Prometheus Safe & Secure Ltd

# Prometheus Safe & Secure Ltd

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Prometheus Safe & Secure Ltd is operated by a company of the same name; Prometheus Safe & Secure Ltd. The service provides a patient transport service specifically for patients requiring transfer to or from a secure mental health unit. We inspected this service using our comprehensive inspection methodology. We carried out the inspection visit on 19 January 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: were they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

**Services we do not rate**

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

We found the following areas of good practice:

- Staff within the service had an excellent awareness of how to report incidents; we saw evidence and examples of incident reporting and learning from incidents.
- The service had enough skilled staff to safely carry out the booked patient transfers. The service ensured a minimum of three staff were allocated to each patient transfer depending on risk and need.
- The service employed competent staff and ensured all staff were trained appropriately to undertake their roles. Staff had a good understanding of the Mental Health Act (1983) and were aware of their restrictions under this legal framework.
- We saw that staff were caring and respectful of patients using the service. Staff treated patients with confidentiality and dignity and sought to gain feedback from patients regarding their journey using a patient experience form.
- The service demonstrated the effort made to meet individual needs of patients using the service; such as considering the gender mix of transport staff and requesting staff that spoke a specific second language to provide translation services if needed.
- Staff told us, and we saw, that the leadership of the service was open, approachable and inclusive.

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

The service should:

- Ensure all staff, including those on zero hour contracts are updating their knowledge of changes to policies and procedures. We saw that staff were informed of updates and changes to policies and procedures via text message and were able to attend the office to further familiarise themselves with these. However we were not assured all contracted staff were attending to familiarise themselves with the new and updated policies.

**Ellen Armistead**

**Deputy Chief Inspector of Hospitals**

# Prometheus Safe & Secure Ltd

## Detailed findings

**Services we looked at:**

- **Patient transport services (PTS)**

# Detailed findings

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## Background to Prometheus Safe & Secure Ltd

Prometheus Safe & Secure is operated by Prometheus Safe & Secure Ltd.

The service opened in 2014. It is an independent ambulance service based in Newport, Shropshire although is in the process of registering a new base in Erdington, Birmingham. The service is available 24 hours per day, every day of the year.

Although registered as a patient transport service; patients carried by the service were physically well which means that vehicles were not equipped in the same way that conventional ambulances might be.

The service provides secure mental health patient transport across the United Kingdom for both adults and children. The service initially worked with hospital trusts within the Birmingham area; transferring patients between wards within the trusts. However, Prometheus Safe & Secure Ltd now provides patient transport services to a number of NHS trusts and private providers across England, Scotland and Wales. The types of transport provided includes transfers from secure mental health services to prison or courts, transfers from mental health inpatient units to general acute settings for medical care, transport from patients' home addresses to a mental health inpatient setting, and transfers for patients using community adult mental health services and learning disability services.

The service has had a registered manager in post since 2014; this individual also became the Managing Director of the provider in 2014.

We inspected this service on 19 January 2017. This was the first time that CQC have inspected this service.

## Our inspection team

The inspection team comprised two CQC inspectors, each with specialist knowledge of the areas to be inspected (secure mental health patients and patient transport services) and an assistant inspector.

# Patient transport services (PTS)

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

## Information about the service

The service is registered to provide the regulated activity of Patient Transport Services.

During the inspection, we visited the address in Newport, Shropshire where the provider's current registration was held and the new location in Erdington, Birmingham which was in the process of being registered. All staff, vehicles and documentation had been transferred to the Erdington address.

We spoke with 20 staff including; health care assistants, registered mental health nurses, consultants and directors. We also spoke with an external training provider who trained the patient transport staff in their duties. We observed one patient being transferred from an acute hospital setting to a secure mental health unit.

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 found that the service was meeting all standards of quality and safety it was inspected against.

Activity (January – December 2016)

- In the reporting period January to December 2016 there were 1800 patient journeys undertaken.
- Information provided by the service in December 2016 reported that the service employed 102 staff of which three were full time; the rest were employed on a zero-hours contract basis whereby the staff members provided their shift availability and were then allocated shifts to be 'on-call' throughout the week. Should a transfer be requested, those on-call staff would be contacted and asked to attend work. Of the total number of staff, 47 were registered mental health nurses (RMNs) and 55 were employed as health care assistants (HCAs). Seven staff also took the role of clinical logistics managers, taking bookings for requested transfers.
- The service had six ambulances and a wheelchair access vehicle. At least four members of staff would be used per patient transfer for those patients detained under The Mental Health Act (1983). At least one member of the transfer team would be an RMN in order to provide clinical support to the transferring patient as necessary.

Track record on safety:

- No patients had absconded from the service's care since it had started trading in 2014.
- Incidents comprised 73 in total for January to December 2016; 20 were 'green' (no harm), 52 were 'amber' (medium risk), and one was 'red' (high risk).
- Within the period of January to December 2016, the service received one complaint.

# Patient transport services (PTS)

## Summary of findings

Prometheus Safe & Secure Ltd offers a patient transport service in the private ambulance industry. The services were available 24 hours a day 365 days of the year, and specialise in the transportation of mental health patients.

We saw the service provided a safe, effective and responsive service to patients which was well led. Staff were caring and respectful towards patients and demonstrated a good awareness of the needs of patients detained under the Mental Health Act (1983). We identified some areas that the service should consider in order to improve. These are detailed at the end of this report.

## Are patient transport services safe?

### Summary

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

We found the following areas of good practice:

- Staff were knowledgeable about how to report an incident and had access to incident reporting forms whilst on ambulances. We saw good examples of completed incident reporting forms. We saw that staff and ambulances appeared visibly clean and tidy and staff used hand gel whilst within clinical areas to maintain good hand hygiene.
- The ambulance fleet was maintained to a good standard. The ambulances were well equipped and modified to provide security whilst transporting patients.
- Staff worked safely and within the framework of the Mental Health Act (1983). Where staff had been required to physically or mechanically restrain a patient; the restraint had been based on a risk assessment and reported as an incident.
- Staff had a good understanding of safeguarding and were able to clearly articulate the process for escalating a safeguarding concern.

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

- If staff reported an incident involving the use of mechanical restraint, it was difficult to identify from the incident report form where staff obtained their legal power to use such restraint. Completed handcuff forms (used as a record when handcuffs are used) were required in these circumstances but were not always referred to in the documentation.

### Incidents

- Between January and December 2016, the service reported 73 incidents. The service had not reported any serious incidents since registration. The service graded incidents as red, amber or green. Within this time period, one incident had been assessed as red (attempted absconsion), 52 had been assessed as

amber and 20 as green. The majority of incidents were related to use of blue lights due to agitated distressed state of patients (19), verbal threats to staff (20) and physical intervention due to attempted assault (22).

- No patients had absconded from the service's care since registration in 2014.
- We saw that completed incident forms contained sufficient information and were reviewed in a timely way by managers. We saw that managers identified 'lessons learnt' following incidents. For example, the service had purchased stab-resistant vests for staff to wear when collecting patients from their home address, following a reported 'near miss' incident.
- Staff told us they received text messages with relevant updates following an incident which aided their practice when undertaking patient transfers.
- A manager or director was on call 24 hours a day, seven days a week. Staff had a single telephone number to call, which diverted to the appropriate manager, in the event they needed to report an incident. Staff told us when they called the number it was always answered, no matter what time of day or night it was.
- Staff backed up verbal incident reports by completing an incident report form which were located in each ambulance. Once completed staff handed these to a manager or, if completed outside normal working hours, left in a secure letterbox in the office.
- Staff completed an incident form if handcuffs had been used. On the forms we reviewed we saw that it was difficult to identify from the incident report form where staff obtained their legal power to use such restraint. Staff were also required to complete "Handcuff Forms" in these circumstances but these were not always referred to in the incident report documentation, which meant it was not immediately clear as to why staff had chosen to use this method of restraint.
- All staff we spoke to were aware of how to complete an incident form and provided examples of where incidents had been reported, including vehicle failure, use of physical and mechanical restraint and if a journey was diverted to a police station for the patient to use bathroom facilities.
- Information from the service reported 90% of staff had completed duty of candour training, although we did not see duty of candour listed on the three training matrices provided by the service. The remaining 10% of staff were due to receive training in 2017. The service did not record any incidents in which the duty of candour regulations were required to be followed. Duty of candour relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide support.

### Cleanliness, infection control and disposal of clinical waste

- Staff did not carry out any clinical interventions on board the ambulances, apart from emergency first aid.
- The ambulances appeared visibly clean and tidy. Staff were expected to leave the vehicle clean and tidy at the end of each transfer, and each vehicle was cleaned weekly by a full time healthcare assistant.
- Data provided from the service in December 2016 and January 2017 demonstrated that pre transfer checks and daily ambulance checks required staff to check upon the cleanliness of each vehicle at least daily.
- Equipment carried on board ambulances included clinical wipes and clinical waste bags to aid staff to maintain a hygienic environment when necessary.
- In the event of a bodily fluid spill in an ambulance, staff had access to a biohazard spill cleaning contractor 24 hours a day, seven days a week. Callout details for the contractor were carried on every vehicle.
- Staff used hand gel provided within hospital settings before and after contact with patients. We saw within the staff handbook provided to all staff during induction, that the service provided basic training to staff in infection prevention and control. We saw guidelines to staff about working with infectious or communicable diseases were also provided.

### Environment and equipment

- The service operated a fleet of seven, unmarked seven-seater 'people-carrier' ambulances. In each ambulance, a metal grille separated the driver from the other passengers. This protected the driver from being attacked and meant the vehicle could be driven safely regardless of any incident taking place in the passenger compartment.
- The ambulances were kept in a locked car park outside of the provider office. Staff would attend the office to collect the designated vehicle keys.
- We saw that patients were asked to wear their seatbelt at all times whilst in the ambulance. Patients' luggage was carried in the boot of the ambulance.
- One full-time member of staff carried out an inspection of each ambulance each week, including equipment

carried and roadworthiness checks. Before taking an ambulance out on a transfer, each driver also carried out a roadworthiness check. We saw completed checklists evidencing comprehensive weekly checks on vehicles, and pre-transfer checklists attached to transfer report forms.

- A local dealer for the manufacturers of the provider's ambulances carried out vehicle servicing. The service replaced their fleet of ambulances every two years. We saw appropriate MOT documentation for the vehicles which were over one year old.
- Each ambulance carried details of a 24 hours a day, seven days a week breakdown recovery service. Guidelines for staff to follow in the event of a breakdown were contained within each ambulance. Staff told us of an incidence of a breakdown since the service opened; however this was not recorded within the incidents for January to December 2016.
- Equipment on board the ambulances included blood pressure machines, sick bowls, incontinence sheets, a basic first aid kit, hospital standard pillow and blankets, water, cut down knife (to cut ligatures), fire extinguisher, hammer for emergency exit, handcuffs (soft and hard), and a phone. Staff securely stored items such as handcuffs and the cut down knife in the front cab of the ambulance. We saw daily ambulance checklists were completed in December 2016 and January 2017 confirming the correct amount of equipment was on board each vehicle.

## Medicines

- Due to the nature of this service, staff did not carry or have access to on-board medications. However, we saw a medicines management policy that covered the transporting of patient medication.

## Records

- Staff completed a patient transfer record for each job they completed. We looked at 22 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 of the forms were legible and included all the information required by the company.
- On their return to their base, staff put the completed transfer form in a secure letterbox in the company's office.
- 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 hospital or establishment. We saw staff request that some paperwork was completed more thoroughly in order to comply with requirements of the Mental Health Act.

## Safeguarding

- Staff told us they received training in safeguarding either through Prometheus Safe and Secure Ltd, or if they also worked for an NHS organisation they received training through their roles there. We saw a selection up to date completion certificates to confirm staff had completed safeguarding vulnerable adults and safeguarding children training. Information provided from the service confirmed staff were trained up to level two for both adults and children. We saw training matrices which demonstrated staff were trained.
- Staff were able to clearly explain how to respond in the event of a safeguarding concern. They explained the registered mental health nurse (RMN) would take responsibility to either hand over concerns to the receiving establishment, or to contact the local multi-agency safeguarding hub (MASH) via telephone in order to make a report to social services if this was assessed as necessary.
- We saw that the service had a safeguarding policy for staff to review.

## Mandatory training

- Staff told us, and we saw that the service had good systems in place to ensure all staff employed were up to date on mandatory training. Data provided by the service outlined training matrices for each member of staff showing compliance with mandatory training. Each matrix identified the dates of renewal for individual training courses so that managers could send reminders to staff in advance. We saw several training matrices for staff which showed up to date mandatory training had been completed. We saw where staff were nearing a trigger date to refresh training; this was highlighted and the staff member was informed.
- Staff reported that if they were employed full time by the service, they received training through the service. Most

staff on zero hour contracts also had permanent positions in the NHS. These staff received training through their NHS employer and informed the service of the dates these were due to expire.

- Staff told us that upon starting, they completed an induction programme that included a five day restraint training course: de-escalation, management and intervention ('DMI'). Following this staff had to complete an annual one-day refresher restraint technique course. We saw selected completion certificates confirming staff had undertaken this refresher training.
- Vehicles were equipped with emergency blue lights for use if staff were unable to control a patient; to allow them to drive as quickly as possible to a location where assistance could be provided. Blue lights could only be authorised by a RMN. Only staff who had completed a recognised response driver training programme (five staff in total) were allowed to drive using blue lights. We saw a clear policy issued in 2016 that outlined the safe and appropriate use of blue lights/ sirens during an emergency.

### Assessing and responding to patient risk

- Staff told us, and we saw that staff asked patients to sit in the middle seat of the ambulance. The back of the vehicle comprised one three-seater row, and one two-seater row located opposite. This meant a member of staff would be located next to, and opposite, the patient in order to maintain control within the ambulance.
- 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 guidance entitled Positive and Safe (2013) and National Institute of Clinical Excellence (NICE) Guideline 25.
- Between January and December 2016, the service reported the use of handcuffs on eight occasions and physical intervention due to attempted assault on 22 occasions.
- We were told fewer than four per cent of the company's patients were handcuffed during transport, and of those only one percent were on the decision of the company's registered mental health nurses. Staff told us they used mechanical restraint as an absolute last resort, and preferred to work on rapport with the patient and gain their trust. We saw staff communicating effectively with a patient in order to build a positive relationship prior to and during a patient transfer. Staff told us they were more likely to ask for mechanical restraint to be removed when collecting patients from NHS trusts or police stations than to use it. They told us healthcare assistants were not permitted to make the decision to use mechanical restraint without authority from a registered mental health nurse.
- Staff told us that if a patient was non-compliant, soft handcuffs would be used first in order to use the least restrictive method of mechanical restraint, where the patient had an assessment in place that identified the need for restraint. Risk assessments were completed by the sending location to identify whether handcuffs would be required for patient transfers. Staff provided examples of occasions they had used their skills and experience to enable them to transfer patients without the need for handcuffs even though they had been assessed as high risk.
- In a situation where a patient acted in such a way that they put themselves, staff or the public at serious risk of harm, or the patient acted in such a way that an offence would be committed if not stopped, the RMN could authorise the use of handcuffs without having a pre–written authorisation document. However staff told us this was a highly unlikely scenario and other, less severe, de-escalation techniques would have been successfully employed prior to this point.
- Staff told us that booking staff always discussed patients with the sending establishment to assess risk and needs. We saw staff also discussed this in person, during a handover with staff at the sending establishment to identify any potential risks. Assessments included current agitated mood or behaviour, any extreme personal views of the patient which may influence their reaction to a particular staff member and any other exacerbating factors.
- Staff told us that when patients had needed to use bathroom facilities during the transfer; they were taken to the nearest open police station regardless whether the patient was sectioned under the Mental Health Act (1983), or not. We saw guidance for staff in respect of this.

# Patient transport services (PTS)

### Staffing

- The service employed 102 staff of which three were full time; the rest were employed on a zero-hours contract basis whereby the staff members provided their shift availability and were then allocated shifts to be 'on-call' throughout the week.
- Of the total number of staff, 47 were registered mental health nurses (RMNs) and 55 were employed as health care assistants (HCAs). The three full time staff worked as HCAs and also as clinical logistics managers taking bookings for requested transfers. Four additional zero hours staff also undertook the role of clinical logistics managers.
- Many of the zero-hour contracted staff worked full-time for NHS mental health trusts, and covered patient escort shifts for the company on their rest days.
- We checked five random employment records. All employment records looked at contained up to date information, including disclosure and barring checks (DBS) and stored copies of training certificates and driving licence details. All staff records were securely stored.
- Staff told us when the company telephoned them to ask if they were available to go on a transfer, they were always asked to confirm they were fit and well before being allowed to work.
- Crews transporting patients who were sectioned under the Mental Health Act (1983) always consisted of a minimum of four staff, at least one of whom was a registered mental health nurse.
- A team of three healthcare assistants transported informal or 'voluntary' patients (patients choosing to attend a secure mental health facility rather than being sectioned under The Mental Health Act 1983).
- A minimum of two members of staff remained in the ambulance's passenger compartment at all times while a patient was on board.
- Clinical logistics managers told us that usually approximately 20 HCA staff, and between five to seven RMN staff would be on call at any one period of time. Therefore there were always enough staff to cover patient transfers booked each day.

### Response to major incidents

- Staff told us vehicles were covered with emergency breakdown cover for any vehicle failures whilst on the road. Staff provided an example of a patient transfer during which a tyre burst on the motorway. The staff described how they dealt with this incident from moving safely to the side of the road, to calling breakdown services and the office for a new ambulance whilst managing the needs of the patient. Staff told us that senior managers attended the scene immediately to offer support, and that staff also received a debrief following this incident.
- We saw there was a comprehensive policy for staff to follow regarding major incidents whilst conducting patient transfers. Vehicles also contained guidelines for staff to refer to as an aide memoire when an incident occurred.
- We saw the service had a risk assessment policy and a medical emergency standard operating procedure detailing steps to take in the event of an emergency including medical emergencies.

## Are patient transport services effective?

### Summary

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

We found the following areas of good practice:

- The service employed competent staff who were well trained and knowledgeable about how to carry out their role. Management maintained training records to ensure staff were up to date.
- Staff worked effectively with other providers in order to provide the transport service. Clinical logistics managers gained relevant information during the booking process in order to appropriately staff ambulances to support the individual patient being transferred.
- Staff conducted excellent handovers both at the sending and receiving establishments; ensuring relevant information was shared in a timely way.
- Staff showed a good understanding of how to work with a patient who did not consent to the patient transfer; referring the Mental Health Act (1983) and using de-escalation techniques.

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

- Staff were informed of updates and changes to policies and procedures via text message and were able to

attend the office to further familiarise themselves with these. However we were not assured all contracted staff were attending to familiarise themselves with the new and updated policies.

### Assessment and planning of care

- Prior to booking a transfer, clinical logistic managers clarified the nature of a patient's mental health with the booking establishment, including whether or not the patient was detained under the Mental Health Act (1983), in order to plan the staff and vehicles used appropriately.

### Evidence based practice

- We saw that the service had a complete and evidence based set of policies that staff followed in the course of their work.

### Response times and patient outcomes

- Between January and December 2016, the service carried out 1800 patient transfers.
- The company operated 24-hours a day, seven days a week. Patient transfer requests were handled via a free-phone number, which diverted to one of seven clinical logistics managers who would be on call at the time.
- Directors told us they committed to attending patients within two hours of their service being requested by NHS trusts in the West Midlands region and within two and a half hours for trusts outside the region. Directors monitored performance against this standard by reviewing patient transfer request forms, on which staff logged the times calls were received and the time the patient was collected. The directors reported they were meeting the two-hour target.

### Nutrition and Hydration

- Staff stocked ambulances with bottled water and were able to provide patients with water as required during a journey. Should the transfer be over a longer distance, such as several hours travelling time; staff provided food such as sandwiches for the patient.

### Competent staff

- All staff received training in de-escalation, management and intervention ('DMI') from the same external training team used by a local NHS mental health trust.
- The company's clinical logistics managers, who handled telephone bookings for patient transport, all had NHS mental health provider experience.
- All of the company's healthcare assistants had over ten years' experience working for NHS mental health providers.
- On starting work with the company, all staff received a structured induction. Staff told us the induction included DMI training, disclosure and barring service checks, first aid training, mental health awareness, health and safety and safeguarding vulnerable adults and safeguarding children training. We saw copies of the staff handbook which clearly outlined training expectations of staff throughout the induction procedure, with space for staff to sign to confirm they had read various policies and guidelines.
- Staff spoke positively about the mental health awareness training they had received. They told us it was delivered by a registered mental health nurse, and included immersive experiences such as trying to have a conversation while wearing a headphone playing a voice telling them to do things, to simulate the experience of living with schizophrenia.
- We spoke with several staff members including RMNs and HCAs. Staff were all trained and had good knowledge around their responsibilities. They were able to articulate the challenges presented by the Mental Health Act (1983) and the Mental Capacity Act (2007) and explain how they adhered to the law to work effectively with patients. Staff also had good knowledge around the issues presented by restraint and use of handcuff/ soft cuffs.
- We saw evidence that yearly appraisals took place with staff members in addition to directors working on the ambulances to provide non-clinical supervision. The service told us for those staff employed as RMNs; their professional registration was checked via the Nursing and Midwifery Council; and dates for revalidation were maintained as per the training matrix held for each staff member. Supervision for clinical staff was held at RMNs alternate place of employment.

### Coordination with other providers and multi-disciplinary working

- 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.

- We saw that handovers at the sending and receiving establishments were extremely good. The handover was requested by the RMN and was seen to be thorough and informative. All paperwork was checked prior to leaving to ensure this was full and correctly completed.

### Access to information

- We saw that staff were able to access information about the transferring patient easily within the sending establishment. Clinical logistic managers told us when booking patient transfers they were able to obtain relevant information with which to allocate appropriate resources.
- Staff told us that they received updates to policies and procedures, and any learning from incidents via text messages, and they were able to enter the office to read any updates when they wished. However there was no set or structured times for staff on zero hour contracts so therefore some staff may choose not to update their knowledge in this way.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good awareness of consent; and talked through how they would manage patients who were apprehensive about the journey depending upon whether they had been sectioned under the Mental Health Act or were a voluntary patient.
- Staff told us about their understanding of lawful and unlawful restraint practices and had a good understanding of how to manage patients that were resistant to being transferred.
- Staff liaised with other professionals at the sending establishment to ensure they understood how best to support the patient prior to engaging with them.
- We saw on staff training matrices that 50 staff were trained in the Mental Capacity Act.

## Are patient transport services caring?

### Summary

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

We found the following areas of good practice:

- Staff presented as respectful, caring and considerate whilst working with a patient.
- We observed staff treat a patient with dignity and respect, and took into account the wishes of the patient and the family members present.
- We saw staff involve family members and provided relevant information to enable family members to continue to support the patient.
- We saw that staff worked confidentially to gain information about the patient, therefore ensuring patient details were not overheard by other patients and hospital visitors.
- Patient experience forms were regularly completed by patients; and demonstrated that they found the staff to be helpful and kind.

### Compassionate care

- A 'patient experience questionnaire' was attached to every transfer report form, which included a box for 'patient comments'. We looked at 22 completed report forms, and saw the questionnaire had been completed on every occasion when the patient was able to do so. The comments were overwhelmingly positive about the service. The only negative comment was about discomfort on a long journey, which was caused by roadworks and was outside the company's control.
- We saw staff ask a patient to fill out a patient experience form after their journey; a staff member assisted the patient to complete this when it was identified the patient needed support however the comments were those of the patient.
- We observed staff treat a patient with kindness, respect and dignity during a patient transfer. The patient presented as agitated when they saw the number of staff who had arrived to collect them, therefore the staff made effort to work discreetly to maintain dignity. The staff also explained the purpose of the staff present so the patient could better understand.
- We observed that staff preserved the confidentiality; dignity and privacy of a patient by ensuring handovers were conducted in a private room where no other patients or relatives could overhear.

### Understanding and involvement of patients and those close to them

- We saw staff explain to a patient why and where they were being transferred to. This was done in simple terms and a friendly caring manner, which helped the patient understand.
- Staff liaised with family members if they were present to provide appropriate information about where they were

transferring a patient to so that family could follow. Should family, or a carer wish to travel on the ambulance with the patient, the service's policy was to contact a clinical logistics manager who would refer to an on call director who would conduct a risk assessment prior to making a decision.
- We observed that staff were respectful of the input of family members and listened to concerns raised. We saw that staff used this input to provide a more personalised approach to escorting the patient to and in the ambulance.

### Emotional support

- Staff told us they were proud of their record on building a rapport with patients and gaining their trust. We saw patient feedback forms describing staff as "polite, nice people" and saying staff "made me relaxed".
- We saw that staff responded sensitively when a patient reported being uncomfortable with the number of staff present; reorganising themselves to present as less threatening.
- We observed staff behave in a friendly and open manner, and making small talk to place a patient more at ease prior to and during the transfer.

## Are patient transport services responsive to people's needs?
(for example, to feedback?)

### Summary

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

We found the following areas of good practice:

- The service was available 24 hours a day, every day of the year. Clinical logistics managers took bookings via a free-phone number and organised the staff to undertake the transfer.
- Staff told us how they considered the individual needs of patients, such as the gender mix of staff for a transfer depending on a patient's risk and needs.
- The service had received an complaint, raised via the safeguarding team at a receiving establishment. The service demonstrated how they worked with the complainant and changed their practice as a result.

### Service planning and delivery to meet the needs of local people

- The service offered a UK wide service to accommodate the needs of those patients who required transfers to mental health units in any area. The service had service level agreements in place with a mental health foundation trust and with individual mental health units to provide patient transfer.
- The service planned its delivery based upon tenders and service level agreements following commissioning through clinical commissioning groups, owners of private secure units, and through acute trusts. Directors told us the service's ongoing performance was monitored through audits and regular meetings with commissioners and those holding a service level agreement.

### Meeting people's individual needs

- Staff told us the service was tailored to each patient's individual needs and risk levels.
- Patients were able to carry personal belongings with them; these were secured stored in the boot of the ambulance.
- When accepting a booking, the clinical logistic managers considered the gender mix of staff required for a transfer. For example, staff told us if a child was being transported, a minimum of two females 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, including Romanian and Spanish; therefore it was usually possible to book a staff member who spoke the same language. Should this not be the case, staff told us that clinical logistics managers would request the sending and receiving establishments have interpreters who could communicate the purpose of the transfer in the patients' own language. This included sign language and Makaton interpreters.
- Staff told us that the service employed nurses 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.
- One of the company's ambulances had been adapted to allow it to convey patients who needed to travel in a wheelchair. The service did not currently have facilities to transport bariatric patients.

# Patient transport services (PTS)

### Access and flow

- Directors told us the company had carried out 3,500 patient transfers between June 2014 and December 2016. Of these, 1800 were carries out throughout 2016.
- The service was available 24-hours a day, seven days a week across the year. Clinical logistic managers told us that enough staff were placed on the on-call rota to enable every job that was booked throughout a 24 hour period to be undertaken. Staff told us all requested bookings were accepted. Staff sent their availability in to the company each week by text message. A manager compiled the messages into availability records, and provided these to each clinical logistics manager to use when responding to transfer bookings.
- Staff told us that most bookings were made on the day of transfer; however, some could be made up to a week in advance.

### Learning from complaints and concerns

- The service had received a complaint via a safeguarding lead at a hospital regarding use of handcuffs on a patient. The patient's mother, who reported this as a safeguarding concern, raised the complaint. The service explained how they dealt with this complaint, and how practice was changed as a result; for example allowing the patient's family to travel on board should the patient require the service again.

## Are patient transport services well-led?

### Summary

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

We found the following areas of good practice:

- The service was well-led with staff describing the leadership as open, approachable and caring.
- Senior management were trained to work as Health Care Assistants (HCAs) therefore could undertake patient transfers and observe and support staff.
- The provider vision was "exceeding expectations, setting new standards". We saw that the staff adhered to high standards of care and quality during patient interaction and transfer demonstrating a good understanding and application of the service vision.
- The service had a full range of up to date and appropriate policies for staff to follow.
- We saw, and staff told us, that staff were well supported and able to contact the management team at any time of the day or night if they had a concern.

### Leadership / culture of service related to this core service

- All of the company's directors, including those who had not come from a healthcare background, had trained as healthcare assistants and went out on transfer cases at least once a month. This allowed them to understand the job done by their staff and to see transfers from staff members' point of view, and provided resilience for the service. Staff spoke positively about this practice and told us they liked having the directors out working with them. Staff told us that the directors had attended the scene of incidents with vehicles to provide extra support to staff.
- Directors confirmed that all zero hours staff were asked to sign the European Union (EU) working times regulation exemption upon induction, therefore legally allowing those staff to work an average of over 48 hours a week. Managers told us they monitored staff working hours to ensure that staff were not working excessive hours per week in both this service and any other employment.
- Staff described the company directors and managers as approachable, open, helpful and supportive, 24 hours a day, seven days a week. They told us the directors would not ask staff to do anything they were not willing to do themselves.
- Staff told us they were proud of the team, and of the way everyone from directors down got along with each other. They said they like the company's professionalism, and liked helping their patients.

### Vision and strategy for this this core service

- The company's vision was 'Exceeding expectations, setting new standards'. There were three core values of 'caring, professional and reliable', which were outlined in the staff handbook provided to each new starter.
- We saw staff displaying these values consistently during the inspection.

### Governance, risk management and quality measurement

- We saw three sets of minutes from management meetings between September to November 2016. Standing agenda items included health and safety, staffing, staff induction and training and operational

updates. We saw that within staffing discussions, management had recognised an in-balance in gender equality within recruitment, reporting on an increased number of female staff in September 2016.

- We saw three sets of minutes from health and safety and risk meetings, between July 2016 to January 2017.We saw that incidents and risks were discussed and subsequent actions were set and taken; such as changes to practice and updating of policies.
- The service provided us with their risk register; however rather than being a live document addressing current risks, this was part of the service's risk policy written in 2014 and was a static list of areas in which risk may be found; with reference to relevant actions and policies to refer to.
- The electronic monitoring device fitted to each of the company's ambulances provided managers with a daily report on the manner in which they had been driven. Monitoring included feedback on acceleration, braking and cornering force, and flagged up when blue lights were used. Staff also asked patients to complete a survey following the transfer, therefore providing an alternative way to highlight any concerns, including the comfort of the journey. In order to further measure the quality of driving, managers directly observed staff working during transfers. We saw forms demonstrating managers provided staff with feedback following the observation.
- The company's vehicle insurance required that all staff who drove for them had to be over 25 years of age, have fewer than six points on their licence and have held a full licence for over two years. The company carried out checks on each staff member's driving licence via the gov.uk website. Staff whose driving licence had points were rechecked more frequently than those who did not, to ensure they had not exceeded the six-point maximum.

### Public and staff engagement

- Staff told us that the management team had set up a group message system which staff could access through applications on their smart phones. This had been done to support staff outside of work. Staff confirmed that management answered any questions or queries quickly when they had been posted on the system.
- Staff and directors were proud of the company's charity work. They told us the company had sponsored a large event for a national children's charity, and that the company had funded the building of a school and supplied an ambulance to a community in Nepal.
- After each transfer, staff asked the patient to complete a patient experience survey in order to gain feedback about the service. We saw examples of completed service highlighting that patients found the service appropriate for their needs.

# Outstanding practice and areas for improvement

## Outstanding practice

- We saw excellent handovers between the registered mental health nurse and both the sending and receiving establishments. These were detailed, informative and enabled a thorough overview of the patient to be gained prior to and post transfer.
- The service had a supportive and open culture, with a strong management overview.

## Areas for improvement

### Action the hospital SHOULD take to improve

- The registered provider should ensure that all staff are fully updated with new or changed policies, procedures and guidelines as soon as feasible after any updates and that this is routinely monitored.
- The registered provider should consider the requirement for a live risk register and associated action plans.
- The registered provider should consider creating a clearer audit trail when completing incident forms following the use of handcuffs; ensuring forms relating to the use of mechanical restraint are referenced.