Delta Medical Services Limited

Quality Report

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Date of inspection visit: 13 August 2019
Date of publication: 14/05/2020

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

Ratings

Overall rating for this location	**Good**
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Not sufficient evidence to rate**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

Delta Medical Services is operated by Delta Medical Services Limited. The service operates a patient transport service and provides services to patients travelling between their homes, places of safety, acute and mental health hospitals. The service primarily serves the communities of the Kent and Essex. It opened in 2014.

The service provides services to an NHS provider of Mental Health Services in a neighbouring county. This is a formal contract to provide inter hospital transfers for patients with a mental health illness to an acute setting.

The regulated activities provided by this service are:

- Patient Transport Services

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 13 August 2019.

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

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

The service had not been rated before. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept mostly good care records. The service managed safety incidents and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and assessed patients' food and drink requirements where necessary. The service met agreed response times. Managers monitored some elements of the service and made sure staff were competent. Staff worked well together for the benefit of patients.
- We saw showed staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They felt respected, supported and valued and were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and staff were committed to improving services.

However;

- The service did not always follow best practice when recording the use of medical gases.
- Actions allocated during team meetings were not followed up or recorded as having been completed.

Following this inspection, we told the provider that it that it should make improvements, even though a regulation had not been breached, to help the service improve.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good	Delta Medical Services is operated by Delta Medical Services Limited. The service provides a patient transport service for people in the Kent and Essex areas, including those with mental health needs and children. We rated the service as good because: The service had enough staff with training in key skills and they managed infection risk well. Staff assessed and managed risks to patients. Staff provided good care and treatment. Managers monitored elements of the service and made sure staff were competent. Written feedback showed staff treated patients with compassion and kindness and respected their privacy. The service met the needs of local people who could access it when they needed it and staff took account of their individual needs. Leaders ran services well. Staff felt respected, supported and valued and were focused on the needs of patients.

Summary of findings

Contents

Good

Delta Medical Services

Services we looked at:
Patient transport services

Summary of this inspection

Background to Delta Medical Services Limited

Delta Medical Services provides a patient transport service to patients travelling between their homes, places of safety, acute and mental health hospitals. Delta Medical Services opened in 2014. It is an independent ambulance service in Maidstone, Kent. The service primarily serves the communities of the Kent and Essex.

The service provides a service to an NHS provider of mental health services in a neighbouring county. This is a formal contract to provide inter hospital transfers for patients with a mental health illness.

The service has had a registered manager since 14 November 2014.

This was the second inspection under the comprehensive methodology that had been carried out. We issued the service with requirement notices following the previous inspection in February 2018. The requirements have in large part been met although there were still some gaps in recording on patient report forms.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Delta Medical Services Limited

The service is registered to provide the following regulated activities:

- Patient Transport Services

During the inspection, we visited the service's headquarters. We spoke with four staff including; patient transport drivers and management. We were unable to speak with any patients. During our inspection, we reviewed eight sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in February 2018.

In the 12 month period prior to the inspection, Delta Medical Services made 1063 patient transport journeys. There were 162 journeys for mental health patients travelling to an appointment at the acute hospital. There were 634 journeys carried out for mental health patients travelling from one hospital to another. There were 67 journeys undertaken for patients travelling from home to an outpatient appointment at the acute hospital or form hospital to respite care. There were 200 journeys for high dependency patients being transported form hospital to hospital.

The service had five vehicles for mental health patients, three were small secure vehicles and two were large secure vehicles. For acute patients there were a total of seven vehicles. Three of these were high dependency ambulances, one patient transport vehicle, one wheelchair vehicle and two response cars.

Track record on safety

There were no never events

No serious injuries

One formal complaint in the reporting period.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Not rated	Good	Requires improvement	Good
Overall	Good	Good	Not rated	Good	Requires improvement	Good

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Not sufficient evidence to rate
Responsive	Good
Well-led	Requires improvement

Are patient transport services safe?

Good

The service had not been rated before. We rated the safe as **good.**

Mandatory training

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

The service had a mandatory training programme that staff completed before they started to work for the service. Some training was provided face to face and some was e-learning. Some elements of the training were assessed by an external provider.

The training included but was not limited to: health and safety, safeguarding, mental capacity act, use of restraint, first aid at work and other modules relevant for the work the crew are undertaking such as use of medical gases and cardiac recognition.

In the personnel files we reviewed, we saw all staff had completed their mandatory training and had certificates to demonstrate completion for some of the modules.

Safeguarding

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

The service had a 'safeguarding vulnerable adults and younger people' policy. This was one document, with separate sections for adults and children. This was comprehensive, version controlled and in date. There was also a flow chart which guided crew through the procedure for reporting concerns.

Safeguarding training was given as part of the induction process. Staff were trained to level two safeguarding vulnerable adults and level three in safeguarding children and had a designated safeguarding lead who was trained to level three in line with national guidance.

During the inspection we saw an example where the crew appropriately raised a safeguarding concern about a patient to protect them and other patients. We saw they had followed their own policy and notified the relevant authorities, including the Care Quality Commission.

Cleanliness, infection control and hygiene

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

The service had an infection prevention and control policy which reflected national guidance, was version controlled and in date.

At the end of each shift staff were required to clean the vehicles they had been using. There was a checklist kept on each vehicle and a book that explained how the cleaning should be carried out. Vehicle cleaning report forms we reviewed were completed, audited and stored in the individual vehicle folders which were kept on the main office. We saw a total of six of these and confirmed that they had been completed correctly.

The service had a formal contract with a company to deep clean their vehicles every six weeks. A deep clean of one

vehicle took four hours to complete. Swabs to test for the presence of bacteria (germs) were taken before and after the deep clean to monitor effectiveness. Areas swabbed were varied from vehicle to vehicle but generally covered areas such as door handles, seats, heater grilles, steering wheels, grab handles and the insides of cupboards. We saw a log demonstrating deep cleaning had taken place and the results of pre and post swabbing for five vehicles.

We saw that there was a Control of Substances Hazardous to Health (CoSHH) cupboard in the area where the vehicles were prepared for use, which was locked. Mops and buckets were colour coded, so staff knew which should be used for which area and what purpose. There were spill kits available to manage any accidental spillages of CoSHH products.

Staff were responsible for cleaning their uniform at home. Uniform that is damaged or soiled during a shift was changed from the service's supplies. Staff were asked to wear a shirt under the uniform, so if any staff member damaged or got there uniform dirty they could remove it and get a replacement.

Personal protective equipment such as masks aprons and gloves were available for crew to use.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service was located on an industrial estate on the outskirts of Maidstone. There was space in front of the main building for their vehicles although it was a little congested. There was a main entrance door that led upstairs to the office where bookings were taken, a meeting room and a mezzanine that looked down on the area where vehicles were cleaned and prepared for use. The lower level of the building where the vehicles were cleaned was in the process of being re-painted at the time of our inspection. However, the process they were using allowed for the area to still be used to clean and stock the vehicles. The area was well ordered with colour coded mops, locked cupboards containing cleaning products as well as stock and linen cupboards. A large room was available to be used for training, but also stored equipment that was not being used or was due for a service.

Any faulty equipment was removed from service and kept in an area in the store room and clearly marked that it was out of service. Staff would then contact the clinical engineering service who would either send out an engineer or ask to send the faulty item to them to have the problem fixed.If the problem could not be fixed, the item would be sold to clinical engineering and the service looked at getting a replacement.

One member of staff had the responsibility to ensure all vehicles were stocked sufficiently for the crews to complete their work. They not only ensured that there was enough stock but also that all stock was in date and fit to be used. We inspected four vehicles and found that all equipment was in date and stored correctly.

Staff could contact the main location, whilst they were out on a job. The service had introduced radios that crews could use when on duty. These were not available on all ambulances at the time of the inspection and crew used mobile phones to stay in contact with the head office during a shift. The radios had a panic button on them which would alert the head office, via a computer. They could then trace where that person was and summon help if required.

All stock was tidy, stored in clean containers and was wrapped in sealed packaging and in date. The store cupboard that contained the stock for the ambulances was locked with a key code lock which only the managers and the member of staff responsible for maintaining stock had access to.

Spare keys to the vehicles were kept securely. They were in a lockable cupboard in the main office and all the keys to the different areas of the building were kept in a combination safe.

Spare linen was stored on the premises and was taken from the hospital commissioning the work. It was then be returned to the hospital following use.

The service was obliged to provide ambulances for their NHS contract that were under five years old. All vehicles used for this work met that requirement and another two vehicles had been ordered at the time of the inspection.

All Delta Medical vehicles were maintained by an external company. We saw a spreadsheet that had details of all the vehicles. This showed the details of when the tax and MOT were due. The administrative staff would then create alerts

on their email system to notify them when these needed renewing. The original documents, including insurance documents, vehicle log books and service records were kept on individual vehicle files in the main office.

Each vehicle carried a copy of the insurance certificate and maintenance records.

We looked in depth at four vehicles. All equipment on them was in date. They were visibly clean, and most defects had been logged. All the vehicle controls were in working order such as windscreen wipers, indicators, reversing lights and reversing warning sounds. An oil warning light was lit on one vehicle and had been reported twice but had not been dealt with. We saw that there were two vehicles that had one worn tyre on each of them. In one case this had been noted by the crew but had not been replaced five days later. This was raised with the service at the time of inspection. The manager undertook to get the tyres replaced the next day.

Clinical waste was managed in line with guidance. It was stored in a small yellow bin, clearly marked as being for clinical waste. When this was full the waste was transferred into a larger yellow bin at the front of the premises for collection. The large bin outside was locked when not in use.

Sharps were also kept in a bin clearly marked for that use. When these were full they were kept in a locked cupboard until they were collected, when they were handed directly to the collection company.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Every booking made had a risk assessment completed even if the patient was someone that they transferred frequently. We saw in the records we reviewed that these risk assessments were taking place and contained a lot of detail about the patient, their condition and potential difficulties including if they were known to self-harm or attempt to self-harm. This ensured that the right crew with the right equipment would be sent to transport the patient.

We saw that the patient records recorded any information about the risks a patient posed that was not known at the time of booking. This meant that if the service were to transfer that patient again, they would have a fuller picture of the behaviours and risks they could encounter.

The booking form records we reviewed were completed thoroughly with all known risks clearly identified. We reviewed six booking forms, chosen at random. These were in relation to the mental health patients. In all cases, risks were identified including whether the patient was high risk of suicide or absconding. The service relied on the information provided by the mental health provider to give them full information about the patient they were transporting. Run sheets, which documented what happened during the journey were matched with the booking forms to review whether the information initially provided accorded with what happened during the journey.

Crews were allocated to patient journeys depending on the needs of the patient and the skills and training of the crew to look after that patient.

The service had a do not attempt cardio pulmonary resuscitation (DNACPR) policy. This was version controlled and in date. The policy explained that at the time of booking, the person booking would be asked if a patient had a DNACPR order. Staff would only intervene in an emergency if there was no DNACPR in place.

The service had a deteriorating patient protocol which guided staff to pull over where safe and dial 999 to await an emergency ambulance. If they were near to a hospital they had collected from or near where they were going to, they would go back or continue as necessary. They did not do anything that was beyond their scope of practice.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers gave bank staff a full induction.

The service employed five permanent staff, predominantly in office based roles. There were six emergency care assistants and three ambulance technicians employed by the service on a non- contracted basis. There were also a further 20 bank staff in total including paramedics and ambulance technicians. While these were primarily used for event work, they could also be used for specialist transfers.

Good

Patient transport services

All staff received an induction at the start of their employment covering a range of topics including vehicle cleaning and maintenance, incident reporting, patient records, driving assessment where appropriate. Staff records we reviewed showed that this had happened.

The service had staff on standby for a whole week. This meant that if anyone called in sick, they could get in contact with the standby staff to get them to attend for a shift. In some cases, one of the office staff, who were also trained could fulfil a shift. When staff were on annual leave, other staff could be moved around to ensure all shifts were covered and they could also call in any one who was scheduled to be on standby. There had been no incidents of shifts not being filled.

Records

Staff kept records of patients' care and treatment although these were not always completed in full. They were easily available to all staff providing care and were securely stored.

Patient records were not always complete. We reviewed eight sets of records, randomly selected. Of the records that we reviewed, the majority lacked full details of the times of collection and drop off. Some lacked details of what was wrong with the patient. In one record there was a lack of detail for a patient receiving cardiac monitoring, only stating that a patient was 'tachy' and what could not be ruled out. However, some records we reviewed were fully completed with all details of the patient captured and comprehensive notes of the handover of the patient.

For acute patients, records were placed in a large envelope by the hospital. They were then sealed by the ward and kept with the patient when transporting them. For out of area mental health patients, the patient records were sealed in an envelope and were kept in the front of the vehicle away from the patient. They were then handed over to the nursing team at the destination. All the journeys undertaken locally there was no paperwork and records were transferred electronically.

We saw original paper records were kept in secure, lockable filing cabinets.

Medicines

The service did not always follow best practice when recording the use of medical gases, they were stored in line with guidance.

There were no medicines used for patient transport journeys except for oxygen. Use of oxygen was noted in the records of patients. However, the volume used, and rate of delivery was not always entered into the patient record.

Other medical gases were stored in line with national requirements. The service had stocks of other medical gases on the premises which were used for their event work. We saw that there were four of these stored in a locked cage. All were in date. Empty and full cylinders were stored separately.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and partner organisations.

The service had an incident reporting policy and procedure, which included the duty of candour. This was version controlled and in date. The duty of candour is a regulatory duty that 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 them with reasonable support.

All incidents are recorded on delta medical services Incident Reporting Form and are returned to base. One of the managers reviewed the incident and where possible deals with it. If the incident needs to be reported further, then a copy is sent to the other provider and / or local authority.

We reviewed two recent incident reports. These were well completed. In both cases, full details of the incident, the investigation and the actions taken were recorded.

If crew felt that the information provided by the commissioning service was insufficient or incorrect and there became a need for physical intervention, this was noted on the incident report forms on the vehicle and fed back to the provider.

Good

Patient transport services

Learning from incidents was shared at group meetings or if there was an immediate need for a message it was sent to crew, via a mobile group messaging application. This could be tracked to ensure that all staff had read the message.

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

Good

The service had not been rated before. We rated effective as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Policies we reviewed reflected guidance and best practice Staff protected the rights of patients' subject to the Mental Health Act 1983.

The service used the National Institute of Health and Care Excellence (NICE) guidance, NG10 (Violence and aggression: short-term management in mental health, health and community settings) and the The Joint Royal Colleges Ambulance Liaison Committee guidelines for ambulance staff.

At the time of the inspection we were told that there were no audits of the patient report forms although it was something the service was looking to implement. Following inspection, we saw evidence that the service had started to audit patient report forms.

Staff had received training around caring for patients that were subject to the Mental Health Act, 2005. A review of booking records showed that the patient's mental health was a primary consideration and detail of the patient's condition was clearly explained.

Nutrition and hydration

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

In general, the hospital that the crew were collecting the patient from provided enough food for the patient before the journey. If they were going on a long journey staff planned and decided on a safe place to stop for food. All vehicles carried bottles of water for use by patients when necessary.

Pain relief

Staff were able to recognise if patients were in pain.

Patients were generally only taken on relatively short journeys, so pain management was predominantly dealt with by the commissioning service. However, crews had access to charts they could use to assess pain as well as pictures that could help those that used non-verbal communication.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients.

All bookings taken in by Delta Medical Services were monitored using the time the job was taken, the time the crew was dispatched, the time the crew arrived at, and left the location, the time the crew got to the drop off destination, the time the crew handed the patient over and the time the crew had left, cleaned the vehicle and were ready for the next patient. This information was kept on a spread sheet to analyse everything and provided to those commissioning the work when required.

The service aimed to give a 60-minute response time for any mental health patient transfers and a 90-minute response for any cardiac patient transfers unless they were pre-booked. However due to unforeseen circumstances like traffic or previous transfers overrunning this was not always possible to guarantee. If there were delays to running times, the control room would contact the service that had made the booking. In the month prior to the inspection the service was completing 77% of journeys within the 60 minutes arrival time.

The service used a satellite navigation provider to monitor the vehicles times to the destination, collection times and drop off times. All the information relating to this was logged on a web based system.

The service did not carry out any formal audits of the response times although these were reviewed by the operations manager who in turn discussed any issues with

the commissioners and contract managers for whom they provided a service, every month. They did not benchmark against other organisations but did review CQC reports into other providers.

Patient outcomes

To monitor the performance of the service, staff would record the time the job was taken, the time job was issued to a crew, the time the staff got to the pickup location, the time the hand over took, the time they left to go to the drop off location, the time they arrived at the drop off location, the time they handed over the patient and the time the crew completed the job and cleaned the vehicle. This information was then transferred from the hard copy run sheets to the computer system where the information would be reviewed.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Approximately half of the crew the service employed were qualified to drive the vehicles used for patient transport journeys. We saw a driving assessment document which staff that wanted to be drivers completed. The operations manager was a blue light trained driver and had received a recognised qualification to do so. This person carried out the assessments of staff driving competence. There was a system that enabled staff to report back on the driving of their colleagues. We saw records that demonstrated who was able to drive the vehicles in staffing records.

We reviewed four staff files. Each one contained a new starter checklist which covered a range of areas such as checks on the employees driving license, disclosure and barring service checks, working time directive waiver, uniform issue, application forms, references, first aid certificates, handcuff and restraint training, a drug and alcohol testing consent form and mandatory training certificates. All files we saw had all the documents on them, they were valid and in date.

Staff appraisals were carried out on a six monthly basis after the staff member had been through their probationary period. The first took place after three month months service and six months thereafter. This included documentation on how the staff member was performing, if they would like to develop themselves and how they could do that. We saw that staff had had or were scheduled to have an appraisal.

Multidisciplinary working

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

When the service took bookings over the phone or via secure email from those commissioning work, those taking he bookings had to establish if the patient required any special treatment or if the patient had a DNACPR in place or any special notes. This meant that the information could be passed onto the crew. The booking agent would also establish the exact location of the patient to assist in deciding what type of equipment was needed to move the patient.

The service had an ongoing contact to provide a service to an NHS mental health trust. They had built strong working relationships with the clinical staff to ensure that patients received person centred care. The service saw some patients regularly and had built relationships with the care providers that ensured that they were got a full picture of the patient they were transporting.

Health promotion

Although staff had relatively little opportunity to impact a patient's health other than for the journey they were making, crews worked to ensure that patients were looked after during the trip and encouraged to make decisions on their own health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The service had a Mental Capacity Act and Deprivation of Liberty Safeguarding policy. The policy was comprehensive, fully version controlled and in date.

Good

Patient transport services

Staff had good knowledge of the Mental Capacity Act, 2005, because of the patient group that the service dealt with. Staff showed a good understanding of the Act and how to apply it, including making best interest decisions.

We saw from records that patients were asked for their consent before any action was taken. This was often incorporated into the risk assessment completed.

Are patient transport services caring?

Not sufficient evidence to rate

The service had not been rated previously. There was insufficient evidence to rate caring.

We did not observe any direct patient interactions as the crew that were operational that day had already left to carry out their work in a neighbouring county. The information contained here was obtained from patient feedback cards we saw during the inspection.

Compassionate care

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

Records showed that the patient was handed over to care staff receiving them and it was explained who the patient was, and why they were there.

The service told us they cared for patients that could present in an agitated or distressed state. They ensured that the patient was comfortable and settled before starting the journey. This could involve sitting with the patient or getting assistance from those caring for the patient at their place of care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

We saw feedback where a relative of a patient had travelled with a patient on a journey. There were many positive comments. In one we saw that a relative stated: "Lovely staff and good transport, felt very well looked after, the crew were polite, explained what each of them was doing and why. The service was outstanding."

Understanding and involvement of patients and those close to them

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

Patient feedback forms and incident report form showed that staff understood the needs of their patients. We saw examples where patients had become distressed during journeys and had been "talked around" by the crew that were caring for them. We also saw examples where crew had interacted with the patient's primary care giver to ensure that their response to a situation was correct and for guidance.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

The service had not been rated before. We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people It also worked with others in the wider system and local organisations to provide care.

The service provided patient transport to an NHS provider of mental health services in a neighbouring county. This was a formal contract to provided inter hospital transfers for patients with a mental health illness to an acute setting. This predominantly involved taking patients to and from outpatient appointments but occasionally it involved taking patients to an acute service for an inpatient stay and then returning them to the mental health service. They also provided a service for patients with mental health illness to get form their home to a place of safety.

The service provided all staff with e-learning that involved Mental health awareness, Deprivation of Liberty Safeguards, safeguarding children and adults, as well as a two day course, from an external provider that included mental health awareness training and conflict resolution.

Good

Patient transport services

A service to transfer patients from a private mental health provider to a patient's home was also offered on an infrequent basis. This enabled the local authority to provide respite care for the patient.

The service also carried out ad-hoc work from high dependency patients travelling from the local acute NHS trust to specialist hospitals. These patients were predominantly requiring operations such as having pacemakers fitted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

If staff were moving a patient that regularly used the service, they would try to send the same crew to transport them. However, that was not always possible. There were a small number of patients the service did transport on a regular basis. These patients, where possible had the same staff go to them to give them consistency. Where they could not send the same crew, they would try to send at least one of the usual crew.

Ambulances contained a flip chart book which had pictures, sign language and multi lingual phrases to assist those patients that did not speak English as a first language, had a hearing impairment or relied on non-verbal communication.

Staff could access a telephone interpreting service but, at the time of the inspection had never had the need to use it. One of the questions asked at the time of booking and recorded on the booking sheet was whether the patient required an interpreter.

Information provided at the time of booking by the provider was key to knowing if the patient required to be restrained, if they were agitated, violent or aggressive. We saw a letter from the NHS mental health care provider that demonstrated the service's staff were authorised to restrain patients where necessary.

The service had full bariatric capability where they could use specialist equipment to get patients and off the vehicles used for patient transport.

The service could offer a covert vehicle for high risk patients or patients that did not want to get into a vehicle that was clearly identifiable as an ambulance.

Access and flow

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

Services that required a patient to be moved could arrange this by calling Delta Medical's contact number. Full details of the patient were obtained, and the journey planned. Depending on the patient and the length of the appointment, the service was able to wait to bring the patient back but ordinarily, the return trip would also need to be booked. When reviewing run sheet records we saw that journeys usually ran on time, but traffic would often be the reason crews were delayed in travelling to destinations in a neighbouring county. Those using the service were kept informed by the control room if there was any delay to the crew attending them.

A service was offered 24 hours a day, seven days a week. Operational staff were in the office between 8am and 6pm. Out of hours, any requests for bookings were diverted to one of the two senior members of staff. During the evening one crew would be on call between 6pm and 11pm and one further crew would be on call between 6pm and 6am the following day.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

There were A4 sheets of paper in the back of the vehicle which had the service's compliments and complaints information on it which included telephone number, email address, postal address, and CQC details. These were also kept in the crew folder that can be handed to patients or other staff.

We saw a comprehensive compliments and complaints policy which detailed how complaints were handled, who had responsibility for investigating complaints and how complaints could be made.

The service received very few complaints and we were only able to review one that had been made near to the time of the inspection. We saw that an apology had been given

along with an explanation of what had happened and why. Assurances were given to the complainant that the issue would be raised with those staff concerned. While the complaint was handled well, we could not see that the learning had been shared with anyone outside those that were directly involved with the incident.

Complaint responses were signed off by a member of the office staff but could be escalated to one of the senior managers if they were more serious. If they related to patient safety, they would be handled by the operations manager.

Are patient transport services well-led?

Requires improvement

The service had not been rated previously. We rated well led as **requires improvement.**

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.

The service was led by a managing director, who was the registered manager, and an operations manager who was directly responsible for the day to day running of the service.

Managers were available to crew throughout their operational duties and when these had been completed. Staff we spoke with told us that leaders were approachable, supportive and available when needed.

Vision and strategy

The service had a vision. Leaders were considering how they monitored progress toward this vision.

The service vision was 'supporting recovery through safer transport'. They planned to achieve this through recruiting staff that were right for the organisation and being recognised by commissioners and providers for the work they did. Staff were aware of the service vision and it was printed on all internal documentation.

Managers were realistic in their plans for service development. Managers in the service were keen to continue working in the specialist area of transporting mental health patients from their place of care to the acute hospitals and back again. They accepted that recruitment was difficult so did not want to over commit and fail to deliver expectations. They wanted to expand into other geographical areas in the same sector but felt they would need to bring in a sales / business manager to promote the business before they could expand.

If they were to expand the service, managers said they would need to move premises as they were at or very close to capacity where they were. In this scenario they were looking at a site very close by that was vacant and could accommodate more of their vehicles.

Culture

The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with described the culture as respectful and that managers had an open door. During recruitment they were keen to only employ those that were right for the business.

Managers told us that they were proud of the honesty and integrity shown by staff. They were proud of the service they provided to their mental health patients. They were also proud of how far they had come since their last inspection.

Staff told us there was an open and honest culture and they felt that they were listened to and could turn to senior management with concerns they might have.

The duty of candour was covered during the induction although it was not described in those terms. They explained how they asked staff to be open, honest and transparent and how they must notify patients if things go wrong. We saw that the service had a comprehensive duty of candour policy which was version controlled and in date.

Governance

Staff had regular opportunities to meet, discuss and learn from the performance of the service.

We reviewed five sets of all staff meeting minutes. There was a mixture of office staff and operational crew in attendance at each meeting however, due to operational demands, not all staff could attend all meetings.

All issues raised were recorded in bullet points and someone was assigned tasks as a result. However, we

could not see any evidence that the action points were followed up in future meetings. Meetings covered a variety of issues such as staffing, feedback from incidents, risk and any other key message that needed to be relayed to crew.

When collecting data, the service would use information about incidents, response times, customer feedback and vehicle defect forms. This information was logged and converted into charts and graphs to give a visual interpretation of areas that needed to be improved.

We saw the service carried out regular auditing of vehicle cleaning reports, however, they did not regularly audit patient record forms, to gain assurance these were being completed fully or identifying any areas for learning.

Management of risks, issues and performance

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact.

We reviewed the services risk register which reflected staff perceptions of the service's risks. The biggest risks they identified related to patients being violent and aggressive, maintaining patient confidentiality and care of patient's personal belongings. The risk register was reviewed regularly and updated when risks changed. Operational risks could be raised by staff as and when they occurred.

We saw that the service had a comprehensive business continuity plan that included processes to follow in the event of fire or power outages as well as difficulties with vehicles and weather. This was version controlled and in date.

Information management

The service collected data but did not use it to analyse the performance of the service

Any documents that were created on any of the service computers was stored on a secure server that could not be accessed without the correct credentials. Once a document was on the server it was then encrypted to ensure it was safe. The information was then backed up off site via secure sockets layer (SSL) connection to another secure server in case of any fire, flood or other acts towards the building.

Any emails from patients or commissioning bodies that contained patient identifiable data were sent to an NHS email to ensure that they were kept secure and safe.

The information collected through the IT systems was used to plan staffing requirements and assess what service they could deliver and when.

Although the service collected data, they did not analyse it and use it to make improvements to their service.

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. Managers held regular whole team meetings and ensured there were effective means of communicating and decisions that were made.

Crew and other staff tried hard to get feedback from their patients however, they were unable to get much feedback.

However, we saw 18 examples of where patients and providers had responded. The comments made were very positive. Patients were grateful for the care provided to them.

The service leaders engaged with staff through the all team meeting. They also routinely checked on staff when they returned from a shift handover or start a shift. They had installed a suggestion box in the area where the ambulances were prepared. However, this had not been used as staff told us that they went directly to the managers if they had ideas for improvement.

The service had regular meetings with the organisations that commissioned their work to ensure that the service provided was meeting the needs of the patients they were transporting and the needs of the commissioning organisation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The service should accurately record the use of medical gases in patient records.

The service should consider they follow up any actions assigned to a member of staff during staffing meetings and record their completion.