Health Connections PTS Limited

Millennium House

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Millennium House is operated by Health Connections PTS Limited. The service provides a patient transport service specifically for patients with mental health illnesses.

We inspected this service using our comprehensive inspection methodology. This was the first inspection of the service. We carried out the first part of the inspection on 8 January 2019, along with a second visit to the service's operational site in Hastings, Sussex on 18 January 2019. Both of these visits were conducted with a short-notice (48 hours) announcement to the service to ensure there would be staff, vehicles and managers present in order to carry out the inspection.

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.

We rated the service as good because:

- The service had a comprehensive booking system which incorporated an individualised risk assessment for each patient.
- There were systems and processes in place for the management of incidents, safeguarding concerns, complaints and vehicle maintenance.
- Staff were aware of their infection prevention and control (IPC) responsibilities, and routine and deep cleaning for each vehicle was recorded and up to date.
- Vehicles were maintained and serviced appropriately to ensure they were safe for use.
- The service used a tailored set of referral and admission criteria. Bookings included comprehensive risk assessments to ensure the safety of patients during transfer.
- Staffing levels were appropriate to meet patient demand and risk and staff rotas were planned to ensure staff received sufficient time off.
- The service had an effective and secure system for transporting patient records between providers as required, to maintain patient confidentiality. The service's own booking forms were audited continuously.
- Policies and procedures were based on national guidance, legislation and best practice. Staff were familiar with them and received updates on any changes.
- The service used a clinical dashboard to monitor their performance. The service was performing well against their targets, including for dispatch and response times.
- Staff were competent to fulfil their roles effectively and supported by managers to do this.
- There was good understanding of consent and mental capacity. The service worked closely with approved mental health professionals (AMHP) to manage situations of fluctuating capacity or best interest decisions.
- There was a strong patient focus, and examples of compassionate care, and maintaining patients' privacy and dignity during transfer.
- During bookings, the service ensured patients felt involved in and understood the process and took the time to alleviate any anxiety the patient might have.

Summary of findings

- Care was personalised to the individual patients and there were initiatives to meet their needs, such as different communication techniques and allowing patients to choose their own music.
- There were effective systems for reporting and managing complaints, although there had not yet been any raised during the service's six months of operation.
- Service leads were visible and focused on supporting staff and delivering high quality care; staff spoke highly of the leadership.
- There was a clear vision, strategy and set of values for the service based on a 'least restrictive' approach to transporting patients with mental health difficulties, which was shared by operational staff.
- There were appropriate governance and risk management systems in place and staff felt empowered to escalate concerns if needed.
- Staff were positive about the working culture and felt engaged in their work and there was evidence of staff reward and inclusion.
- The service had processes and initiatives for continuous learning, improvement and development, including plans for a dedicated control room, and gradual investment in more staff and vehicles.

However, we also found the following issues that the service provider needs to improve:

- The service transported children under 12 on occasion (as passengers with adult patients rather than as patients themselves) but did not have their own paediatric equipment on vehicles. Although staff would use appropriate equipment such as booster seats provided by the provider making the booking, and we saw this was documented as part of the booking process, it was not formalised in a service level agreement to assure themselves that the equipment was safe and fit for use.
- There was no policy or procedure to set out the process for cleaning and replacing uniforms when contaminated, although the service did have shower facilities and keep spare uniforms at their Hastings site.
- There were some training modules with low compliance.
- At the time of inspection there was no formal arrangement for communicating with patients whose first language was not English so staff were relying on online translators, or on staff at the relevant provider if available.
- Only one manager had access to the risk register at the time of inspection, which meant it could not be updated or reviewed by any of the managers based in Norfolk. However, when we raised this the service were proactive in changing the system to ensure all managers had access.
- The service had not yet completed their registration process to register the Hastings operational site as a separate registered location, although they were already taking steps towards this by the time of our inspection.

Following this inspection, we told the provider that it should take some actions, even though a regulation had not been breached, to help the service improve. We did not issue the provider with any requirement notices.

Amanda Stanford

Deputy Chief Inspector of Hospitals (area of responsibility), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Good 	Patient transport services were the sole service provided by Millennium House. Please see above for the summary of our findings.

Good

Millennium House

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Millennium House

Millennium House is operated by Health Connections PTS Limited. The service opened in August 2017 but has been operational since July 2018. It is an independent ambulance service registered in Great Yarmouth, Norfolk.

Millennium House is the sole registered location of Health Connections PTS Limited, a patient transport service dedicated to transporting patients with mental health illnesses, including patients detained under the mental health act, with the use of restraint, where required.

The service has a separate operational site in Hastings, Sussex and primarily serves the communities of the Sussex region, although does also provide some ad hoc transport in the Norfolk region. The Norfolk base provides primarily head office corporate and governance functions. At the time of inspection, the service was in the process of registering the Sussex base as a separate registered location.

The service has not been previously inspected. The service was formed by two mental health clinicians and registered in August 2017 but has only been fully operational since July 2018.

There are five PTS vehicles based at the Sussex site and 12 members of operational staff, all of whom have backgrounds in working with patients with mental health illnesses. There are three senior managers based at the Norfolk site and one operational manager based at the Sussex site.

The service carries out ad hoc PTS work for two local trusts and does not currently operate under any contracts. Staff are therefore employed on zero-hours contracts and booked for journeys as and when they are scheduled.

The service has had a registered manager in post since August 2017. The registered manager is Warren Stanton and the service is registered for the RA of transport, triage and medical advice provided remotely.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and an assistant inspector, with off-site support from an inspection manager. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Detailed findings

Facts and data about Millennium House

The service is registered to provide the following regulated activities:

- Transport, triage and medical advice provided remotely.

During the inspection, we visited the service's Great Yarmouth site on 8 January and the service's operational Hastings site on 18 January 2019. We spoke with seven staff including the registered manager, operations manager, two other directors and three operational staff. We were unable to speak with patients and relatives or observe patient journeys; however, we reviewed feedback from patients and relatives. We also inspected three vehicles, observed a booking, and reviewed booking forms, service policies and other documents.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which had taken place in July 2017. However, the service had only been operational since July 2018.

Activity (July 2018 to January 2019)

- In the reporting period July 2018 to January 2019 there were 841 patient transport journeys undertaken.
- This included seven patients under the age of 18.

Eighteen mental health support staff, including six team leaders, were employed at the service, which also had a bank of temporary staff that it could use. The service did not have an accountable officer for controlled drugs (CDs) as they did not manage, store or administer medicines including CDs.

Track record on safety (July 2018 – January 2019)

- No never events
- 11 incidents
- No serious injuries
- No complaints

Our ratings for this service

Our ratings for this service are:

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

Patient transport services (PTS)

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

Information about the service

Patient transport services (PTS) were the only service provided by Health Connections PTS Limited. Please see the 'Information about this location' section above.

Summary of findings

We rated the service as good. We found the following areas of good practice:

- The service had a comprehensive booking system which incorporated an individualised risk assessment for each patient.
- There were systems and processes in place for the management of incidents, safeguarding concerns, complaints and vehicle maintenance.
- Staff were aware of their IPC responsibilities, and routine and deep cleaning for each vehicle was recorded and up to date.
- Vehicles were maintained and serviced appropriately to ensure they were safe for use.
- The service used a tailored set of referral and admission criteria and bookings included comprehensive risk assessments to ensure the safety of patients during transfer.
- Staffing levels were appropriate to meet patient demand and risk and staff rotas were planned to ensure staff received sufficient time off.
- The service had an effective and secure system for transporting patient records between providers as required, to maintain patient confidentiality. The service's own booking forms were audited continuously.

Patient transport services (PTS)

- Policies and procedures were based on national guidance, legislation and best practice and staff were familiar with them and updated on any changes.
- The service used a clinical dashboard to monitor their performance and they were performing well against their targets, including for dispatch and response times.
- Staff were competent to fulfil their roles effectively and supported by managers to do this.
- There was good understanding of consent and mental capacity, and the service worked closely with approved mental health professionals (AMHP) to manage situations of fluctuating capacity or best interest decisions.
- There was a strong patient focus, and examples of compassionate care, and maintaining patients' privacy and dignity during transfer.
- During bookings, the service ensured patients felt involved in and understood the process and took the time to alleviate any anxiety the patient might have.
- Care was personalised to the individual patients and there were initiatives to meet their needs, such as different communication techniques and allowing patients to choose their own music.
- There were effective systems for reporting and managing complaints, although there had not yet been any raised during the service's six months of operation.
- Service leads were visible and focused on supporting staff and delivering high quality care; staff spoke highly of the leadership.
- There was a clear vision, strategy and set of values for the service based on a 'least restrictive' approach to transporting patients with mental health illnesses, which was shared by operational staff.
- There were appropriate governance and risk management systems in place and staff felt empowered to escalate concerns if needed.
- Staff were positive about the working culture and felt engaged in their work and there was evidence of staff reward and inclusion.
- The service had processes and initiatives for continuous learning, improvement and development, including plans for a dedicated control room, and gradual investment in more staff and vehicles.

However, we also found the following issues that the service provider needs to improve:

- The service transported children under 12 on occasion (as passengers with adult patients rather than as patients themselves) but did not have their own paediatric equipment on vehicles. Although staff would use appropriate equipment such as booster seats provided by the provider making the booking, and we saw this was documented as part of the booking process, it was not formalised in a service level agreement to assure themselves that the equipment was safe and fit for use.
- There was no policy or procedure to set out the process for cleaning and replacing uniforms when contaminated, although the service did have shower facilities and keep spare uniforms at their Hastings site.
- There were some training modules with low compliance.
- At the time of inspection there was no formal arrangement for communicating with patients whose first language was not English so staff were relying on online translators, or on staff at the relevant provider if available.
- Only one manager had access to the risk register at the time of inspection, which meant it could not be updated or reviewed by any of the managers based in Norfolk. However, when we raised this the service were proactive in changing the system to ensure all managers had access.
- The service had not yet completed their registration process to register the Hastings operational site as a separate registered location, although they were already taking steps towards this by the time of our inspection.

Patient transport services (PTS)

Are patient transport services safe?

Good

Incidents

There were systems in place for incident reporting and investigation. Staff knew how to report incidents.

- There were incident forms stored in each vehicle and also at the Sussex site for staff to complete in the event of an incident. The three members of operational staff we spoke with at the Hastings site knew how to report incidents and who was responsible for investigating and reviewing them, and could give examples.
- Incident forms were then handed in to the operations manager based at Sussex, who reviewed them and scanned them into the service's electronic system for review by the registered manager who would identify any actions, learning or investigations required. This person was trained in root cause analysis.
- The service had reported 11 incidents from July 2018 to January 2019. The main themes related to staff having to use physical intervention to transport patients and patients displaying challenging behaviours such as aggression and violence.
- There were no serious incidents or never events reported in this timeframe. Never events are serious incidents 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 providers.
- We reviewed the completed incident reports for all 11 incidents, which were readily accessible on the electronic system. We saw evidence of appropriate grading in relation to level of harm, comprehensive outline of events, and review by the registered manager.
- Incidents had appropriate actions and learning identified. For example, in an investigation into an incident raised about a member of staff using a mobile phone while driving, there was a full interview and review of the evidence carried out, resulting in dismissal of the member of staff. This was the only incident that had occurred within the service so far that had required a full investigation.
- Incidents where patients displayed challenging behaviours were shared with all crews to ensure patient and staff safety; for example, to make staff aware of potential risks or triggers for an individual patient.
- There was an up-to-date policy on serious untoward incidents which was based on NHS England's framework on serious incidents. This provided guidance for staff on recognising and reporting serious incidents.
- Staff and managers showed an awareness of duty of candour when asked. The duty of candour is a regulatory duty that relates to openness and transparency and requires the providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Duty of candour was also highlighted specifically in the service's incident policy and complaints policy; namely 'All staff … are encouraged to adopt an honest and open attitude throughout their practice, we strongly believe that this enables those who use our service to feel we are a trusted organisation.'. There was an additional specific duty of candour policy to explain situations where it would be required and ensure staff understanding and compliance.
- The service was in the process of developing a system to monitor themes and trends in incidents to ensure consistent oversight as the service gradually grew and developed.

Mandatory training

There were systems in place to monitor mandatory training compliance and a comprehensive training programme, although there were some gaps in training compliance.

- Mandatory training for operational staff consisted of online learning in modules including, but not limited to, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), mental health, positive behaviour support, equality and diversity, data protection, infection prevention and control, moving and handling, and health and safety.

Patient transport services (PTS)

- At the time of our inspection in January 2019, the registered manager was looking into options to include face-to face learning in mandatory training, especially in safeguarding modules as they had researched this and found it to be more effective.
- As of January 2019, there was an overall compliance rate of 85% for mandatory training. There was no formal target rate specified but service leads told us they aimed for 100%. The module with the lowest compliance was basic life support with 65%. However, the compliance rates did include a member of staff who was still in their induction period and staff who had been off sick and not able to complete mandatory training.
- We spoke with the control room manager who was responsible for bookings and administrative functions, and they were not up to date with their mandatory training as they had not had the time to dedicate to it. We raised this with this person and the registered manager as a concern at the time and they assured us they would book time to complete their refresher training as a priority. Operational staff confirmed they received sufficient time to complete training so the concern was not widespread.
- There was no formal driver training, but induction included license checks, including for C1 (ambulance) vehicles, and a supervised driving period.

Safeguarding

There were systems and processes in place for staff to recognise and report safeguarding concerns.

- There were up-to-date policies for safeguarding children and vulnerable adults. These were based on national guidance including Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (March 2014) and HM Government: Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children.
- Staff could access the safeguarding policy on the staff intranet and in hard copy at the Hastings site, and there were details for key safeguarding contacts at the local authority carried on each vehicle.
- Operational staff were trained to level two in safeguarding adults and children. There was a named safeguarding lead (the registered manager) trained to level four in both safeguarding adults and children and staff knew to contact this person for concerns or guidance in accordance with national guidance. Named safeguarding leads have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place.
- Safeguarding training compliance rates were 76.5% for safeguarding adults and 70.5% for safeguarding children. Therefore, not all staff were up to date, although this did include two (out of 19) staff who were in their training completion stage of their induction.
- At the time of inspection, the registered manager was researching additional face-to-face training options for safeguarding to deliver to all staff to further improve their awareness and understanding.
- We spoke with three members of operational staff in Sussex, all of whom knew how to escalate safeguarding concerns and could give examples of situations that might be of concern, although they had not yet had to report any.
- The booking process included specific questions about safeguarding concerns or protection plans.
- Disclosure and Barring Service (DBS) checks were carried out for every member of staff as part of the recruitment process.

Cleanliness, infection control and hygiene

There were systems and processes to ensure cleanliness and to minimise risk of infection or cross contamination.

- The roles and responsibilities for infection prevention and control (IPC) were set out in an up to date IPC policy, and the three members of staff we spoke with were familiar with this. Routine cleaning was done by operational staff after each patient journey and deep cleaning was done under a contract with a local external company.
- We inspected three vehicles and saw they were visibly clean, internally and externally. There was a range of personal protective equipment (PPE) available in each vehicle, and cleaning wipes and antibacterial spray. Staff had access to additional cleaning materials at the Hastings site.

- Deep cleaning was carried out every six weeks as standard. The deep cleaning contract also provided that the cleaning company could be called out on an ad-hoc basis if a vehicle had been contaminated, for example by a patient vomiting, and would arrive within two hours to perform a deep clean. Deep cleans included swab and adenosine triphosphate (ATP) testing. ATP testing is a process of rapidly measuring actively growing microorganisms to identify infection risk.
- We reviewed the deep cleaning records, which were stored in a folder and reviewed by the operations manager at the Hastings site. Deep cleans had been conducted six-weekly in accordance with the contract and policy, and future deep cleans had been scheduled for each vehicle.
- We asked what would happen in the event that staff uniform was contaminated. The operations manager at Hastings told us staff had access to shower facilities at the site and they also kept spare clean uniforms there for staff to change. However, this was not specified in the service's IPC policy, which we raised with the registered manager at the time of our inspection. There had not yet been any incidences of uniform contamination.
- There was hand gel and personal protective equipment, such as gloves, available in vehicles. The service did not produce any clinical waste due to the nature of the service.
- The booking form specifically asked about any risk of infection. There had been an incident where the discharging hospital had not informed the service that a patient had hepatitis C and the crew only found out this information on the ward. As a result, the service changed their booking form to ask specifically whether the patient had any blood borne viruses.
- The service was not yet carrying out regular local IPC audits to monitor aspects such as hand hygiene but were in the process of developing an audit schedule at the time of inspection.

Environment and equipment

The equipment and environment was generally suitable to meet patient needs safely, although we had concerns about access to paediatric equipment.

- The premises at the Norfolk head office site comprised of one small office space where bookings were taken, staff files were held and the three senior managers worked from. There was no operational activity taking place from this site at the time of inspection.
- The premises at the Hastings site comprised of an office space, staff kitchen and shower/toilet facilities, and this was where day-to day operations were managed from.
- There were five vehicles operating from the Sussex site. This included three rapid response vehicles (RRV), one celled vehicle which was previously a police vehicle and one wheelchair access vehicle (WAV).
- Vehicles were taken home by the team leaders at the end of their shift and kept there. This was specified in the staff policy and was due to the service not having dedicated vehicle space at the site. It was also better suited to staff working arrangements because they could leave directly from home rather than coming into the station to pick up the vehicles before departing for a booking.
- All vehicles were held under a long term leased through approved companies, which included contractual provisions for vehicle maintenance. The registered manager and operations manager accessed servicing schedules and MOT information online from the external companies, which was then used to plan resources to enable scheduled maintenance to take place. We reviewed servicing and MOT records for all five vehicles and saw they were all in date with dates scheduled for their next service and MOT.
- We inspected three vehicles in total (two RRVs and one ambulance) and saw they were all visibly clean and well maintained with PPE available and harnesses and seatbelts in proper working order.
- There was one defibrillator shared between the vehicles. This was stored securely in one vehicle we checked during inspection and was within testing date.
- The service used restraint equipment if patients had been risk assessed as requiring it, or if a patient escalated or became aggressive during transfer and required restraint. All vehicles had a set of hinged handcuffs available. These were checked once a month

to ensure they were in proper working order, and were cleaned after use. Checks for this maintenance and cleaning were recorded as per the service policy, and we saw these in the vehicle folders kept at the Hastings site.

- There was an up to date 'Restrictive Interventions Policy' which included guidance on the safe use of mechanical restraint. This was in line with guidance from the National Institute of Health and Care Excellence (NICE), published in 2015, on the use of mechanical restraint; and made reference to relevant legislation, notably the Mental Health Act 1983 and the European Convention on Human Rights.
- All occasions where restraint had been used were reported as incidents and these were reviewed and signed off by the registered manager. Staff could explain their roles and responsibilities in ensuring the safe and necessary use of restraint and were trained in the use of restraint.
- The service was due to start trialling soft handcuffs in January 2019 as the operations manager had been on a training day for the use of this equipment. This person was trained to deliver training to others so was going to roll out the soft handcuff training to all operational staff.
- The service did not keep fire extinguishers on their vehicles. This had been risk assessed and the recommendation was that they did not need them as there were two points of exit on vehicles and medical gases were not stored or transported.
- We had concerns that the service did not have access to their own equipment for transporting children, such as child harnesses, seatbelts and booster seats. The Motor Vehicles (Wearing of Seat Belts) Regulations 1993 specifies that 'children under the age of 12, or below 135 cm tall, are not allowed to use an adult seat belt without 'additional restraints' (child seats, booster chairs and booster cushions). There is a legal exception to this for unexpected necessary journeys such as an emergency hospital visit, but as the service was not providing an emergency service it was not best practice to rely on another provider's equipment. In the case of children under three, the Regulations provide no exemption from the legal requirement for appropriate child restraints.
- The service transported patients aged 13 to 18 and this was specified on their statement of purpose. From July 2018 to January 2019 they had transported seven patients in this age group. However, there had been instances when children younger than this were transported in the vehicles not as patients but when their parent was a patient.
- The service would rely on the provider making the booking (or a parent) to provide the appropriate equipment and this was discussed at the time of booking. There was evidence of this being arranged as part of the telephone booking process for a child, and they would refuse to transport a child if the provider did not provide the appropriate equipment. However, the registered manager and operations manager acknowledged they could not have full assurance that the equipment being used was safe, for example that it had not previously been in a vehicle accident. When we raised it, they acknowledged the concerns and made plans to look into more robust arrangements for having their own paediatric equipment as part of quality improvement in the service.

Assessing and responding to patient risk

There were systems in place to appropriately assess and manage patient risk, and staff were confident with responding to individual patient risks.

- The service had a tailored set of referral and admission criteria completed by staff who had previously worked in the mental health field. Admission to the service involved comprehensive discussions about specific patient risks. This allowed staff to decide on the level of vehicle security required and to ensure that any use of the celled vehicle was necessary.
- There was an up to date 'restrictive interventions policy' in place which included a section on the use of mechanical restraint. The use of restraint was emphasised as a 'last resort' option, and staff gave examples of where they had used communication and taken their time with a patient to help keep them calm and lower the risk they posed, rather than using restraint.
- The service used a range of formal risk assessments including for suicide, absconsion, and violence and aggression. These risk assessments used a comprehensive range of indicators from speaking with the patient, the patient's previous medical history and

any symptoms such as psychosis or substance use. The information provided by these specific risk assessments fed into an overall 'risk matrix decision' to arrive at a red/amber/green risk rating for each patient.

- Staff at the Sussex base and senior managers based in Norfolk all showed good awareness of using the risk assessments and responding to patient risks, and could give examples of this.
- The service had an up to date deteriorating patient policy which specified staff should dial 999 in the event of patient deterioration such as cardiac arrest. However, there had been no incidents of this occurring since the service had become operational in July 2018. The three staff we spoke with were aware of this policy and procedure.
- Staff received basic life training and training in the use of the defibrillator.
- The service did not transport patients with a do not attempt cardiopulmonary resuscitation (DNACPR) order in place.

Staffing

Staffing was appropriate to safely meet patient demand and individual risks and the service had no vacancies at the time of inspection.

- The service employed 18 members of operational staff (mental health support staff) who drove the vehicles and supported patients during their transfers. Staff all had healthcare backgrounds in caring for patients with mental health illnesses.
- Patient journeys were generally staffed by three members of staff unless the patient had been assessed as low-risk, in which case there would be two members of staff. The service did not carry out single-crew transfers and this was confirmed in the booking forms we reviewed.
- We reviewed rotas from December 2018 and January 2019. There was evidence that staffing was appropriately mapped to patients' individual risk when bookings were made. Planned staffing levels matched actual staffing levels on patient transfers. If a booking was requested and it could not be assured there would be sufficient staff (either two or three, dependent on the risk of the patient) the service declined the booking.
- Staff were all on zero-hours contracts but were generally working around 40 hours per week. There was also opportunity for overtime hours. Staff worked on a four days on, four days off pattern with two crews of three staff each working over each 24-hour period. The service was 24 hours a day so staff on their working days, were called in for patient journeys once a booking was made.
- Staff reported back to the duty manager (either the operations manager, registered manager or nominated individual) to confirm they had finished their shift and to confirm their 11-hour rest time, to help ensure staff safety and safe working hours. They were also supported by managers to take breaks on long journeys or if they had had a particularly difficult patient transfer.
- The service had only recently become operational (as of July 2018) and had recruited staff through advertising in the local area. They had not faced recruitment barriers because they had not yet had to complete large scale recruitment drives, and they had no vacancies at the time of inspection.
- From July to October 2018 there had been a total of 11 staff sickness days.

Records

Records from both discharging providers and the service's own booking forms, were appropriately managed and staff could explain their documentation responsibilities.

- The records maintained by the services consisted only of the booking forms used to assess patients before and during transport. There was space in the booking form to complete observations during transport, for example if the patient changed in their behaviours and presentation.
- Once a journey had been completed, staff posted the complete booking forms into a locked drawer in the Hastings site to which only the operations manager had access. The operations manager reviewed these forms to ensure they matched the planned bookings, and then filed them in a locked storage cabinet.
- We reviewed 11 completed booking forms from January 2019 and saw they were clear, complete and contained all the information staff would need to care for and transport the individual patient appropriately.

Patient transport services (PTS)

- Body maps were completed for patients where staff noticed injuries or wounds. This information was then passed to the receiving provider and a second copy kept with the booking forms that the service retained. This was good practice as it meant that if the service was challenged about an injury during transfer they had records to support their own observations during transfer.
- The service had an effective and secure system for transporting patient records between providers as required, to maintain patient confidentiality. They would be transported in a tamperproof package sealed with a unique ID number, and would be checked and signed for by a nurse at the discharging provider and the receiving provider. The ID numbers were then stored as part of the booking form and journey record. This process was specified in an up to date patient records management policy and staff were confident with the process.
- Due to the small size of the service, all records were checked by the operations manager as part of a continuous auditing process.

Medicines

The service did not store their own medicines.

- The service did not carry or store medicines and staff did not prescribe, dispense or administer any medicines to patients.
- The service did transport patients' own medicines, for example when being discharged from hospital and there was an effective process in place to ensure these were transported and monitored safely. They would be transported in a tamperproof package sealed with a unique ID number, and would be checked and signed for by a nurse at the discharging provider and the receiving provider. The ID numbers were then stored as part of the booking form and journey record. This process was specified in an up to date medicines management policy and staff were confident with the process.

Are patient transport services effective?

Good

Evidence-based care and treatment

Care and treatment was based on national guidance and best practice and was provided to support good outcomes for patients.

- Policies and procedures were all in date and based on national guidance and best practice, and were tailored to the specific nature of the service provided. There was evidence of reviewing and updating policies where required. For example, the registered manager had recently attended a level four safeguarding residential course and was going to implement the learning from this into the service's safeguarding policies. The introduction of soft handcuffs following training was also going to be implemented into local policy and procedure as it was in accordance with the focus on the 'least restrictive option' for patients.
- Staff could access policies and procedures through the staff intranet or in hard copy at the Hastings site.
- The service was in the process of recruiting a dedicated governance specialist, whose remit it would be to monitor and update policies and procedures as practice changed.
- Staff and managers were strongly familiar with the mental health legislation governing their work and the rights of patients.
- Due to the small size of the service, the operations manager was auditing all conveyances in terms of record keeping, risk assessments, booking information and response times. However, managers acknowledged that as the service grew and developed, this may not be feasible and they may have to audit just a monthly sample.
- The service had a clinical audit policy which provided named leads and highlighted that all staff should be involved. The policy prioritised a list of audits, including complaints, documentation, incident investigations and performance indicators. However, as the service had

only been operational for six months, they had not yet completed all these, but were developing the audit schedule at the time of inspection to ensure they were acting on results.

Nutrition and hydration

The service had measures in place to meet patients' nutrition and hydration needs.

- Any specific nutrition and hydration needs, such as diabetes, were documented as part of the booking assessment. If the patient required food during the journey due to their condition this would be provided by the hospital or care provider making the booking and recorded on the booking form.
- The service was generally transporting patients in the local region of Sussex so long journeys were not common, but all vehicles had water bottles for patients. If the patient was assessed as being at high risk of self-harm, one of the crew would remove the lid from the bottle before giving it to the patient, although they tried to limit this to necessity, because of the focus on enhancing patients' own independence and dignity.

Response times / Patient outcomes

The service routinely collected and monitored key information including response times.

- The service used a clinical dashboard to monitor their performance including number of incidents, clinical activity, demographics, levels of harm, usage of restraint and service user feedback.
- The service did not have formally imposed key performance indicators as they worked on an ad-hoc basis rather than under a contract established by a clinical commissioning group. However, they had a self-imposed window of two hours to collect patients, which referring providers were made aware of, due to the ad hoc nature of booking and the large geographical area covered.
- We reviewed the results of the dashboard for October to December 2018 and saw there was good performance by the service against the indicators being measured. For example, the average dispatch time was between nine and 11 minutes, against a target of under 30 minutes. The average response time (to arrive at the patient) was between one hour 12 minutes and one hour 35 minutes, against a target of two hours. There had been no cancelled journeys in this period.

Competent staff

There were systems and processes to maintain and develop staff competencies to ensure they carried out their roles effectively.

- There was a comprehensive induction procedure for all staff, which involved corporate introduction to the service's aims and objectives, familiarisation with policies and procedures, and vehicle orientation.
- The service had a supervision policy to ensure staff were confident with knowledge relevant to their roles and to provide staff with the opportunity to discuss clinical issues and to identify areas for development. This also covered appraisals which, according to the policy, were to be done yearly. However, as the service had only been operational for six months at the time of our inspection, staff had not yet had appraisals. There was an appraisal schedule in place to ensure staff received these within the one-year timeframe.
- Team leaders provided feedback monthly to the operations manager about the competencies and performance of their crew.
- Driving license checks were checked firstly as part of the recruitment process and then completed every three months in accordance with the policy on driving licenses. We checked staff records and saw this had been done for all staff in accordance with service policy.
- DBS checks were carried out as part of the staff recruitment process and then every three years. We checked staff records and saw DBS checks had been completed for all staff in line with the service policy.
- The service did not provide any driving assessment or training before new staff commenced employment, but there was tracker technology in each vehicle to consistently monitor staff driving. The operational manager also did regular 'ride outs' with drivers to check they were competent and working in accordance with service policy.
- Managers actively monitored staff performance and competencies, through the driver tracking system and

clinical dashboard and through conversations with staff. Individual poor performance was discussed formally at governance meetings. For example, the October governance meetings showed discussion of an individual's performance where actions were documented and a disciplinary meeting held, leading to dismissal of the individual.

- As the service was new and still cautiously managing its workload, there had not yet been any formal opportunities for staff development or additional training. However, we were told by the operations manager and the three staff we spoke with that there were plans to develop the service's work in the Norfolk region and when this happened there would be opportunities for development, for example for the team leaders to undertake blue light training or for team leaders to help train teams in the Norfolk region which would allow mental health support staff to fill roles as team leaders in Sussex in the interim.

Multi-disciplinary working

There was evidence of effective multidisciplinary (MDT) working, both internally and externally, to maximise patient experience and outcomes.

- The service worked closely with approved mental health professional (AMHPs) for advice and support around the delegation of assessing an individual's capacity to consent and to plan for the most appropriate means of transporting and communicating with each patient.
- The operations manager liaised on a daily basis with the bed managers at the local Sussex NHS trust with whom they worked closely. This allowed them to communicate potential delays and anticipate planned discharges for the day.

Health promotion

- There was a clear focus on maximising people's health, promoting their independence and supporting their needs. For example, there had been instances where a discharging provider had requested a celled vehicle for a patient, and when the crew arrived to transport the patient they did not assess the patient as presenting the level of risk required for a celled vehicle. They would speak to the patient and staff at the provider and return to swap the celled vehicle for a standard vehicle to ensure they adhered to the 'least restrictive' approach.
- There was a strong emphasis on communication with patients to manage behaviours and establish relationships and to help keep them calm when agitated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There was good understanding of consent and mental capacity.

- Staff and managers could explain principles of consent and mental capacity and there were up to date policies which reflected legislation and national guidance.
- All staff were up to date with training in the Mental Capacity Act 2005 (MCA) and had refresher sessions twice a year.
- The service worked closely with approved mental health professionals (AMHP) to manage situations of fluctuating capacity or best interest decisions. 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 assessment and admission to hospital for detained patients.
- The service's 'Restrictive interventions policy' highlighted that 'The conveyance of a Service User will at all times be completed on a consenting basis. However, there will likely be times whereby a Service User is transported with fluctuating capacity and consent or under the MHA 1983. There may be times where the free mobility of a Service User may need to be restricted in their best interests and to manage safety of Service user and staff.' These situations always involved comprehensive discussion with AMHPs and/or the provider making the referral.

Are patient transport services caring?

Good

Compassionate care

There was evidence of a kind, compassionate and individualised approach demonstrated by all operational staff and senior managers.

Patient transport services (PTS)

- There was an overarching focus on the 'least restrictive option' when transporting patients. Staff were encouraged to communicate with the patient to best meet their specific mental health needs and displayed a kind and empathetic approach at all times and this approach was reflected by the three operational staff we spoke with at the Hastings site.
- The service's restrictive interventions policy highlighted this, stating 'Positive relationships between the people who deliver services and the people they support must be protected and preserved'. In our interviews with staff and managers it was emphasised that maintaining patients' privacy and dignity was important.
- We were unable to observe any direct staff and patient interactions at either site; however, we did observe a booking taken over the phone. The member of staff liaising with the patient and their carer was kind and compassionate in their conversation over the phone. They allocated a crew with an appropriate gender mix dependent on the patient's preference and reassured them that staff would look after them.
- The service obtained patient feedback about patients' care and experience through a feedback form, which asked patients whether they felt safe and respected and whether they found the crew caring. There was a high response rate of 59% in the December feedback form audit, and all feedback forms from December rated the service as five on a scale of one to five about the patient's experience. There had been no negative comments recorded.
- There was a focus on maintaining patients' privacy and dignity, for example, by using blankets and blacking out windows if requested by the patient.

Emotional support

Staff provided emotional support to patients and families.

- Although we were unable to observe patient journeys, there were examples of where staff had supported patients emotionally. For example, in January 2019 there had been a transfer of a 14 year old patient who was very nervous and distressed at the beginning of the journey. Staff explained how they reassured them by encouraging questions and chatting to them, discussing what the hospital admission would be like. This helped mitigate the patient's anxiety and by the end of the journey the patient was 'laughing and smiling'.
- For regular patients, the service tried as far as possible to book the same crew each time to maintain continuity of care. This meant crews could build up a rapport with patients and support them emotionally.

Understanding and involvement of patients and those close to them

Staff communicated with patients well to ensure they felt involved in their care and transport.

- The service focused on communication and engagement with patients rather than restricting them or limiting their independence.
- Although we were unable to observe any patient journeys, staff could give examples where they had used different communication techniques to ensure patients felt involved in their care and understood the role of the transport service.
- We observed a transport booking taking place over the phone and saw that there was discussion around the patient's interests and triggers for their anxiety. The person making the booking took the time to communicate the process clearly to the patient and reassure them.

Are patient transport services responsive to people's needs?

Good

Service delivery to meet the needs of local people

Services were planned and delivered to meet the needs of the population served.

- The service took referrals on an ad hoc basis from both NHS and private health care providers, including acute and psychiatric hospitals, and other care facilities. Each referral was risk assessed jointly between the service and the referring provider in accordance with service

policy to establish the individual requirements for the journey, including staffing, equipment, and type of vehicle. Once agreed, the service provided a quotation within 30 minutes outlining the costs of the transfer.

- As the service did not have any contracts they only accepted bookings they knew they had the capacity, experience and skills to carry out safely and in a timely manner.

Meeting people's individual needs

There were initiatives to meet the needs of individuals and the service was focused on providing personalised care.

- The service had one wheelchair access vehicle (WAV) to meet the needs of patients using wheelchairs and all staff were trained in the use of the lifts and wheelchair safety.
- There were examples of the service using initiatives to help keep patients calm and make the experience more comfortable for them. For example, the vehicles had sound systems that could be connected to the patient's own device to play their own music. One member of mental health support staff could communicate in Makaton with patients (a form of communication using signs and symbols in conjunction with speech).
- The service did not transport bariatric patients as they did not have the equipment, vehicles or staff training in order to do this safely.
- The service had extensive conversations at the time of booking with the referring provider as to the patient's individual needs and how best to meet them, for example anything that might make them anxious or topics to discuss to help keep patients calm. This booking process included highlighting where a patient was living with dementia or learning disabilities and how best to meet these needs. This was then documented on the booking form.
- The service had 'easy read' versions of their documentation and patient information on each vehicle.
- At the time of inspection, there was a lack of clear procedure for meeting the needs of patients whose first language was not English. The three staff at Hastings did not show awareness of a translation service and said they had sometimes used an online translator or asked a nurse who spoke the same language as the patient at the hospital to assist them. This could pose a risk as there was no formal reliable system. However, when we asked the control room manager, they told us they had recently introduced a translation service point of contact following a transfer where a patient had become agitated due to a language barrier. They said this was about to come into effect, but the operational staff were not yet aware of it.

Access and flow

Patients could access transport services in a timely way and the service monitored response times, cancellations and delays.

- The service was operational 24 hours a day, seven days a week.
- Bookings were made over the telephone (through the service's Great Yarmouth office) and there was always a manager on duty to take calls if they came in overnight.
- The service took referrals from NHS and private health care providers who were providing care for patients with mental health illnesses. Each referral was jointly risk assessed to establish vehicle, equipment, communication, staffing and other needs. Once agreed, a quotation was provided to the referrer outlining the costs of the individual journey within 30 minutes of request.
- We have reported on response times under the 'effective' domain.

Learning from complaints and concerns

There were effective systems for reporting and managing complaints, although there had not yet been any raised during the service's six months of operation.

- There was an up-to-date complaints policy, approved in March 2018. This set out the responsibilities of staff when responding to a complaint, namely to ensure complainants are 'treated with dignity throughout the process'. Complainants received a direct point of contact. Staff were encouraged to resolve each complaint independently but if support was required they could escalate to their manager.

Patient transport services (PTS)

- The target time for initial acknowledgement of the complaint was stated as three days by telephone, however, there was no specific timeframe for the follow up and management of the complaint. The policy stated only that an 'appropriate time frame' would be given in each case but it was not clear how this was determined.
- The complaints policy also outlined the process of acting on and learning from feedback and complaints. It stated that action plans would be developed to detail persons responsible for the implementation of each point and time scales provided, to be reviewed at board level to ensure lessons are being learnt.
- There had not yet been any formal complaints raised, but staff could explain the process if a patient wanted to raise a complaint and were aware of the policy.
- Patients and relatives could raise a complaint via the service website or phone line, and leaflets were available on patient journeys explaining the complaints process.

Are patient transport services well-led?

Good

Leadership of service

Service leads had the skills, knowledge and capacity required to manage the service. Leads were visible and focused on supporting staff and delivering high quality care.

- The senior leadership team comprised of the registered manager and chief executive officer alongside a control room manager who was the main person responsible for bookings.
- Day to day operations at the Sussex site were managed by an operational manager who reported to the registered manager and other two members of the senior leadership team, who were based at the Norfolk head office.
- Service leads were in frequent communication with each other. At the Norfolk head office site, all corporate and governance functions were done from a sole office so senior managers could speak directly to one another, and they were in daily contact with the operational manager in Sussex.
- Staff were clear on the leadership of the service and well supported by all service leads, both on site at Sussex and over the phone at Norfolk. Staff spoke highly of the visibility and involvement of the leaders; for example, one of the senior team in Great Yarmouth visited the Hastings base at least once a fortnight and the operational manager at Hastings frequently joined the operational staff on patient journeys.

Vision and strategy for this service

There was a clear vision, strategy and set of values for the service which was shared by operational staff.

- The service was initially set up by the registered manager and nominated individual who both had many years of clinical experience in the field of mental health and had felt passionate about the quality of transport services to meet the needs of these patients. The service had a focus on a 'least restrictive approach' with an emphasis on communicating with patients in the best way for each patient.
- We spoke with three members of operational staff and it was clear this was a vision they shared. They felt their contribution to the direction and future of the service was valued.
- The service had an overarching aim set out in their clinical governance strategy, namely 'to provide a high quality, responsive and adaptable service that is competitive and cost effective'. To achieve this there were several objectives defined in this document, including 'to ensure service users receive a service based on best practice'; 'to ensure the service adopts a culture of continuous review'; and 'to ensure the organisation adopts a strong safety culture throughout its clinical practice'.
- As a relatively new organisation the senior managers had focused largely on their frontline operations and acknowledged that their financial and business management required further development. They were in the process of developing their management and governance structure to align with their gradual growth in demand. This included employing a governance lead and employing, on a consultancy basis, an approved mental health professional to provide professional advice on clinical policies, mental health law and safeguarding in particular. This was outlined in their clinical governance strategy and they were planning embed this more developed structure by April 2019.

- The registered manager informed us they had been researching and liaising with potential external support for business and corporate functions including HR support, so that as managers they could focus on the clinical operations.
- The service had recently developed a clinical strategy, corporate strategy and governance strategy for the next 12 months. This included actions and targets, measures of assurance, and responsible persons for leading these. For example, there were plans to invest in more vehicles and staff, and to develop training to cover the use of soft cuffs, which was intended to 'enable a four-step escalation approach to managing aggression and increase ability to use least restrictive option'.
- These strategies were still in draft form and had not yet been shared with staff but that was the planned next phase of strategy develop

Culture within the service

There was a patient focused culture and staff felt positive about the working culture.

- There was a positive, team based and open culture at the service. Staff worked well together and were proud of their work, and described the service as 'like family'.
- Managers fostered an inclusive culture and made efforts to support and engage with staff, for example ensuring they received debriefs after any incidents.
- There was a highly patient-focused culture shared between all staff and managers.

Governance

There were clear systems of accountability to support good governance and staff were aware of governance systems and how to escalate concerns.

- The service had a clear governance structure and escalation process for raising and managing concerns. Staff reported concerns to their team leader. Team leaders had monthly meetings with the operational manager to discuss any issues, good practice or changes, and the operational manager would then report to the registered manager and chief executive. This system of feedback and communication worked also from the senior leadership back to mental health support staff.
- There were governance meetings which were intended to be monthly but the operations manager told us they were not always adhering to the schedule because the managers spoke to each other so frequently (at least once a day) anyway.
- This was a concern because, although the service was small enough that this means of communication was sufficient for managers to have oversight of risk and performance, there was a risk that without adhering to the formal governance meeting schedule, the service may not have consistent documentation and tracking of any issues that were flagged up.
- The last governance meeting had been in November 2019 and the service had not had a meeting in December due to being more busy than usual. They were planning to have one before the end of January 2019.
- We reviewed meeting minutes for September, October and November meetings and saw there was a comprehensive standing agenda, including clinical updates, operational performance, commercial and financial progress, incidents and risks.

Management of risk, issues and performance

There were processes for managing risk, issues and performance, although the risk register could only be accessed by one manager. The service was in a stage of development so were continuing to work on their systems for oversight and management.

- There was a risk register which was overseen by the operations manager and reviewed at monthly governance meetings. The risk register was comprehensive with an outline of each risk, rating and mitigating actions
- However, we had concerns that the risk register could not be accessed by the managers based in Great Yarmouth. The registered manager acknowledged this was an issue particularly if the operations manager had to go on sick leave with no notice, for example. They assured us they would change the system so there was shared access.
- In addition, the risks on the register did not have named leads or target dates for review and compliance, although the operations manager, registered manager and nominated individual managed them jointly through governance meetings.

- The registered manager described their biggest concerns as elements of running a business including HR processes, and finance management. This was because the managers had previously worked in clinical capacities and were relatively inexperienced with running a business.

Information Management

Information was accurate and comprehensive and there were systems to monitor and manage information.

- The service did not have any KPIs imposed externally but worked to their own KPIs for dispatch and response times. They ensured the accuracy of this data through tracking technology in vehicles and used a comprehensive clinical dashboard to monitor this.
- Computers used in the Sussex and Norfolk bases were password protected.
- Staff were contacted on their own mobile phones to say they had been booked for a journey, only on the days they were already rostered to work.

Public and staff engagement

Patients and staff were encouraged to be involved in the continuous improvement of the service.

- The three members of staff we spoke with felt engaged in their work and within the service.
- The service had recently implemented a staff reward system whereby staff could vote for another staff member anonymously in a box for their work, care and commitment. At the end of the month the votes would be counted and there would be a small reward for the member of staff with the most votes, such as a gift voucher.
- There were examples of social activities between the managers and operational staff including team meals and activities.
- The service engaged with patients and relatives through the patient feedback forms and were planning to introduce focus groups as an opportunity for the local population who used the service to help inform the future of the service.

Innovation, improvement and sustainability

The service had processes and initiatives for continuous learning, improvement and development.

- At the time of inspection, the service was working on an ad hoc basis, but service leads were liaising with two local NHS trusts about the potential to develop their work with them and formalise their work into contracts. The service leads emphasised they were taking their time around these discussions and plans to ensure they had sufficient capacity, resources and systems in place to maintain their standards of care in the event of taking on more work.
- The service leads had a rational and cautious approach to expanding the service as they did not want to take on more work if it would risk impacting on patients' individual experiences.
- As a result, they were employing additional staff gradually and reviewing finances and resources regularly to ensure this was feasible. This included an additional three mental health support staff in February, two control room booking staff in April and a governance lead who was due to start in January 2019.
- There was evidence of a learning culture to drive service improvement and development and this was outlined in the service's clinical, corporate and governance strategies for the next 12 months. For example, there was a plan to develop a dedicated control room with its own staff if the work continued at its current rate. The service leads were also carrying out market research into external training providers and experienced practitioners to focus and develop additional training on particular areas. The strategies were still in draft form and about to receive staff consultation.
- There was also evidence that managers were developing initiatives to improve patient experience; for example, at the time of inspection, they were looking into the potential for televisions in the back of vehicles and subdued lighting as an initiative for keeping patients calm.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The service should ensure there are systems and processes to verify the safety of any paediatric equipment used (such as seatbelts and booster seats)
- The service should formalise the process for cleaning and replacing uniforms when contaminated into service policy.
- The service should ensure all staff are up to date with mandatory training, including safeguarding children and vulnerable adults.
- The service should develop a comprehensive and regular audit schedule, including but not limited to the audit of infection control, to monitor and improve on individual aspects of the service.
- The service should ensure there is reliable access to translation services for patients whose first language is not English.
- The service should ensure more than one manager has access to the risk register for reviewing and updating risks, and should include target dates for mitigating risks.
- The service should continue the work they are doing to ensure prompt registration of the Hastings operational site.