times, the service would decide on appropriate action in discussion with hospital staff.

Are patient transport services effective?

Evidence-based policies

- We saw evidence of a regular process for reviewing and updating policies and procedures.
- Each ambulance had a red folder on it that included hard copies of some of the policies such as the driving and care of vehicle policy so that it could be easily referenced when required by the crew.
- Staff had access to a phone application called 'My HR Toolkit' on their phones. Managers could upload updated policies to this and they could monitor which staff had confirmed that they had read the updated policy.

Assessment and planning of care

- A HATS manager attended bed meetings at Chelsea and Westminster to gather information relevant transport planning for patients being discharged. Booking forms also captured the key transport related information for patient care and whether a patient needed a stretcher vehicle, wheelchair accessible vehicle, seated ambulance or a vehicle designed to take patients of a certain weight.
- Risk assessments were completed for complex patients, including patients with bariatric needs. The World Health Organisation describes people who have a body mass index (BMI) greater than 30 as obese, and those having a body mass index greater than 40 as severely obese (WHO, 2000). Bariatric needs are those that make supporting patient's mobility, moving and handling needs hazardous to staff due to the patients BMI being greater than 40.

Nutrition and hydration

- Every ambulance had bottled water available if required by patients.
- For longer journeys, over two hours, snack packs could be ordered from the requesting hospital for the journey. There would also be a prepared plan to stop for rest and refreshment in order to meet the individual needs of the patient, as a maximum after the first two hours travelling.

Response times and patient outcomes

- Each hospital PTS set its own key performance indicators (KPIs) for transport outcomes as the two services fulfilled very different patient needs. HATS captured information on the key outcomes, number of journeys, response times and patient time on the vehicle electronically.
- At St Pancras Hospital the journeys were quite short and all confined to the normal working day. The KPIs related to response times for pre-booked journeys and that ad hoc journeys were provided within 30 minutes of request. Most KPIs were met in the year from September 2015 to August 2016, although the service had just missed the 100% target for journeys to be no more than 20 minutes late, achieving 98% over the year.
- Chelsea and Westminster hospital required HATS patient transport to work more flexibly and at different times of day. The range of measurements was more complex. The KPIs included measurement of total activity compared with the same time the previous year, total

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abortive journeys (journeys where the patient did not answer the door or refused to travel), the number of morning and afternoon discharges, on the day discharges, incidents and journeys over 25 miles.

- Patients attending Chelsea and Westminster for outpatient appointments were given an indicated time they should be ready to be collected so they could arrive some time in advance of their appointments. Patients living locally (within a three mile radius) were required to be ready at least an hour before the appointment. Patients travelling distances of up to 25 miles were asked to be ready two hours before. 97% of patients were expected to arrive 30 minutes before their appointment time. 90% of outpatients returning home should be picked up within 45 minutes of notification that they were ready and 100% within an hour. In almost all areas the service was exceeding the targets set by the hospital, although we noted that only 93% of patients were taken home from appointments or upon discharge from a ward, within an hour between May and July 2016.
- The Chelsea and Westminster hospital aimed to notify the service of 75% of journeys the day before. Short notice journeys, which were notified on the day, formed 15% of activity.

Seven day services

- Most journeys provided at Chelsea and Westminster were between 9am and 6pm to coincide with the timing of outpatient clinics. However some weekday journeys were later than 6pm. HATS provided an on call service for patients discharged from wards at weekends and for discharges of relevant non-admitted patients from the emergency department. The control room operated 24 hours a day, every day.

Competent staff

- All staff were provided with the training to enable them to work effectively. Induction of new staff included company policies and procedures, orientation to the site, vehicle orientation for the different vehicles, local security procedures, clinical paperwork and end of shift procedures and reporting procedures. Training also included oxygen delivery equipment, stair chairs, wheelchairs and ramps. We saw evidence that the member of staff and their manager both signed a form on completion of induction, with the manager confirming satisfactory completion.
- Emergency Care assistants (ECAs) were staff who had undergone an additional level of training to enable

them to carry out a higher dependency inter-hospital transfer. Their training included the First Response Emergency Care Level three award which needed to be completed every three years. Records checked showed that all of these staff were within date for this qualification.

- The ECAs were trained in blue light driving so that they were competent to do this where required on emergency inter-hospital transfers. Crews confirmed that they undertook blue light training from an accredited external service every three years. Records checked showed that all these staff were within date for this qualification.
- Driving skills of other ambulance drivers were assessed by the blue light qualified drivers. We saw an audit of driving competency checks from December 2016.
- ECAs were also trained in three lead electrocardiogram monitoring, so they were able to identify any abnormalities or changes in patients being monitored on inter-hospital transfers.
- The driving of each ambulance was constantly monitored electronically. This took account of the speed travelled, braking times and force of braking. These aspects of driving had a direct impact on patient comfort during the journey and were part of the driving skill required.
- Records showed that all staff had had appraisals in the current year.

Coordination with other services and multi-disciplinary working

- For inter-hospital transfers, crews reported that where a patient might require medication or treatment during the transport, or monitoring with a specific piece of equipment on the journey, a member of hospital staff would accompany them. A minimum of one paediatric nurse was always present for inter-hospital transfers involving babies.
- The manager of the care centre that booked journeys for patients with mental health needs attending the St Pancras hospital day centre spoke positively about the relationship with the service. He told us he had the regular drivers' direct contact details in the event of need, and was also able to contact the bookings office to make any changes as necessary.

Patient transport services (PTS)

- When hospital staff transferred a patient's care to another healthcare service such as another hospital or hospice, they ensured the patient handover at pick up was precise to enable a clear handover to staff receiving the patient.
- We observed good communication among the control staff, with callers and the crews. We observed the call takers clarifying information with the callers and received positive feedback from staff about how well the whole team worked together.
- We did not witness any delays in the control staff answering calls.
- The HATS manager at Chelsea and Westminster hospital had a good working relationship with the hospital staff involved in patient discharge so any issues could be sorted out quickly. This ensured timely discharges for patients.

Access to information

- Hospital staff booking patient transport were asked to notify the service with information about the patient. For example, whether oxygen was required, mobility requirements such as wheelchair or bed bound, their weight if over 17 stone, information about sensory or mental impairment and their need to be accompanied by a carer or escort, as well as confirmation of timing of arrival and confirmation of the destination. The Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) or Advance Care Plan (ACP) status of patients was flagged at the point of booking.
- Ambulance crews reported that for inter-hospital transfers and journeys for patients who were being discharged, they were able to view a discharge summary when receiving a handover from a nurse on the ward.
- Staff training included DNACPR and staff we spoke with understood what the orders meant, for example that only CPR could be suspended, and the order did not mean other medical treatment should be withheld. HATS managers worked closely with resuscitation officers at the hospital to ensure the organisation was up to date with national guidelines.
- In cases where a DNACPR order was in place, such as when the ambulance was transferring a patient to a hospice, the crew would receive the original copy and a doctor's letter that would include specific instructions about what interventions could be carried out in the event of a patient deteriorating.

- Patient information was kept secured during transfers and journeys in sealed envelopes.
- The electronic hand held device enabled the crew to see the patient record and provided information to dispatch as to their status during their shift, for example if they were mobile or waiting to pick up a patient. The crew could also use the tablet to telephone and/or send messages to the control centre.
- The personal electronic device received details of the calls and also provided up to date satellite navigation to direct them to patients' addresses or where they needed to be transferred.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ambulance crews completed training on the Mental Capacity Act (MCA) 2005 and Mental Health Act, 1983, including deprivation of liberty safeguards as part of their initial training and had annual refresher courses. This training included staff showing respect for individual patient preferences where possible, and gaining consent for assisting patients.
- We observed a crew asking a patient for consent before transferring them from a stretcher to a chair and incorporating their preferences for a relative to assist as well. Training also included information about assisting people with dementia appropriately. We saw instructions for staff on how to manage a patient who refused help and who to report this to.

Are patient transport services caring?

Compassionate care

- Patients said ambulance crews were respectful and caring and 'went above and beyond in making sure I am in my home before driving off'.
- Staff were passionate about providing good experiences for patients and building relationships with patients using the service regularly.
- Patients we spoke with confirmed that staff treated them with kindness, compassion, dignity and respect.
- We spoke with one patient who had used the transport service on a number of recent occasions. They stated that they were very happy with the service provided and

Patient transport services (PTS)

felt that they were 'treated like a VIP which they had not experienced in other patient transport services. They said that staff caring for them would 'go the extra mile' to accommodate their needs.

- The service trained staff in safe moving and handling of patients which ensured staff maintained patient dignity during patient transport.
- We observed a crew attending to a patient who needed to be transferred from their stretcher to a wheelchair at home. They observed the patient's wishes in that they had assistance from the patient's relative to transfer them in a comfortable manner that ensured dignity was maintained. They showed respect for patients' diverse cultures, ethnicities and faiths.
- We observed another journey undertaken for a multiple group of patients. The ambulance care assistant had established a good rapport with this group as he knew them well and was able to attend appropriately to their needs and assist them when required in using seatbelts. The group told us that they liked the transport service and that the drivers were kind and friendly.
- Staff understood they had a duty of care that patients would be left safely when they arrived at their intended destination, and ensured patients could enter their homes.
- We observed staff had respectful and caring attitudes to relatives and carers travelling with patients.

Understanding and involvement of patients and those close to them

- We observed excellent communication from the staff to the patients and their carers. It was evident the drivers knew some of the patients well.

Emotional support

- Staff were encouraged to be engaging and compassionate and we observed this during the inspection.
- Staff that we spoke to were aware that travel to or from hospital may be a stressful time for patients and described how they reassured patients to alleviate their fears.
- Staff were aware of the diversity of patients they transported and respected religious, cultural and other needs of patients.

Supporting people to manage their own health

- Crew encouraged patients to be as independent as possible and provided support where required. We saw

staff enabling and encouraging patients to move independently, providing support and advice as necessary, for example, to help patients transfer from a wheelchair independently and safely.

- Explanation of eligibility for the patient transport service was primarily the responsibility of the hospital where HATS provided PTS, but the HATS had a role in overseeing this too. Eligibility was sometimes a cause of frustration to patients because of inconsistent decisions on wards. HATS was supporting the hospital in the assessment and eligibility process and in training ward staff about eligibility. Individual drivers did not have a role in referring patients to other transport services.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The service had separate contracts with each of two NHS hospitals. Regular meetings took place and monthly and quarterly activity reporting enabled HATS staff to discuss demand and plan their service, including identifying areas in which there was opportunity for improvement to better meet the needs of patients.
- The service had been contracted Chelsea and Westminster to carry out patient journeys including outpatient appointments, hospital discharges, hospital admissions, inter-hospital transfers and bariatric patient transfers. The service worked with the hospital to meet the needs of patients who required a long journey. HATS staff asked for information in advance so that they could organise the journey and ensure that an ambulance was the most suitable form of transport for the patient's needs.
- Each hospital used their own key performance indicators (KPIs) as specified in the contract to monitor the service's performance against contract. Both contracts had been in place for several years. Results for November 2015 to January 2016 showed HATS had mainly met the KPIs for each hospital.

Patient transport services (PTS)

- Performance was compared with the same period the year before, and the previous month and quarter. The electronic audit software created reports for managers so they could discuss monthly and quarterly management performance reviews.
- At St Pancras Hospital, journeys were mainly to clinics or day centres, and only a small number of hospital discharges or inter-hospital transfers.
- In both hospitals, HATS monitored response times to patient pickups to ensure that waiting was kept to a minimum.
- HATS staff attended bed meetings at Chelsea and Westminster hospital to enable prompt transport planning for patients being discharged which contributed to effective working between the two organisations. Many discharge bookings at Chelsea and Westminster hospital were made on the day and most happened in the afternoon (on average 89 in the morning and 251 afternoon discharges).

Meeting people's individual needs

- The service aimed to take account of the needs of different people, including those in vulnerable circumstances. The service had an equality and diversity policy. The aim of the policy was to ensure there were defined guidelines for employees to follow if necessary. We observed staff caring for all patients consistently regardless of race, gender, gender identity, religion, belief, sexual orientation, age or physical/mental capability. Staff had been trained in dealing with patients with complex needs including those living with dementia, older people with complex physical or medical needs or those requiring access to translation.
- Staff told us when a patient was living with dementia or was confused an escort was usually present.
- Bariatric vehicles were designed to ensure a safe and dignified transport solution to those whose weight, or condition, required specialist transport.
- Each ambulance was equipped with disposable cups and flexible straws so that patients could have water provided in the most appropriate container to suit their needs.
- The service tried, where possible to allocate the same staff to regular journeys to give continuity to patients, particularly where people were living in vulnerable circumstances. We saw an example in observing two staff provided for a multiple patient journey from a day centre. The drivers knew the patients by name and were able to assist them appropriately. The patients reported that this was a real benefit of the transport service, and the day centre manager endorsed this view.
- A patient from Chelsea and Westminster hospital reported that where they had requested this, they had always been allocated the same crew for a journey and really appreciated this part of the service.
- A regular service provided for St Pancras hospital was taking patients with mental health needs to a day centre. The patients had reported that they felt uncomfortable with an ambulance being seen to collect them each day and in response HATS had removed the ambulance stickers from the vehicles used for these journeys so that it looked like a minibus.
- One member of staff who provided regular group transport for patients with mental health conditions told us that he had received information about patients' specific needs and preferences from the care centre directly. This meant that he was able to better accommodate patients' needs, for example, by adjusting the order in which he delivered patients to their homes to suit the individual's needs.
- Staff understood patient confidentiality and that they could not discuss patient details, even with the family unless the patient agreed, but that they could pass on relevant information to a nurse at a hospital or a care manager at a residential or nursing home.
- Where translation was needed, HATS used hospital arranged translation services. HATS staff that were bi-lingual were identifiable by their ID badges which were also in braille.
- HATS staff attempted to contact all patients with pre-booked journeys in advance. Patients were contacted using the patients' preferred method of communication, a phone call or email or text message. This was to prevent abortive journeys in the event that a patient was unwell or their hospital appointment had been cancelled. Staff also followed up abortive journeys with the patient to avoid a recurrence. However, patients flagged as living with dementia would not be called directly if there had been an abortive journey, to avoid causing further stress and anxiety.
- HATS were not contracted by Chelsea and Westminster hospital to transport deceased patients; however they worked flexibly to meet the hospital's and families' needs. We were given an example of a transfer from

Patient transport services (PTS)

hospital to hospice the where the service had worked closely with the clinical nurse specialist from the Neonatal intensive care unit to ensure a deceased baby was transported promptly and with dignity.

- Staff told us they checked vehicles when transporting patients in case the patient had left anything. On the occasions when items were left, they returned the items as soon as possible.

Access and flow

- The service provided patients with timely journeys to enable them to access treatments and out-patient appointments. The contact centre monitored on-scene and turnaround times. They allocated and prioritised bookings to achieve best use of vehicles and avoid unnecessary waits. The facility to draw on a bank of trained drivers from elsewhere in the organisation was helpful in ensuring good patient flow.
- The discharge lounge staff based at the acute hospital worked very closely with the control room and ambulance crews to ensure patients being discharged from hospital were not delayed unnecessarily.
- Delays for outpatient appointments were rare. The policy for patients travelling long distances was for patients to be ready to leave home two hours before their pickup time. Patients we spoke with did not mind this request because they were waiting in their own homes.
- Where regular transport was provided for patients in one geographical area going to the same or nearby destinations, more than one patient was sometimes conveyed at the same time.
- The Chelsea and Westminster contract managers praised HATS contribution to patient flow at the hospital.
- The service occasionally sought support from another CQC registered patient transport service. We saw example during our inspection when HDU transport was needed to transfer a patient between hospitals at the same time as the HATS HDU ambulances were pre-booked for long journeys. The external agency was also sometimes used to transport bariatric patients.

Learning from complaints and concerns

- The complaints and concerns policy was clear. Where possible complaints were dealt with at the time by the site manager. A complaint could be followed up jointly with hospital staff. The focus was on learning from outcomes of the investigation. The manager told us that

patients generally complained to the hospital rather than the transport service as they perceived their travel as part of their hospital experience. The Patient Advice and Liaison Service (PALS) took the lead in responding to formal complaints or calling the patient. HATS responded to PALS on complaints within the three to five day timelines specified in the contract. Outcomes were used for training purposes.

- For a complaint relating solely to HATS the aim was to investigate and respond to complaints at the earliest possible date and within 21 days.
- At the St Pancras hospital there had been 15 transport related complaints in 2016. The percentage ratio of complaints to journeys was 0.04% which was very low.
- At Chelsea and Westminster hospital there had been only two formal transport related complaints in 2016.
- The HATS board had a monitoring and assurance role over themes and trends from complaints.

Are patient transport services well-led?

Leadership / culture of service

- The leadership team of the service consisted of a chief executive who led the service. The second tier included finance, human resources, a risk and quality manager and a fleet and logistics lead. The group operations manager had an operations supervisor at each patient transport site and there was a crew team leader at each site. Supervisors were aware of key risks to the service and understood how to flex driver plans to respond to unexpected pressures.
- HATS shared a PTS risk log quarterly with Chelsea and Westminster hospital covering areas such as staff Safety and welfare, infection control, safe transportation of wheelchairs and use and storage of oxygen. All risks were rated green after mitigating actions had been taken.
- Staff told us that the managers were visible, supportive and accessible and that they would have no concerns in raising any issues directly with them should the need occur.
- Ambulance crews were able to see their manager on daily at their hospital site.
- Although the transport service differed between the two NHS sites, we did not see a difference in the staff culture between sites.

Patient transport services (PTS)

- Turnover of staff was low. One member of staff had left in the preceding 12 months. Sickness was also low, 0.4% for office staff and 0.7% for ambulance staff.

Vision and strategy for this this core service

- HATS worked in partnership each of the hospitals contracting the patient transport service. Its vision was to be a nationwide service, meeting the transport needs of patients with staff that were well trained, safe, caring, smart, enthusiastic and proud of the job they do. All staff we spoke with understood the vision and demonstrated the HATS values of respect, courtesy, integrity and teamwork in their roles.

Governance, risk management and quality measurement

- Performance was discussed at monthly meetings with the contractor. Performance was also discussed at the patient forum. Current information on performance was on display in the patient transport lounge.
- The software used for monitor journeys enabled the organisation to generate a variety of reports for audit purposes. In addition, HATS carried out an audit each month with a specific focus, for example, training in January and the patient survey in June.
- The Director of Risk and Compliance had a senior role in the organisation. We saw a risk register covering potential risks of harm to patients and staff, last reviewed in March 2017. This identified risk under categories such as staff welfare, passenger safety, vehicles, use and storage of electronic medical equipment, information governance and data protection and the risk was scored before and after control measures. The highest potential risks identified were equipment failure in medical equipment and shared patient identifiable information.
- There was a separate risk register for operational risks covering issues such as unavailability of fuel or of vehicles, or telecommunications failure (all three of which were identified as critical), and other risks such as workplace disruption from gas or water failure. We saw evidence that appropriate measures had been undertaken to control these risks. We did not identify significant risks beyond those identified by the service.
- The service also logged specific site risks, such as lone working and temporary obstruction of ambulance parking areas.
- The service used several dashboards to monitor the safety of their service. This included performance on

control room performance (talk time, allocation time, and abortive journeys), inward and outward journeys, infection control practices, capacity and demand. The service monitored performance through the use of observational, manual and electronic audits.

Public and staff engagement

- HATS had been involved in planning the new build of the patient transport discharge lounge in 2015 at Chelsea and Westminster hospital. As part of this, staff used their patient forum to identify what key areas were important to the patients using the lounge. Following patient feedback, arrangements were made within the re-design and new build for an area for guide dogs, hearing loop availability, fresh reading material and information on display about cleaning frequency. Another change in response to feedback was an amendment to the contract to provide a dedicated patient liaison officer.
- A staff survey (Voice of the employee –VOTE) showed that 96.6% of staff would still like to work for HATS in twelve months' time.
- We reviewed staff survey results which were positive: 90% of staff thought their role benefited patient's experience of care and 80% thought they had good management support. The survey also gave staff the opportunity to raise concerns. We saw evidence that managers acted on these.
- A staff representative had been voted in by the staff and managers had recently held a meeting including the staff representative to discuss the responses from the staff survey and how best to move forward. The lack of sick pay offered by the service had been raised as an issue by staff and managers had undertaken a cost analysis of this and were updating their policies to introduce sick pay based on length of service from April 2017.
- No staff meetings were currently organised, although ambulance crew told us that these had happened in the past. Appropriate timing had been an issue as meetings had to be held in the evenings or weekends when patient journeys were fewer. Staff had requested regular meetings again, and managers were considering how best to plan these.
- The clinical commissioning group for CNWL had carried out a patient transport survey in December 2015. Patients had reported high levels of satisfaction with transport services.

Patient transport services (PTS)

- There was a patient forum for transport Chelsea and Westminster hospital. Patient surveys were carried out. 98% of users considered the service good, very good or excellent. 53% reported it excellent.
- HATS also monitored patient feedback through comment cards and PALS leaflets in the ambulances, transport lounge and PALS offices.
- The CEO of Chelsea and Westminster hospital reported very favourably on the performance of HATS. One patient transport employee had won an award from the hospital trust in 2016 for being caring and effective in his role.

Innovation, improvement and sustainability

- In 2015, HATS had commissioned a study of wheelchairs to establish which were compatible with modern transport safety guidelines and wheelchairs were labelled suitable or not for use as a vehicle seat in an ambulance. In 2016 the hospital was given a Wheelchair Safety award.
- Staff who spoke more than one language wore badges to indicate the languages they spoke.
- On vehicles used in a regular service taking patients with mental health needs to a day centre, the service had removed the ambulance stickers to avoid the stigma patients perceived in being collected by ambulance so the vehicle looked more like a minibus.