Pegasus Medical (1808) Limited

Quality Report

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Date of inspection visit: 3 March 2020
Date of publication: 14/04/2020

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Pegasus Medical (1808) Limited is operated by Pegasus Medical (1808) Limited. The provider is a patient transport service specialising in transporting patients with mental ill health based in the Erdington areas of Birmingham.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 3 March 2020.

Summary of findings

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.

The provider had not been inspected since it registered with CQC. We rated it as **Good** overall.

- We saw the provider had exceeded it's 90% compliance target for active staff completing statutory and mandatory training.
- The provider had an effective staff recruitment processes with all necessary checks on new staff having been carried out.
- We observed the provider`s staff providing care in a very sensitive and dignified way.
- The provider`s staff were able to describe how they met the needs of patients including meeting the needs of patients from diverse backgrounds.
- Managers we spoke with understood the challenges to quality and sustainability and could identify the actions needed to address them.

Heidi Smoult

Deputy Chief Inspector of Hospitals on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	The provider is a patient transport service specialising in transporting patients with mental ill health. They are based in the Erdington area of Birmingham and transport patients anywhere in the UK. The provider was not commissioned or a contracted service. The provider had carried out 484 patient journeys between 1 February 2019 and 1 February 2020. We found the service to be safe, effective, caring, responsive and well led.

Summary of findings

Contents

Good

Services we looked at
Patient transport services

Summary of this inspection

Background to Pegasus Medical (1808) Limited

Pegasus Medical (1808) Limited is operated by Pegasus Medical (1808) Limited. The service opened in June 2018. It is an independent ambulance service in the Erdington area of Birmingham. The service primarily serves the communities of the West Midlands area.

The service has had a registered manager in post since June 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager, a CQC mental health inspector and a specialist advisor with expertise in patient transport. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Pegasus Medical (1808) Limited

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the operating base at Erdington. We spoke with nine staff including; the nominated individual, the registered manager, the operations manager and operational staff.

During our inspection, we reviewed 18 sets of patient records, six booking forms, five staff files, six policies and observed one patient transport.

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 had not previously been inspected.

Activity (1 February 2019 to 1 February 2020)

- In the reporting period 1 February 2019 to 1 February 2020 there were 484 patient journeys undertaken.

The provider`s operational staff were on zero hours contracts and were not employed. The registered manager worked 25 hours per week, the quality assurance manager worked 30 hours per week, the operations lead worked 35 hours per week and a team leader worked 15 hours per week and worked on patient journeys.

Other staff worked on a zero hours contract. The service had 20 registered mental health nurses it could call upon and around 30 health care assistants.

Track record on safety

- No never events
- Clinical incidents. No reports of no harm, no low harm, no moderate harm, no severe harm, no deaths.
- No serious injuries
- No complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are patient transport services safe?

Good

This is the first time we have rated this key question. We rated it as **good.**

Mandatory training

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

Managers told us if staff were recruited to work for the provider and their primary employment had been with an NHS provider, they were required to supply original training certificates. We saw evidence of copies of training certificates in the staff files we reviewed on inspection.

The provider maintained a spreadsheet which recorded staff mandatory and statutory training with dates courses had been completed and when refreshers were required. The spreadsheet included training which had been completed by staff in their primary employment.

The spreadsheet was RAG rated, green meant the training was in date, amber meant due for renewal within three months and red meant out of date.

Managers told us the red rated training was related to staff who were dormant and had not worked for the company for several months. If they re-registered an interest in working for the company, they would not be allowed to until the mandatory and statutory training which had lapsed had been completed.

Managers told us because of the nature of the service they carried out they used an accredited external training provider to deliver physical intervention and handcuffing courses regardless if staff had been previously trained in these areas. All staff had to complete the courses. This training was considered as mandatory by the provider.

The provider had set their own target of 90% of staff to have completed their mandatory and statutory training. Managers acknowledged this figure was in some areas affected by dormant staff who`s training had lapsed, or they had not attended refreshers. Dormant staff could not recommence working for the company until they had completed their mandatory and statutory training. We saw the 90% target for active staff had been attained.

We saw evidence managers ensured staff were kept up to date with their mandatory training by having future training booked before the current training expired.

Safeguarding

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

We saw evidence 48 active staff had completed both adult and children safeguarding level two training.

There was a safeguarding lead trained to safeguarding level three in children and adults and a deputy trained to safeguarding level three in children and adults.

Both were on an out of hours on call rota to provide staff with advice if required.

Staff we spoke with knew how to make a safeguarding referral and we saw evidence of referrals having been made in a timely way.

The provider`s patient booking form, managers daily transfer log checklist and patient record form all had sections to record safeguarding concerns.

The provider had a safeguarding policy which was in date and was aligned with January 2019, the fourth edition of the intercollegiate document, 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' published by the Royal College of Nursing.

The policy included a list of Social Services emergency duty team contact numbers throughout the country by local authority in alphabetical order.

The registered mental health nurse (RMN) on the journey we observed was trained to level three for safeguarding children. All the other three staff were trained to level two for safeguarding children.

Staff discussed safeguarding concerns as part of the handover process from the approved mental health professional (AMHP) at the handover we saw. Each vehicle had a staff guidance manual which clearly outlined the safeguarding process and policy and had relevant contact numbers for making referrals. Staff we spoke with all fully understood the safeguarding process for adults and children. If a referral was made out of hours, then staff would also immediately inform the on-call manager for the service, who was always accessible.

Cleanliness, infection control and hygiene

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

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The provider had an infection prevention, control and decontamination policy which was in date being due for review February 2022. The policy contained enough information to give staff the guidance they needed. The policy included staff duties, organisational framework, monitoring, infection control training, background information and cleaning.

The policy had appendices which covered, category three diseases which broadly correspond to infectious tropical diseases such as leishmaniasis or malaria, Pegasus declaration of contamination status form, management of spillage of body fluids/blood, management of human bites, scabies exposure flowchart, inoculation incidents (needle stick injuries), vehicle cleaning schedule.

The provider`s operating base was a conventional office and not an operational ambulance station.

The office and kitchen/rest room was visibly clean and tidy.

The provider`s vehicles were not kept in a garage. They were parked near to the provider`s operating base in a commercial car park used by surrounding businesses. There were no clinical areas therefore to be cleaned.

We inspected four of the provider`s vehicles. The vehicles were not ambulances but adapted mini buses.

The four vehicles were visibly clean both inside and out. The vehicles all contained hand cleansing gel, decontamination wipes and personal protective equipment. Each had a bin for clinical waste.

The seating areas in all the areas appeared clean and were in tact with no splits or apparent wear on the seat covers.

Managers told us any clinical waste acquired during a transfer would be left at the receiving provider`s premises.

Each vehicle had a folder which had evidence inside they had been cleaned weekly in accordance with the weekly cleaning schedule and deep cleaned every six months.

Each vehicle had detachable seat covers and carpets which were washed weekly.

We saw evidence 36 spot checks had been carried out during jobs attended by managers. There were 14 areas audited which included vehicle cleanliness and cleaning supplies on the vehicle. Any issues identified were fed back to staff to action.

Staff were supplied with uniforms which they washed at home. The provider`s policy on washing uniforms was included as part of the Infection Control Policy.

On the journey we observed, we saw that the vehicle pre-inspection check was carried out to ensure there were no infection prevention and control risks. Each vehicle has a plastic box that contained gloves, aprons and wipes. We saw staff using the hand gel that was available on each

vehicle, and on arrival to the destination unit where they were transferring the patient to. On return to the office base, we saw that all staff ensured the vehicle was cleaned and left tidy ready for the next journey.

During the inspection we reviewed the provider`s monthly decontamination forms which were an infection prevention control audit. We reviewed the forms from the last 12 months and saw evidence the audits had been done every month. The audits covered 10 areas. The 12 forms we reviewed showed compliance in every area.

Environment and equipment

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.

The building where the provider's operating base was, had other business operating within it. Entry to the building was through a key pad lock. There was a buzzer for visitors to use to gain access.

The provider`s operating base was a conventional office and not an operational ambulance station. The administrative office was based on the first floor and there was a kitchen/staff rest room opposite. The administrative office was accessed using a staff key fob. The office contained two desks with computer work stations, various document storage, a box for staff to leave completed patient record forms (PRF`s) in and a shredding box supplied by an external company. There were notice boards which displayed various current information for staff to read.

The building was alarmed and had both internal and external 24 hours, seven days a week CCTV coverage.

The provider managed the servicing, repair and replacement of vehicles through an external company. Managers told us all vehicles except one were on 24-month leases. At the time of the inspection the provider was about to take receipt of two new vehicles.

Each vehicle had a folder with documentation related to that vehicle which included a vehicle inventory list. In each folder we reviewed for the four vehicles we inspected there was evidence all had been serviced and had a valid ministry of transport test certificate (MOT).

At the operating base there was an equipment store on the ground floor with supplies of consumable items. There was a stock list in the store which recorded stock levels. The equipment store was managed by the operational lead. They told us stock levels were reviewed weekly and items replaced if required.

Due to the type of service provided there was very low usage of consumable items. Staff we spoke with told us there was never a problem obtaining replacement items.

During inspection we inspected four of the provider`s vehicles. They were not ambulances but adapted mini buses.

Three vehicles had the service's logo and details on them. Staff said they would use these vehicles for transporting patients under a Mental Health Act (1983) section. This is a law that applies to England and Wales which allows people to be detained in hospital (sectioned) if they have a mental health disorder and need treatment.

The fourth vehicle was unmarked and would be used for picking up patients from their home and escorting patients for Section 17 Mental Health Act (1983) leave to maintain privacy and dignity.

In all the vehicles inspected the re-usable equipment appeared visibly clean. All vehicles appeared in good condition both inside and out and the lights and doors were working properly. Staff had use of mobile phones and satellite navigation systems. These were not kept in the vehicles when not in use, so they could be charged and to prevent theft.

Each vehicle had extendable seat belts for children and bariatric patients.

All essential emergency equipment required was available including first aid bags. There was evidence the equipment had been checked and the checks recorded in the vehicle folders.

There was evidence the equipment carried on each vehicle had been serviced in accordance with manufactures guidance and any electrical equipment had been portable appliance tested (PAT). Stickers were displayed on the equipment showing the serving date, re-serving date and date of PAT test.

On the journey we observed, we saw that the vehicle pre-inspection was carried out and the vehicle checklist

was completed to ensure the vehicle was fit for use and roadworthy. Vehicles had a discrete metal grill separating the driver's compartment from the main seating area. Portable hand scanning devices were available for carrying discrete security checks. Protective vests were available on each vehicle for each staff member if required as part of the initial risk assessment before the journey commenced.

Staff said they were looking forward to the proposed move to new premises, which would provide more space and a secure, fenced parking lot.

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.

Appropriate procedures were in place to assess and respond to patient risk, including appropriate response to vehicle breakdown.

Before booking a transfer, managers clarified the status of a patient's mental health with the booking unit/service, including whether the patient was detained under the Mental Health Act, or subject to a Deprivation of Liberty Safeguards authorisation. Managers also clarified the physical health condition and the medically fit for discharge status of the patient. This ensured that managers had time to plan for the correct number of staff to use on the transfer and the most appropriate vehicle to use.

We saw the staff handover for a journey and staff clearly articulated the potential risks involved in the transfer of the patient. We then observed the handover from the approved mental health professional (AMHP) to staff which included a review of all relevant documentation and clear discussion about potential risks for the patients, staff and the environment staff may be working in. AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating patient assessment and admission to hospital if patients are sectioned.

Staffing ratios were determined by the level of risk the patient posed to themselves or others. There were set staffing levels which were; informal patients: three healthcare assistants, detained patients: one registered mental health nurse and three healthcare assistants, detained patients being conveyed/transferred to a low secure psychiatric intensive care or a higher level of security: one registered mental health nurse and four healthcare assistants.

When the transport was requested by a provider a patient booking form was completed. The form included patient warning markers, presenting risk, previous risk history and gender/race/sexual behaviour concerns.

The patient referral form (PRF) included forensic history, any racial or gender concerns, violence or aggression, risks of self-harm/attempted suicide, alcohol substance misuse, any blood borne viruses, safeguarding concerns, physical health conditions, use of weapons and absconding risk.

The information in relation to gender concerns enabled the transport coordinator to review the staff allocated to the patient transport to ensure they were gender appropriate. Managers told us of examples would include if a patient was displaying sexually disinhibited behaviour towards a particular gender or if a patient has had a traumatic experience, for example, sexual abuse. The staffing would be allocated accordingly to reduce the risk of the patient becoming upset, agitated or staff being subject to sexual assault or verbal abuse.

The information in relation to racial concerns took account of patients who could display any behaviours or expressed any negative views of others of a particular race or ethnicity. The transport coordinator would plan the staffing accordingly to minimise the risk of the patient becoming agitated and abusive to staff and also to reduce the risk the racial abuse of staff.

The PRF also included a body map of the patient and any existing injuries or bruising could be recorded. This was to reduce the risk of any complaints being made where there was an allegation of assault or unnecessary use of restraint which caused injury.

There was also a section on the PRF to record when the patient had last received their medication. The was to reduce the risk of a patient either missing their medicine or being given a double dose of medicine and so staff would be aware of any additional monitoring that may be required during the journey.

We reviewed six transport logs which were the provider`s PRF`s and found that in all cases a risk assessment had been undertaken before transport. This included a body

map to log any injuries or conditions that the patient may have before they were placed into a vehicle. A detailed statement outlining the journey was also completed at the end of each transport and where required there were also details of any interventions that were required.

All transport logs detailed who was in the vehicle and what role they had undertaken and where they were sat.

We reviewed six incident forms and the documents related to the incident management meetings. They were complete and detailed and contained all the information required to correctly document all incidents. The incident management meetings had given each incident a red, amber or green rating which meant that managers could see where risks had occurred and put in place measures to mitigate future risk.

Staff told us any form of restraint they used was the minimum amount necessary for the shortest possible time, and as a last resort. This complied with the Department of Health and Social Care guidance entitled 'Positive and Safe' (2013) and National Institute of Health and Care Excellence (NICE) Guideline 25. Staff said they hardly ever had to use any form of physical restraint as verbal de-escalation techniques were usually successful. Risk assessments were completed by the sending unit/location to identify whether handcuffs would be required for patient transfers. Any incidents where restraint was used were documented and discussed at the debrief meeting on return to the office base at the end of the journey. Body map forms were completed before and after each journey.

Managers at the office base were able to accurately track where staff were on their transfer using a real time satellite navigation system linked to a mobile telephone application. This meant that for any given journey, staff at the office base could identify where the vehicle was, and staff said this gave them reassurance.

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 and adjusted staffing levels and skill mix and gave bank, agency staff a full induction.

All managerial staff were employed by the company. The registered manager worked 25 hours per week, was also on call and worked on patient journeys, the quality assurance manager worked 30 hours per week, the operations lead worked 35 hours per week, was on call and worked on patient journeys. The provider had recently employed a team leader working 15 hours per week and worked on patient journeys.

Other staff worked on a zero hours contract. The service had 20 registered mental nurses (RMNs) it could call upon and an RMN was always part of the staff crew for any journeys involving transporting a patient under a section of the Mental Health Act. The service also had around 30 health care assistants with a range of skills and expertise.

Staffing levels and expertise were carefully planned for each journey to ensure patients' needs could be met. Staff said most journeys would usually have four staff in the vehicle and they took turns at driving for longer journeys. Breaks were planned for longer journeys and staff ensured they looked after their own and their colleagues' wellbeing. The staff we spoke with all worked substantively for local mental health trusts and would carry out work for the service when they had availability.

There were no set shifts. The service operated an availability roster, so staff would make themselves available to suit their own work and personal life balance.

Managers told us they had always found enough staff to carry out a transport.

The service's protocol was that staff would be given an hour's notice for all journeys, on the days they said they would be available. Some journeys would be planned the day before. At the end of each journey, staff would report back to the main office for a review of the journey and for a debrief with the manager.

Staff generally undertook one journey per shift. One staff member told us about the comprehensive induction process they had received. A manager was always immediately available out of hours for telephone advice.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Good

Patient transport services

Patients' individual care records were well managed and stored appropriately. Records seen were accurate, complete, legible and up to date in all cases.

Staff completed a patient transfer record for each job they completed. We looked at 12 completed transfer records, which included staff details, times, collection and transfer addresses, details of the patient's condition during the journey, details of whether any form of restraint was used and whether an incident form was completed for the job. All the forms were legible, included all the information required by the company and were dated, timed, with a signature and identifiable number.

On their return to their base, staff met with managers for the debriefing session and reviewed all documentation. Staff told us, and we saw that they transferred patient hospital records where appropriate with the patient. This included any forms relating to sections under the Mental Health Act 1983. We saw staff check patient records as part of a handover process at the sending and receiving unit/ establishment.

The provider had a do not attempt cardiopulmonary resuscitation (DNACPR) policy which was in date and due for review September 2021. The policy provided guidance to staff in relation to the performance or non-performance of CPR. The policy included guidance for DNACPR procedures and the emergency treatment of anaphylaxis.

Up-to-date do not attempt cardiopulmonary resuscitation (DNACPR) orders and end of life care planning was appropriately recorded and communicated when patients were being transported through the patient booking system.

Each vehicle had a secure document bag which was used on patient transports to hold the PRF which was used at the handover at the receiving facility.

Regular audits of PRF`s and booking forms were undertaken by the nominated person to check if the content was legible and all the fields had been filled out. Any issues or themes were raised with individual staff and discussed at governance meetings and changes made where necessary to ensure safety of patients.

Completed PRF`s and booking forms were posted in a locked box in the main office. Following review, the forms were stored in a locked cabinet in the main office.

The provider used an external company to dispose of any confidential waste. There was a labelled locked shredding box in the main office for confidential waste to be left in before collection and disposal.

Medicines

Due to the nature of this service, staff did not carry or have access to on-board medications. Staff did check whether patients were prescribed any medicines and checked them before carrying out the journey. No medicines were given on journeys, staff said they always asked patients and their carers to ensure all medicines had been taken before the journey. Any patient medicines transported were kept in the glove compartment of the drivers' section of the vehicle in a secure locked bag and was documented on the patient record form (PRF).

If the patient was an informal patient and not under any order, they could carry their own medication. All other patients' who were on any other type of order the medicines were the responsibility of the registered nurse who was on the transport.

There was a section on the PRF to record when the patient had last received their medication. This information would be passed to the receiving facility during patient handover. This was to reduce the risk of a patient either missing their medicine or being given a double dose of medicine.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff were aware of their roles and responsibilities regarding the reporting of incidents. There was a single process for reporting of incidents. Initially, staff were required to report incidents directly on to an incident reporting form which were readily accessible on vehicles, then staff discussed the incident at the debrief session with managers at the end of the journey.

Good

Patient transport services

In the 12 months preceding the inspection the service had not recorded any clinical incidents or never events.

Never events are incidents of serious patient harm that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare provider`s.

The provider recorded all use of physical intervention and any use of handcuffs as an incident.

We saw evidence all incidents were RAG rated to identify the risk patients posed to themselves and staff. This was used in future risk assessments of patients who were regularly transported.

The provider carried out a monthly handcuff audit where any use of handcuffs was reviewed and recorded on a handcuff report form. This was to ensure the use was proportionate and a least restrictive option was considered and to ensure staff who applied and removed them were trained to do so.

In the reporting period staff had used handcuffs 14 times and utilised physical intervention 24 times. On seven occasions the above numbers included the use of both physical intervention and handcuffs.

The information from each incident was discussed at the monthly governance meetings and shared with staff. The information was considered in risk assessing future journeys of patients known to the provider who had been handcuffed, restrained or both previously.

The provider had no reports of having had to apply the duty of candour principles. The provider had a duty of candour policy which was in date. Staff and managers, we spoke with understood the principles behind the duty of candour and gave hypothetical examples when they would apply the principles.

The duty of candour places a legal responsibility on every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress and to apologise to the patient or, where appropriate, the patient's advocate, carer or family.

Are patient transport services effective? (for example, treatment is effective)

Good

This is the first time we have rated this key question. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.

We saw evidence a patient's eligibility for the service was assessed at the point of booking. Managers told us they were able to transfer patients who used walking frames if they are able to transfer into the vehicle safely. The service would not transport patients who were in a wheelchair. The reason for this was because the vehicles used by the provider were not adapted for wheelchair users. Providers who requested patient transport were aware of this.

We saw evidence staff were made aware of patients with mental health needs following the patient booking process which included which orders were in place.

The rights of people subject to the Mental Health Act 1983 (MHA) were protected. Staff and managers, we spoke with and observed had regard to the MHA Code of Practice when dealing with patients.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Patients' nutrition and hydration needs were considered and there were effective arrangements such as bottled water in the vehicles, which could be given to the patient if required. We saw staff offer a patient and their relative water during the journey we observed. A range of snacks were also available to meet patients' needs if required.

Response times

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

Good

Patient transport services

The provider was not commissioned or contracted and as such it had not been given key performance indicators such as response times by the service requesting the patient transport.

The provider had devised their own key performance indicator for response times. It was expected staff would arrive at the base within an hour of being informed of the job details and start time.

Unless the job was pre-booked or requested for a specific time then the response time to the collection address was two hours within the West Midlands area.

The service did not benchmark and compare itself to other providers.

We reviewed the response time data collected by the provider which showed out of 484 transfers there were three occasions where the two-hour response time was not met. Two of the occasions were due to the collection point for the patient being in Cambridge and one was due to traffic delays.

Competent staff

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

Staff had the skills, knowledge, and experience to deliver effective care and treatment, including for younger adults. The service had systems in place to manage the effective staff recruitment process.

Effective staff recruitment processes were in place. All necessary checks on new staff had been carried out. Staff told us of the comprehensive application and recruitment selection process and that all necessary Disclosure and Barring Service (DBS) checks, references, and work histories checks had been carried out.

During inspection we reviewed a spreadsheet the provider used to record DBS checks. The spreadsheet included 59 staff and included certificate number, date of issue, expiry date, DBS type, outcome, other information, convictions and risk assessment. It was noted two staff were awaiting DBS checks to be returned and three were due to be renewed in three months, from the date of the previous DBS check.

The recruitment and selection process had been carried out to consider the competency of applicants for the role. Staff said they received regular supervision sessions from managers. The emphasis was on developing the service to deliver the best possible care. Debriefing sessions were held with managers after the end of each patient journey to discuss what went well and what could be improved. Staff reported this was very useful.

During inspection we reviewed 37 pending applications for staff who wished to work for the company. There was 24 different areas to complete before the applicant could be appointed.

During inspection we reviewed the provider`s spreadsheet which contained the driving licence information of 46 drivers who worked for the company. The spreadsheet included the driver number, the expiry date, the date the on-line driver vehicle licencing authority (DVLA) check had been completed and endorsements. The information was monitored and reviewed by the nominated person who would alert staff if their driving licence required renewal.

We saw evidence of 36 spot checks had been carried out during patient transports attend by managers. The checks included observation of staff receiving, transporting and handing over patients. Individual staff would receive real time feedback if any issues were identified.

The provider had an appraisal system for staff. Managers we spoke with acknowledged the difficulties in doing appraisals with staff who were on zero hours contracts and did varying amounts of work.

The provider had a spreadsheet with 47 staff appraisals which were RAG rated. Red was overdue, amber due within three months and green due within six months. The spreadsheet showed 21 appraisals were green, six were amber and 20 were red. Managers we spoke with told us the commitment of staff to work was constantly reviewed and often staff were designated as dormant if they had low levels of deployment. Dormant staff could not therefore be appraised, and this affected the ability to have a 100% appraisal rate.

There was evidence staff had received training in restraint which had been provided by an accredited external training provider.

We saw evidence training was in place including refresher training, to prepare staff for supporting a patient experiencing a mental health crisis and to understand the legal powers in relation to transporting patients with mental ill health.

Managers and staff, we spoke with could explain the various orders a patient could be detained under and what the implications were for staff.

The provider had 19 core policies contained in the staff policy file which all staff were expected to read and sign to say they had done. The polices were risk, first aid, emergency first aid, medication management, safe driving, non-detained informal patients, detained patients, transport policy, physical interventions, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), do not attempt cardiopulmonary resuscitation (DNACPR), infection control and decontamination, minimal lifting, personal protective equipment (PPE), Control of Substances Hazardous to Health Regulations 2002 (COSHH), operations policy and procedure, use of mechanical restraint, duty of candour, management of violence and aggression.

We saw evidence in the staff files we reviewed staff had signed to say the policies had been read.

Managers told us when they did the spot checks, they would take the opportunity to ask staff about the policies to check levels of understanding. If there were any gaps in knowledge identified staff were asked to re-read the policy.

Multidisciplinary working

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

Staff were able to access information about a patient easily on the referral paperwork. The booking manager would obtain full information about the patient's needs and this enabled managers to allocate appropriate resources.

Staff told us members of staff from the NHS trust or other provider who were caring for the patient being transferred were able to travel with the patient if they wanted to, and if it improved the experience for the patient.

Generally, the service provided its own staff and RMNs. We saw that handovers at the sending and receiving units were very detailed and effective. A handover was requested by the RMN and was seen to be thorough and informative. All paperwork was checked before leaving to ensure this was full and correctly completed.

At the receiving unit, again the handover was detailed and thorough. We reviewed the handover notes for the journey we observed, and saw they were fully completed in line with the service's policy to ensure all relevant information was recorded and handed over.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff showed full awareness of consent protocols for adults and younger adults. Staff told us about their understanding of lawful and unlawful restraint practices and had an effective understanding of how to manage patients that were resistant to being transferred. Staff liaised with other professionals at the sending unit to ensure they understood how best to support the patient before engaging with them. Staff fully understood the Mental Capacity Act and Deprivation of Liberty Safeguards.

There was evidence staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004, and Deprivation of Liberty Safeguards and other relevant national standards and guidance

Staff and managers, we spoke with were clear about their responsibility in obtaining consent. The PRF had a section to record this. Staff could give examples of when they obtained consent from patients and recorded it in the PRF.

The provider had a policy on the use of the Mental Capacity Act 2005 which was in date. The policy was detailed and had considered the patient mix that staff may be transporting. The policy contained enough information to give staff the guidance they needed.

Good

Patient transport services

The service promoted supportive practice that avoided the need for physical restraint. The provider carried out a monthly handcuff audit. The audit covered where any use of handcuffs recorded on a handcuff report form to ensure the use was proportionate and other least restrictive options had been considered. It also was to ensure staff who applied handcuffs and removed them were trained to do so.

Are patient transport services caring?

Good

This is the first time we have rated this key question. We rated it as **good.**

Compassionate care

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

Care was provided by staff in a very sensitive and dignified way. We saw staff treat a patient with kindness, respect and dignity throughout a patient transfer. Before picking the patient up, staff actively discussed the impact of this journey for the patient and their family and were fully cognisant of the wellbeing of the patients coupled with a full understanding of potential risks and strategies to be used to deescalate any concerns.

We saw the staff welcome the patient at the collection address and took great care in reassuring them and their family. They carefully explained the process, which included a discrete and respectful security check. Staff did everything possible to make the patient comfortable during the journey we observed. Staff used appropriate tone of voice, eye contact and body language to make the patient feel at ease.

The staff member driving the vehicle did so with great care and carefully explained what was happening at various times during the journey. They also ensured the environment in the van was warm to meet the patient's requirements and that music was played that the patient wished for. Staff offered drinks at various times. Staff engaged the patient and their family member in appropriate and considerate conversation during the journey.

We saw the transfer process to the specialist unit and staff were very respectful, calm and considerate always. The entire pick up, patient journey and handover process to the specialist unit staff was conducted in a very calm, composed, considerate and respectful manner by all four staff that were involved. Staff also ensured that the patient and their family member were comfortable in the specialist unit before wished them well and departing.

Staff actively sought patient feedback for each journey where it was appropriate to do so. We saw the patient complete a patient feedback form. Comments included "The staff were really kind' and 'They explained everything to me'.

We saw a sample of comments and feedback messages received by the service, which were complimentary about the care and respect shown by staff to patients. They referred to their kindness and professionalism of the staff.

Some of the patient feedback comments included, felt very safe in vehicle, staff made me feel safe, they listened to me, would like them to come back again, they kept me safe, a good team great to travel with really nice people and you gave me respect so thank you.

Understanding and involvement of patients and those close to them

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We accompanied staff on one patient journey. We saw staff explain to a patient and their family members why and where they were being transferred to. This was done in simple terms and a friendly respectful manner, which helped the patient understand.

Staff were able to describe how they met the needs of patients, included meeting the needs of patients from diverse backgrounds. There were effective arrangements for ensuring and maintaining the privacy and dignity of patients. Staff had a defined process for supporting patients with their needs on longer journeys and ensured boarding and leaving the van was done so in a safe and unhurried manner. Patients were encouraged to be involved in the planning and delivery of their care as much was practicable given the nature of the service provided.

Good

Patient transport services

We saw evidence in the PRF`s we reviewed which showed parents had been allowed to travel after a risk assessment had been carried out with their children. Partners, relatives and carers had also been allowed to travel with the patient to provide additional support and reassurance after a risk assessment had been carried out.

Emotional support

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff demonstrated a full awareness of the needs of patients and their relatives and carers and how they would support them at times of distress, especially during emergency situations. Information was available to staff so they could signpost patients to relevant external support organisations. Staff had enough time to provide emotional support to patients. Staff showed us a range of items they would use to help patients manage their own anxiety during transfers.

All staff were fully aware of how to meet the needs of all patients, with a range of presenting conditions and cognitive abilities, in a range of differing circumstances. The mental health and physical wellbeing of all patients was of paramount importance for all the staff we spoke to.

All staff displayed high emotional intelligence for their patients, themselves and their colleagues during the journey we observed.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

This is the first time we have rated this key question. We rated it 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.

The service offered a UK wide service to accommodate the needs of those patients who required transfers to and from mental health units in any area.

The service operated on an as required basis and did not have service level agreements in place with mental health trusts or with individual mental health units to provide patient transfer.

Information about the needs of the local population was used to inform how services were planned and delivered. The service used information available from other organisations to help shape the design and delivery of its service. Feedback from commissioning organisations was actively used to consider service design and improvement.

The provider gathered information from the patients they transported and recorded the legal status of the patient, gender, age in groupings 12 years apart for example 18-30, 30-42, up 102 years old. The ethnicity of the patient was also recorded. This information was reviewed by the provider to ensure they had the correct skills mix and training of staff to meet the needs of patients.

Although the service was not commissioned or contracted, they had worked for two years on an as required basis supporting local NHS providers meeting the demands of local people.

At the time of the inspection the patient transport services capacity to cope with differing level and nature of demand in different localities was not subject to longer term planning. The request for patient transport services tended to be spontaneous or for the next day.

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 service was tailored to each patient's individual needs and risk levels. Patients were able to carry personal belongings with them; these were securely stored in the boot of the ambulance.

When accepting a booking, managers considered the gender mix of staff required for a transfer. For example, staff

Good

Patient transport services

told us if a woman was being transported, a minimum of two female staff would be allocated to the job. Staff told us about how they worked with patients whose first language was not English.

Staff reported that there were several staff who spoke a variety of languages; therefore, it was usually possible to book a staff member who spoke the same language. Staff also explained how family members would also act as interpreters, provided their presence on the journey was appropriate and it met the patient's needs.

One staff member we spoke to had basic sign language expertise. Staff also had access to a pictorial book for communicating with those patients with limited speech ability. Staff told us that the service had access to a nurse with specialist knowledge in working with patients with learning disabilities. Therefore, if a patient was identified as having a profound learning difficulty or disability, appropriate staff could be booked.

Staff had access to translation line if required.

The needs of people including; individual preferences, culture and faith were taken account of at the point of booking and recorded on the PRF.

The provider had an equality and diversity policy which was in date which include culture and faith.

We saw evidence staff were equipped to deal with violent or aggressive patients through their training. In addition, they had personal protective equipment such as a spit mask, stab proof vests and metal detectors to search for concealed weapons.

Managers told us of a patient who they regularly transported had wanted to get married. The provider transported the patient to the registry office and dressed the vehicle in white ribbons as a wedding car.

In each of the vehicles we inspected there was a sensory box with various items inside including pictorial books which patients who required mental stimulation could use to reduce the possible stress associated with the transport. Each vehicle had dementia friendly signage displayed.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

The service was not contracted or commissioned and therefore there was no formal service level agreement to manage access and flow.

The booking of patient transports was through a phone call to the provider. The time and date of the transport was agreed between the provider and the provider requesting the service.

Managers told us in two years they had not declined any requests for transport.

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 provider had not recorded any complaints in the reporting period.

Effective procedures were in place to respond and learn from any complaints. Patients and family members were made aware of how to make a complaint or raise a concern.

The service advised patients of how to make a complaint through feedback leaflets which were on the provider`s vehicles. Patients could also complain to the NHS hospital or mental health unit and the service could receive complaints through this route.

Staff we spoke with were fully aware of the complaints' process and had read the complaints' policy. They told us they would receive feedback if a complaint was made and said that any complaints were investigated thoroughly. Learning opportunities would be discussed at debrief meetings. Staff also said they actively asked for feedback on very journey and received this in most cases. Almost all feedback was positive, staff said.

Are patient transport services well-led?

Good

This is the first time we have rated this key question. We rated it as **good.**

Leadership

Good

Patient transport services

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience they needed to ensure the service met patient needs. There was a clear management structure which ensured consistent leadership from the registered manager and nominated individual. Staff told us, and we saw, that the leadership of the service was open, approachable and inclusive. They could identify the leaders and knew what their roles were.

The leaders were the registered manager who worked 25 hours per week, the quality assurance manager who worked 30 hours per week, the operations lead who worked 35 hours per week and a team leader who worked 15 hours per week. The registered manager, operations lead, and team leader also worked on patient transports.

The operations lead and team leader were on call out of hours to take patient transport bookings and to inform staff they were required to work.

Managers we spoke with understood the challenges to quality and sustainability and could identify the actions needed to address them.

Vision and strategy

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.

Staff said the service had a clear vision underpinned by strong patient-centred values. The company's vision and core values were to ensure the best possible care for every patient, every journey.

The provider had a company strategy plan. The plan included an overview, objectives, target market, product demographics, desired outcome, identified preferred provider trusts/companies, target strategy, budget and strategy narrative.

The provider`s strategic objective was to provide a reliable secure patient transport servicer that improves patient experience when using mental health transport throughout the United Kingdom by implementing best practice.

The provider`s values were, compassionate care, integrity and quality. These were displayed on staff notice boards in the provider`s operating base.

There was evidence that the key drivers for providing effective PTS were understood by relevant staff. The ability to deliver a service within a two-hour window was a unique selling point for provider`s.

Managers we spoke with understood key pressures, risks, goals and plans for the PTS including market share, economies of scale and commercial / competition factors. They were aware because the service was not contracted or commissioned this presented a risk the work and associated income could cease without notice.

At the time of the inspection the provider was in the initial provider engagement stage of a tendering process with a consortium of NHS provider`s. The aim of the tender was to obtain a formal contract to provide secure patient transport for patients with mental ill health.

Managers told us they had been activity involved with the provider`s to design the contract specifications in relation to service provided linked to the current staffing levels and number of vehicles. If the tender was successful staff would be offered contracts and become employees as the provider`s income would be guaranteed.

There was evidence when staff attended the provider`s operating base for face to face training the provider`s vision, values and strategy was part of that training.

Culture

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

The leaders promoted a positive staff culture and encouraged staff development to deliver the best possible care and treatment for all patients. Staff described working in a setting which promoted candour and openness.

Good

Patient transport services

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The service had an open and learning culture, fully focused on patient care. Staff worked with mutual respect, candour and honesty. Staff shared learning through debrief sessions with managers and their one to one session. The organisational culture promoted staff wellbeing.

Managers debriefed the crew after patient journeys, and we saw clear evidence of peer support and the strong focus on wellbeing. All staff spoken with would highly recommend the service as a place to work to friends and colleagues. There was a clear understanding of raising concerns and whistleblowing.

There were mechanisms for providing all staff at every level with the development they needed, including appraisal, career development conversations and managerial observations.

There was evidence the provider managed organisational change through consultation with staff. The tendering process is an example where staff contributed to the tender and were aware of the implications of a successful tendering bid.

The was evidence of a low turn in over in the core operational staff which implied they happy to work for the company.

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.

Effective governance systems were in place to ensure patients received safe and high-quality care and treatment at all times. Staff spoken with were very clear on their role and who to report to.

There was evidence of effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services which regularly reviewed and improved. Examples included the 100% audit of PRF`s and the recording of every patient handcuffed or where restraint had to be used as an incident which were reviewed.

Even though the provider had not been given key performance indicators (KPI`s) from the providers requesting patient transports the service was working to their own two-hour response time which was regularly monitored.

In addition, the service recorded patient information which was shared with the provider requesting the transport. The information was used by the provider requesting the transport for budgetary purposes. The information recorded included the patient NHS number, date of the transport, manager requesting and the number of staff involved in the transport.

The provider also recorded details of the demographic of the patients they transported, and which orders were in place.

The performance information, patient demographic, risk register, and progress of the provider`s strategy was discussed at the monthly management meeting. We reviewed the minutes of the last two meetings which had a set agenda and attendance by the nominated individual, registered manager and operations manager. Any information or actions from the meeting which operational staff needed to be aware of was shared by e mail or displayed on staff notice boards.

The governance framework provided assurance that MHA procedures were followed. This was because of the extensive knowledge, training and experience of the staff in addition to the supporting audits of PRF`s.

The organisational governance was underpinned by the provider`s 19 core policies. We found they were very detailed and had taken account the patient mix that staff may be transporting. The policies contained enough information to give staff the guidance they needed.

Management of risks, 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.

Good

Patient transport services

There were effective arrangements in place for assessing quality and for managing risk. Staff operated an effective risk management system on the journey we observed, mindful of potential risk in all aspects of their work.

We saw evidence of extensive risk assessments in relation to patient journeys with actions and mitigation.

The patient booking forms and PRF`s also included a risk assessment. Every use of handcuffs were reviewed, and risk assessed.

The provider had a risk register which was RAG rated and reviewed at the monthly management meetings.

Managers we spoke with told us they felt the top three risks were, violence and aggression by patients towards staff, staffing -v- demand, and not meeting compliance in relation to the health and social care act. These were on the risk register with appropriate mitigation in place.

There was evidence of a systematic programme of internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken.

We saw evidence in the tendering submission the provider had considered developments to services, efficiency changes, how this impacted on quality and sustainability.

The provider had a vehicle guidance handbook and major incident policy which gave staff information to deal with following to maintain the service; accidents, patient escorting, vehicle breakdowns with staff actions, process for patient management during breakdown/accident, staff replacement protocol, vehicle phones, refuelling of vehicles and general information.

The provider had an identified suitable office with secure parking facilities as part of their business continuity plan should the current operating base become inoperative.

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

Although the service was not commissioned or contracted the only key performance indicator used was the two-hour response time which had been devised by the provider.

The provider did share information with another single provider who had requested information about patient transports, but these could not be considered as a KPI.

The was evidence quality and sustainability both received enough coverage in relevant meetings and through the audit processes.

There were effective arrangements in place to ensure data or notifications were submitted to external bodies as required. An example of this was safeguarding referrals. The 100% audit of PRF`s ensured safeguarding referrals were submitted in accordance with the provider`s safeguarding policy.

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.

Staff said that they felt listened to and the managers were approachable. We saw that patient feedback was very positive, complimenting staff on their helpfulness, punctuality and all recommending the service for future use.

Managers told us they had attempted to obtain formal staff feedback but there had been low levels of returns. Managers thought this was because some staff did not work regularly for the provider and did not think the request for feedback applied to them. In addition, managers were in daily face to face contact with staff who would take the opportunity to raise issues with them.

The last staff survey had five questions for staff to feedback on. There were 14 responses which all had positive responses to each question asked.

The provider acknowledged not all staff had responded, but it did give them an indication how they were doing in terms of patient care, staff members feeling valued and working in a safe environment.

The provider actively sought patient feedback. The feedback forms had three areas which were; did service

users feel safe whilst travelling, staff introduced themselves to the service user and were friendly and service users overall experience of Pegasus Medical (1808) Limited was positive.

We reviewed the provider`s January 2020 feedback audit. There had been 50 transfer reports, 32 feedback forms completed by service users, 16 uncompleted or refused to complete, one was unwell, and one patient was agitated.

We reviewed the provider`s February 2020 feedback audit. There had been 41 transfer reports, 21 feedback forms completed by service users and 20 uncompleted or refused to complete.

The feedback comments were reviewed by managers and any themes identified. These would be shared on staff notice boards, team e mails and individual feedback.

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.

Managers and staff strove for continuous learning, improvement and innovation. This was evidenced through the audit process.

The provider used a private contracted company to supply, repair and service their vehicles. This meant the vehicle part of the business was sustainable and the provider would not be hit by unexpected financial costs associated if a vehicle was off the road and patient transports could not be carried out.

Managers recognised not being a commissioned or contracted service carried its own problems and risks in relation to sustainability. At the time of the inspection the provider was in the initial provider engagement stage of a tendering process for contracted patient transport services. Managers told us if they were successful the business would be sustainable with guaranteed income.