Secure Care UK Limited

Secure Care UK Headquarters

Quality Report

Unit 1, Cubitt Way, St. Leonards-on-sea,
East Sussex, TN38 9SU
Tel: 0203 5985938
Website: www.securecareuk.co.uk

Date of inspection visit: 2 April to 3 April 2019
Date of publication: 26/06/2019

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

Ratings

Overall rating for this ambulance location	Requires improvement 
Patient transport services (PTS)	**Requires improvement** 

Summary of findings

Letter from the Chief Inspector of Hospitals

Secure Care UK Headquarters is run by Secure Care UK Limited. The service provides patient transport for adults and children with mental health disorders, as well as the transport and supervision of people in section 136 suites whilst awaiting mental health assessment. A 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act by the police following concerns that they are suffering from a mental disorder.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 2 April 2019, along with a short-announced visit to the service on 3 April 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.

We rated it as **Requires improvement** overall.

Although the service had improved since our last inspection in February 2018, we found two areas where the service still did not meet legal requirements, and therefore we could not rate this above requires improvement.

We found the following issues that the service provider needs to improve:

- At the last inspection there was poor staff compliance with the completion of vehicle cleaning. The systems and processes to ensure cleanliness of vehicles were still not adequate.
- We still had concerns about two governance processes; updating of policies and the management of incidents, which were highlighted at the last inspection. Although, the service had a stronger governance structure, this was only recently implemented and needed embedding.
- At the last inspection, the service had not met its requirement to apply the duty of candour for incidents. At this inspection, we did not see records which showed the service had or had not discharged its responsibility to the duty of candour.
- At the last inspection, the service had not implemented changes to improve patient assessment and record keeping. The documentation of restraint was still a serious concern at this inspection and there was no consideration for a patient's mental capacity or their deprivation of liberty safeguards. The clinical risk assessment at booking stage was not always complete which might lead to an inappropriate management plan for the patient.
- There was poor compliance to mandatory training with some compliance rates as low as 17%. None of the mandatory training compliance rates met the provider's target of 80%.
- Management and storage of equipment within vehicles was poor. There was no standardised equipment checklist which meant the equipment carried on each vehicle varied.
- Policies did not always reflect the service provided and contained unclear information. They did not always reflect national guidance or best practice. No input from healthcare professionals was sought to develop the provider's clinical policies.

However, we found the following areas of good practice:

- Since the last inspection, there was improved staff compliance to completing vehicle inspection checklists which ensured the vehicle was safe to use.
- Staff awareness of the interpretation service had improved since the last inspection.

Summary of findings

- The service had improved its recruitment processes and checks since the last inspection. This ensured that persons employed were fit to carry out their jobs.
- All staff received a comprehensive three staged induction which included face to face training, online training and shadowing of shifts.
- All staff knew how to escalate safeguarding concerns and more questions were asked at the booking stage for patients under 18 years old.
- There was an overarching focus on communication and therapeutic intervention with patients rather than restricting them or limiting their independence.
- Staff worked well as a team and relationships with external stakeholders showed effective multidisciplinary working.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notice(s) that affected its patient transport service. Details are at the end of the report.

Nigel Acheson

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Requires improvement 	Secure Care UK specialised in the transport of adults, children and young people with mental health disorders. It also watched patients in section 136 suites. The service ran from a single location in Sussex but had hub stations across the country. Although the service had improved since our last inspection, we found two areas where the service still did not meet standards, so we could not rate this above requires improvement.

Requires improvement

Secure Care UK Headquarters

Detailed findings

Services we looked at
Patient transport services (PTS

Detailed findings

Contents

Background to Secure Care UK Headquarters

Secure Care UK Headquarters is run by Secure Care UK Limited. The service opened in 2013 but it has changed its legal entity since then from sole trader to organisation.

It is an independent ambulance provider and has one location registered with CQC in East Sussex. However, the provider has hub stations in Birmingham, Leeds, Lincoln and Hampshire.

The service provides patient transport to three NHS foundation trusts and two clinical commissioning groups across England. On average, the provider completes 348 patient journeys a month and of these, three are for children and young people.

The types of transport provided include: transfers from secure mental health services to prisons 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 mental health services and learning disability services. The service also provided one to one observations of patients on mental health wards and monitored patients at section 136 suites. A section 136 suite is a dedicated unit for the reception and assessment of patients with mental health disorders.

The service has had a registered manager in post since 2013. At the time of the inspection, a new registered manager had recently been appointed and was registered with CQC in December 2018.

We carried out an unannounced inspection of this service in October 2017 and issued the provider with a warning notice because the provider was not compliant with Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this time, the provider took voluntarily suspension of transporting children and young people. The provider reinstated this service following a compliance assessment in July 2018.

We carried out a focused, announced inspection of this service in February 2018 and issued the provider with four requirement notices.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two CQC inspectors, and a mental health CQC inspector. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Detailed findings

Facts and data about Secure Care UK Headquarters

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we visited two ambulance stations, the headquarters in East Sussex and a hub station in Hampshire. We spoke with 19 staff including; mental health transport assistants, control room staff, team leaders, hospital staff, and management. During our inspection, we reviewed 10 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.

Activity (March 2018 to February 2019)

- There were 4,181 patient transport journeys undertaken, of these 4,129 were adults and 52 were children and young people.
- The service employed 120 mental health transport assistants (MHTA), eight control room staff, 14 team leaders, two staff in human resources, one finance director, three registered mental health nurses and one trainer.

Track record on safety

- No never events
- 113 clinical incidents but categorisation of harm was only implemented from January 2019 and are as follows: 28 no harm, 27 low harm, 1 moderate harm, 1 severe harm and no deaths
- No formal complaints

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Requires improvement	N/A	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	N/A	Good	Requires improvement	Requires improvement

Notes

Patient transport services (PTS)

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

Information about the service

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we visited two ambulance stations, the headquarters in East Sussex and a hub station in Hampshire. We spoke with 19 staff including; mental health transport assistants, control room staff, team leaders, hospital staff, and management. During our inspection, we reviewed 10 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.

Activity (March 2018 to February 2019)

- There were 4,181 patient transport journeys undertaken, of these 4,129 were adults and 52 were children and young people.
- The service employed 120 mental health transport assistants (MHTA), eight control room staff, 14 team leaders, two staff in human resources, one finance director, three registered mental health nurses and one trainer.

Track record on safety

- No never events
- 113 clinical incidents but categorisation of harm was only implemented from January 2019 and are as follows: 28 no harm, 27 low harm, 1 moderate harm, 1 severe harm and no deaths
- No formal complaints

Patient transport services (PTS)

Summary of findings

Although the service had improved since our last inspection, two areas where the service still did not meet legal requirements, so we could not rate this above requires improvement.

We found the following issues that the service provider needs to improve:

- At the last inspection there was poor staff compliance to the completion of vehicle cleaning. The systems and processes to ensure cleanliness of vehicles were still not adequate.
- We still had concerns around two governance processes; updating of policies and the management of incidents, which were highlighted at the last inspection. Although, the service had a stronger governance structure, this was only recently implemented and needed embedding.
- At the last inspection, the service had not met its requirement to apply the duty of candour for incidents. At this inspection, we did not see records which showed the service had or had not discharged its responsibility to the duty of candour.
- At the last inspection, the service had not implemented changes to improve patient assessment and record keeping. The documentation of restraint was still a serious concern at this inspection and there was no consideration for a patient's mental capacity or their deprivation of liberty safeguards. The clinical risk assessment at booking was not always complete which might lead to an inappropriate management plan for the patient.
- There was poor compliance to mandatory training with some compliance rates as low as 17%. None of the mandatory training compliance rates met the provider's target of 80%.
- Management and storage of equipment within vehicles was poor. There was no standardised equipment checklist which meant the equipment carried on each vehicle varied.
- Policies did not always reflect the service provided and contained unclear information. They did not always reflect national guidance or best practice. No input from healthcare professionals were sought to develop the provider's clinical policies.

However, we found the following areas of good practice:

- Since the last inspection, there was improved staff compliance to completing vehicle inspection checklists which ensured the vehicle was safe to use.
- Staff awareness of the interpreting service had improved since the last inspection.
- The service had improved its recruitment processes and checks since the last inspection. This ensured that persons employed were fit to carry out their jobs.
- All staff received a comprehensive three staged induction which included face to face training, online training and shadowing of shifts.
- All staff knew how to escalate safeguarding concerns and more questions were asked at the booking stage for patients under 18 years old.
- There was an overarching focus on communication and engagement with patients rather than restricting them or limiting their independence.
- Staff worked well as a team and relationships with external stakeholders showed effective multidisciplinary working.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement

We rated SAFE as **requires improvement.**

Incidents

The service did not manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Not all incidents that required escalation and investigation were. There was evidence of changes to practice following incidents.

- The service had guidance for staff on recognising and reporting serious incidents. The provider's, 'Incident Management and Serious Incidents Requiring Investigation (SIRI) Policy' outlined types of incidents, responsibilities of staff, the reporting process, incident investigating and grading of incidents. This policy was up to date and was based on NHS England's framework on serious incidents.
- Staff completed a paper incident form which was given to their team leader. The team leader reviewed every incident report and recorded each onto a central incident log. The crew also informed the control room when an incident had occurred on a journey. This created duplication of work and slowed down the process of investigating incidents. The clinical governance meeting minutes for January 2019 showed there was a four-week backlog of investigations at one hub station and one investigation was overdue for completion by a month at another hub station.
- Information provided to managers was inaccurate and provided false assurance. We reviewed ten incident reports and their entry on the central incident log. The central incident log did not always the reflect the information recorded by the crew as it had a summarised version of events, interpreted by the team leader. The type of incident recorded was not always correct, for example an incident involving a crew member getting injured was categorised as a confidentiality incident.
- The service had plans to implement an electronic reporting system to replace the paper incident forms. Managers felt this would improve the efficiency of investigating incidents and shared learning.
- Although there was not an official debrief after incidents as recommended by the National Institute for Health and Care Excellence (NICE) Guideline 10, crew reported if they had been involved in a violent attack during a patient transfer they were contacted by their line manager who discussed the incident and ensured the crew member was well enough to continue work.
- Staff did not always follow the provider's policy when reporting the use of restraint. The provider's, 'Mechanical restraint policy for adults and children', said all incidents resulting in the use of restraint are recorded and include type of mechanical restraint applied, location of mechanical restraint, rationale for use and the length of time restraint was applied. However, only four of the seven incident reports relating to restraint named the type of restraint used. Only one named the rationale for use. None named the location of restraint or the length of time restraint was applied.
- The provider shared learning from incidents through an electronic newsletter circulated via its internal mobile phone application. Staff were able to provide examples of where practice had changed because of incident reporting. This included extending face to face mandatory training for new starters from two days to three days in Hampshire as this team manage a more challenging group of patients.
- The service reported no never events or serious incidents. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

- The provider's, 'Induction and Training Policy', was up to date and outlined the three-phase mandatory training process for new starters followed by an annual cycle of mandatory training for all staff.
- The first phase consisted of a two-day face to face mandatory training course (three day for staff based in Hampshire). The course was delivered by a designated an accredited in-house trainer. The course included legislation and policies which govern the service, control and restraint techniques, person-centred care, conflict management, record keeping and health and safety. As of 12 February 2019, all staff had attended and completed competencies for the first phase of mandatory training.
- The second phase consisted of online training modules including, but not limited to, infection control, pressure ulcer prevention, moving & handling, basic life support, dementia awareness, care certificate, mental capacity act and the deprivation of liberty safeguards, conflict management and person- centred care.
- The third phase consisted of the new starters shadowing four shifts with experienced members of staff. The local service delivery manager signed new starters off as competent. If any concerns were raised, the new starter completed the first phase of training again. As of 12 February 2019, all staff had completed the shadowing shifts and competencies.
- After 12 months of employment, all staff undertook refresher face to face training and completed the 14 online training modules.
- Staff compliance to mandatory training was poor. Compliance rates ranged from 17% to 65%. None of the mandatory training compliance rates met the provider's target of 80%. The provider told us it could not find all training records to evidence staff attendance for mandatory training, therefore it had decided to re-baseline all mandatory training figures. The provider had a focused plan for the retraining of staff where it did not have the training records. As of 10 June 2019, mandatory training compliance rates ranged from 46% to 98%. This showed an improving picture in regard to mandatory training compliance.
- The training manager took responsibility to remind staff when their face to face training was due. One team leader in Hastings had been tasked with ensuring staff completed mandatory training but access to the central spreadsheet was restricted. This meant other team leaders could not help to drive the improvement needed.
- Not all team leaders had oversight over their team's compliance to mandatory online training as they did not have access to the training compliance database. Staff told us one team leader had been tasked with prompting all staff to complete any outstanding learning modules.

Safeguarding

Staff understood how to protect patients from abuse. All bookings for patients under 18 years old were reviewed by the safeguarding lead.

- The provider's, 'Safeguarding Vulnerable Adults and Children' policy, was up to date and outlined types of abuse, responsibilities of staff, reporting and investigation, contact details of local authorities and the referral form for adults at risk. The policy did not include the referral form for children. The policy did not provide clear guidance to staff on their responsibilities upon finding abuse and provided contact details of staff, to escalate concerns to, who no longer work for the service. We escalated our concerns to the management team who told us this policy was to be reviewed and updated within four weeks.
- The registered manager was the safeguarding lead and the training manager deputised as safeguarding lead when the registered manager was absent.
- Staff reported safeguarding concerns as incidents. Staff had access to a risk assessment form which helped them to determine if a concern needed to be reported as a potential safeguarding. All staff knew who the safeguarding lead was for the organisation and told us they escalated their concerns to their team leaders or the control room in the first instance.
- We reviewed one incident report relating to safeguarding concern which showed crew took the correct action to safeguard an adult at risk.
- As of 10 June 2019, 58% of staff had completed training in adult at risk safeguarding. This was much worse than the provider's compliance target of 80%.

- Staff discussed any concerns with the registered manager who logged the safeguarding concern and reported it to the local safeguarding authority.
- The provider has made no safeguarding referrals to the local authority in the 12 months prior to inspection.
- Control room staff told us when they entered the patient's date of birth on the booking system, more questions were generated if the patient was under 18 years old. These questions included whether the patient was known to the children and adolescent mental health services and whether a child protection plan was in place.
- Staff told us all bookings made for children and young people had to be reported to the safeguarding lead before the transfer took place. The safeguarding lead checked the patient details and contacted the crew who had been deployed, to ensure they were aware of the patient risk assessment.
- As of 10 June 2019, 58% of staff had completed training in safeguarding children. This was much worse than the provider's compliance target of 80%.
- Frontline staff and control room staff had completed safeguarding training level one and level two. The safeguarding lead had completed safeguarding training to level five and his deputy had completed training to level four. This is in line with Safeguarding Children and Young People: Roles and Competences for Healthcare Staff Intercollegiate Document (2019).
- Disclosure and Barring Service (DBS) checks were carried out for every member of staff as part of the recruitment process. We reviewed six staff files and saw completed enhanced DBS checks in each. DBS checks were completed every three years.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Vehicles were visually dirty and untidy. Cleaning checklists were not always completed.

- The provider's, 'Infection Control Policy', did not provide clear guidance to staff on standard operating procedures and did not reflect the service provided despite being updated in January 2019.
- In November 2018, the provider undertook an audit into vehicle management. It found various cleaning checklists existed throughout the organisation, limited records were kept showing cleaning and the cleaning of vehicles lacked a regular schedule. Managers told us a new cleaning checklist would be rolled out to all hub stations and reported to headquarters weekly. The checklist we reviewed included cleaning tasks such as vacuum all carpets, wipe dashboard and shampoo seats.
- Control room staff took responsibility to ensure crew were aware when vehicles needed deep cleaning or a valet. They had access to a vehicle cleaning log which showed scheduled cleaning dates throughout the year. Control informed the crew when the vehicle was due a valet or deep clean and once completed, the crew informed control who updated the central vehicle cleaning log. However, the vehicle cleaning log sent to us by the provider post inspection showed the last entry for a completed clean was 28 February 2019. Therefore, we were not sure vehicle cleaning was being completed.
- As part of the pre-journey vehicle inspection, staff reviewed and scored the cleanliness of the vehicle. Scores were out of five, with one being very poor and five being excellent. The provider's standard was four or above. We saw scores of one recorded in two patient records but there was no record to show what action, if any, the staff took. Staff told us if the score was three or below, they wiped or brushed down the vehicle before use.
- We saw the vehicles were not clean internally and externally. All four vehicles we inspected were ready for deployment. We found food wrappers, used gloves and wipes on the floor and in the door pockets of the vehicles. The floor of the vehicles was visibly dusty.
- All four vehicles had personal protective equipment and decontamination wipes. However, only two of the four vehicles had hand gel for staff to use before and after direct patient contact. The service did not produce any clinical waste due to the nature of the service.
- The clinical risk assessment completed at booking by the control room staff specifically asked the referrer whether the patient is known to have any blood borne viruses. These are viruses that some people carry in their blood and can be spread from one person to another. If the patient had a blood borne virus, crew wore personal protective clothing.

- All mental health transport assistants completed an online learning module for infection, prevention and control. As of 10 June 2019, 57% of staff had completed this training within 12 months prior to this inspection. This was much worse than the provider's compliance target of 80%.

Environment and equipment

The service had suitable premises and equipment and generally looked after them well. However, the equipment carried on each vehicle was not standardised.

- The premises at the Sussex headquarters included staff offices, a kitchen, a training room, a meeting room, a stock room and a control room where all bookings were received. This is where day to day operations were managed from. The premises at the Hampshire site included an office.
- There were three vehicles at the Sussex site and six vehicles at the Hampshire site. We inspected four vehicles (two at each site) and found all to be taxed and have MOT certificates. These vehicles were used to transport patients who are detained under the Mental Health Act.
- The provider did not take a proactive approach to vehicle maintenance which might cause unnecessary delays in service provision. It subscribed to two mobile phone applications, one provided by the vehicle leasing company. These applications provided a comprehensive online vehicle tracking tool of servicing, tax, MOT, repairs and insurance. Vehicles under lease were serviced by the leasing company while other vehicles were serviced by third party garages. However, staff were notified when a vehicle needed servicing when the warning light showed on the vehicle's dashboard. Managers told us a new vehicle management system would be deployed in June 2019 and this would enable a proactive servicing schedule. The provider was also considering using one company for managing the servicing of all its vehicles.
- Crew inspected their vehicle before each shift and completed the vehicle inspection checklist. This consisted of questions about general function such as fuel level, lights check, wheels check and vehicle appearance. There were pictures of the vehicle whereby crew recorded if there was any external damage to the vehicle. We reviewed five vehicle inspection checklists and found these to be completed.
- There was no standardised list for vehicle equipment. We inspected four vehicles and found the equipment stored in them varied. We escalated this to the management team who reported an equipment checklist had been signed off by the board. However, we reviewed this equipment checklist and found it did not reference the contents of the first aid kit, and it did not include commonly used items such as disposable gloves or decontamination wipes. This meant the equipment list was not fit for purpose.
- Management did not have assurance fire equipment was safe to use. Fire extinguishers were not available on two of the four vehicles we inspected and the pin from one fire extinguisher was missing. We escalated this to the team leader who removed the fire extinguisher from the vehicle. None of the fire extinguishers had a label displaying the last service. Managers reported a fire extinguisher servicing schedule had been introduced since inspection
- Staff told us if a vehicle was faulty, it was taken off the road and the fault recorded and reported to control. The team leader also added a note to the set of vehicle keys to ensure crew were aware not to use.
- All vehicles were fitted with a GPS tracking system. This enabled control room staff to locate vehicles, see if the vehicle is stationery or moving, detect speed and harsh breaking. Managers used this information in performance conversations with staff.

Assessing and responding to patient risk

Staff did not always complete comprehensive risk assessments for each patient.

- The provider's, 'Resuscitation' policy did not reflect current practice despite being reviewed in February 2019. It outlined responsibilities of staff, do not attempt cardiopulmonary resuscitation orders and procurement of resuscitation equipment. The policy said, 'all operational staff will also ensure that the resuscitation equipment is functional and clean'. We escalated this to

the managers who reported defibrillators were removed from vehicles ten months ago. We discussed this further with the registered manager who reported some vehicles had defibrillators and some did not.

- All staff knew what to do if a patient became unwell during a transfer, despite the unclear resuscitation policy. They carried out basic life support if needed and called 999 for an ambulance. Crew also informed the control room and complete an incident form.
- Staff reported if they experienced any problems during a patient transfer they contacted the control room for advice or to request more resources.
- All mental health transport assistants received basic life support training during their induction and then yearly. As of 10 June 2019, 95% of staff had completed this training within 12 months prior to this inspection. This was much better than the provider's compliance target of 80%.
- The provider did not have assurance restraint was applied correctly by the crew. The provider's, 'Mechanical Restraint Policy for Adults and Children', was overdue it's review. It said all forms of restraint are recorded and include; name of trained staff, type of mechanical restraint applied, location of mechanical restraint, time applied, time removed and details of rationale for use. However, none of the paper records we reviewed had this level of detail and the central booking log only had details for handcuffs. The policy also refers to a monthly audit on restraint, however this had not been carried out.
- All staff told us they used de-escalation techniques in the first instance and then used the minimum amount of restraint necessary for the shortest possible time, and as a last resort. This followed the National Institute for Health and Care Excellence (NICE) Guideline 10.
- We saw a poster in the Hampshire office which displayed the seating plan for staff and patients in a nine-seater vehicle depending on the assessed level of risk. For example, patients were never seated behind the driver or in the middle row unless they had mobility issues. However, this was not included in the policies we reviewed, nor did it have any review date or version control.
- During the booking process, control room staff asked the referrer a standard set of questions relating to the patient's mental health condition. This included a clinical risk assessment based on the risk of violence, suicide, self-harm and absconding. If there was a risk for any of these, more questions were asked such as last attempt, method and what aids de-escalation. This enabled the control room staff to complete a risk management plan which included, the number of escorts needed, if a healthcare professional was needed, any triggers that the escorting staff should be aware of and whether there had been a request for mechanical restraint or the use of a celled vehicle. These were specially designed ambulances that had a secure section in the rear.
- Associated risks for the transfer were not always assessed. We reviewed 11 booking forms and the clinical risk assessment. We found six were fully complete, three were partially completed and three had no clinical risk assessment. An incomplete risk assessment could lead to an inappropriate risk management plan being used for the patient. For example, the incorrect number of escorts might be assigned.
- Patients with serious medical conditions were not transported as the service could not provide this level of clinical care. During the booking process, control room staff also asked the referrer about the patient's physical conditions. If the control room staff had concerns they discussed this with the team leader before accepting the booking.

Staffing

The service had enough staff to meet the demands of the service.

- The provider employed a mix of staff including;
- 120 mental health transport assistants (MTHA)
- Eight control room staff (at Sussex site)
- Three registered mental health nurses (at Birmingham site)
- 14 team leaders
- The provider employed staff either on a flexible, part time or full-time basis. All staff, regardless of their contract type underwent the same recruitment process and training.

Patient transport services (PTS)

- Team leaders took responsibility for rostering shifts and the control room had access to the completed rosters. Shifts were 12 hours long between 6am and 6pm or between 6pm and 6am. Full time staff worked four consecutive shifts followed by four rest days.
- Staff worked on an on-call basis and were expected to answer a call from control room within 15 minutes and arrive at base within 40 minutes of the answered phone call.
- Most patient journeys were pre-booked which enabled staffing levels to be estimated. If more staff was needed, team leaders informed control room who contacted the flexible workforce.
- Staff told us they received breaks during their shifts. Breaks were planned and enforced within 136 suites following recent learning from incidents. A 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act by the police following concerns that they are suffering from a mental disorder.
- Some staff were dual trained in control room duties and patient escorting duties which meant during high levels of activity, the service could utilise this and allocated control room staff to frontline duties. In addition, it had access to a flexible workforce who were requested to work at short notice.

Records

Staff did not keep detailed records of patients' care and treatment.

- The control room took bookings over the telephone or by email. They recorded the information on an electronic booking form and sent a confirmation email to the referrer. Control staff also inputted data from the booking form into a centralised booking log.
- At each base, the electronic booking form was printed out and copies given to the crew who discussed the contents before starting the patient journey.
- If the crew was already out on the road or the printer was not working (as was the case at the Hampshire site during our inspection), control room staff read out the booking form to the crew word for word whilst the crew recorded the information on a blank booking form. This increased the risk of recording errors.
- Staff completed a patient record for each patient transfer they completed. This record included two body maps (pre and post journey), observations of the patient and a patient survey.
- The service did not have assurance patients did not sustain harm during the patient journey. We reviewed five pre and post body maps and found three were completed fully, one completed for pre-journey only and one did not have any body maps completed. This showed staff did not always follow policy.
- Staff did not always record observations of the patient during the transfer. We reviewed five patient observations and found four were completed and one was not recorded. Information included patient requests, patient behaviour and patient's mood.
- Staff did not always seek the views of patients about the service provided. We reviewed five patient surveys and found two were completed and three were not completed but did not have a rationale for its non-completion.
- In response to our concerns, the provider worked with their NHS contracts to devise a new patient care record. This record was comprehensive and included details of restraint if used, patient presentation, patient's property and/or medication and body maps. Staff received a 'how to guide' on completing the new patient care record.
- The service stored records securely. When crew returned to base, they placed all patient record in the tray on the team leaders' desk who locked the records in a cupboard with restricted access. At the Hampshire site, a member of staff took the paperwork to head office once a week. All patient records were stored in a locked cupboard within a locked room at the head office.
- Most records were paper based, which the provider recognised affected the efficiency of their workforce and led to duplication of work when paper records needed to be manually entered onto an electronic database. Managers reported they had invested in an electronic dispatch system which will replace paper-based forms. Each vehicle will be issued with a tablet and staff can use this or their mobile phone to access the electronic dispatch system and document electronically. This enabled real time reporting.

Patient transport services (PTS)

Medicines

Due to the nature of this service, crew did not administer or have access to on-board medications.

- The provider's, 'Medicines Management Policy', was up to date and outlined the responsibilities of staff in relation to the transportation of patient medications.

Are patient transport services effective?

Requires improvement

We rated EFFECTIVE as **requires improvement.**

Evidence-based care and treatment

The service's policies, including those recently updated, were not always based on national guidance or contain guidance relevant to the service provided.

- The process for ratifying policies was ineffective and policies were not always developed, reviewed and updated to reflect current practice. For example, the infection control policy, updated in January 2019, had guidance on how to clean the environment and equipment. However, this included how to clean dressing trolleys, individual patient rooms and nebulisers which were not used in the service.
- Policies were not always based on national guidelines or standards. The infection control policy referred to the Equality Act 2010 but did not include any references or national guidance on infection prevention and control.
- Similarly, the Mental Capacity Act policy said staff completed a Mental Capacity Act assessment form as part of the incident report, however the provider's incident reporting policy does not refer to this nor does the service have a Mental Capacity Act assessment form.
- Policies and procedures were not reflective of each other. For example, the infection control policy said the provider will ensure that gloves are always freely available to staff, but gloves were not included in the standardised list of equipment for vehicles.
- We escalated our concerns about policies to the management team who told us they had begun work to review and update policies. At the time of our inspection, 14 policies had been reviewed, updated and put on the mobile phone application. There were plans for all policies to undergo the same review process.
- The process used to update, and review policies was ineffective. We reviewed policies that had undergone this recent review and had been updated within two months of this inspection. However, we found they still had information that did not reflect the service provided or were not in line with national guidance.
- Staff who worked remotely accessed updated policies through a mobile phone application. However, this application had only 14 policies as these were the ones which had been reviewed and updated. Other policies were available through the shared drive or staff requested a hard copy from their team leader. There was confusion amongst staff on how to access policies and some managers did not have access rights to the shared drive. This presented a risk of staff members accessing old policies.

Nutrition and hydration

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

- Crew told us they supplied a bottle of water to patients and they ensured each vehicle had one before a patient journey. There were no provisions for food, although crew told us they asked the referring hospital to supply food for longer journeys.
- One incident form we reviewed, showed a patient requested water during the journey but staff did not supply the patient with water. A rationale for this was not recorded. This showed the crew did not meet the patient's needs.

Response times

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

- Between 1 March 2018 and 28 February 2019, the service carried out 4,181 patient transfers.
- Secure Care UK Headquarters ran 24-hours a day, seven days a week.
- The service did not take part in national audits or accreditation processes.

Patient transport services (PTS)

- The control room recorded the time of booking, time of arrival at collection, time of arrival at destination, time crew cleared and time crew back at base. This enabled the provider to monitor key performance indicators.
- The service monitored and reported its contractual NHS key performance indicators (KPI) monthly. We reviewed the quarterly performance reports for one NHS contract.
- In Hampshire, the KPI compliance target was 95%. The service exceeded its compliance in proper employment checks, utilisation of crew by gender for under 18s and representation at the section 136 Pan-Hampshire multi agency working group. The service did not meet the target in three areas: attendance within two hours of receiving initial booking (85%), attendance within one hour of receiving initial booking (79%) and mandatory training for staff (69%).
- The service had provided commentary on all KPIs which described the data analysis and the accuracy of the information. The service acknowledged that service delivery had greatly improved and underperforming response times was as a result of systemwide pressures due to bed shortages.

Competent staff

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

- All mental health transport assistants (MHTA) staff completed a two-day restraint course (three days for Hampshire to cover 136 suites) during their induction and then undertook yearly refresher training. The restraint training included handcuff/ soft cuff, Prevention Management of Violence and Aggression (PMVA), break away techniques and conflict resolution. The service provided staff with refresher training in restraint yearly.
- As of 10 June 2019, 98% of MTHA had completed PMVA training and mechanical restraint training within 12 months prior to this inspection. These figures were much better than the provider's compliance target of 80%.
- However, the service found gaps in staff's knowledge of restraint and therefore scheduled additional refresher restraint training across the organisation for all crew. Data showed 44 mental health transport assistants attended this training as of 10 April 2019.
- Control room staff completed an induction over two weeks which included shadowing shifts and completion of a workbook.
- Data showed 100% of staff had completed an induction.
- Managers undertook performance reviews in the form of one to one meetings, probation reviews, appraisals and ride outs with crew. We saw a combination of these records within staff files, however the dates suggested these occurred on an ad-hoc basis.
- We requested the data for appraisal completion rates, but the provider informed us it did not have any central records for the completion rates for all staff although appraisals were conducted. There were plans for midyear reviews to take place in June 2019 and end of year appraisals in December 2019.
- As part of the provider's action plan for quarter one, all staff had a one to one meeting with their manager. Data showed 100% of staff completed a one to one meeting between January and April 2019. We saw records of these meetings which included assessment of performance (either good, average or poor across a range of topics such as attitude, time keeping and team working), identified development needs and targets to complete by next meeting.
- If managers had concerns about the competence of staff, they escalated this with their line manager and training manager. The aim of these conversations was to find learning needs and to support staff in their development.
- The management team had a false impression of driving assessment completion. They believed the service delivery managers carried out driving assessments for new staff. Staff told us they did not receive driving assessments and we did not see records of these in staff files we reviewed.
- Human resources (HR) staff checked the driving licences of all drivers for penalties upon employment and then every three months. We saw all eligible staff had driving licence checks.

- Managers told us all staff had the opportunity to progress in their careers. Control room staff could become escorts or drivers with full training and induction. Escorts and drivers could become team leaders**.** We saw examples of staff progressing from frontline staff to management.
- HR staff stated they had been given the opportunity to undertake courses and formal qualifications funded by the company.
- All staff completed a three-phase interview process which included submission of curriculum vitae (CV), followed by a telephone interview if they had been shortlisted and then a face to face interview if they had been successful at telephone interview.
- All staff were asked to supply two references upon employment. Six new starters we spoke to on their first day of training confirmed this However, we saw three out of six staff files did not have references. This meant these staff did not have statements to support the information provided on their application. We escalated this to HR who reported these were for historical references. Staff were completing a back-dating exercise for references and we saw the database for this. We saw where references had been chased, there had been no review since. HR told us this was due to low staffing levels between October 2018 and February 2019, but the department was now fully staffed, and this was a priority for the HR team.

Multi-disciplinary working

There was evidence of effective multi-disciplinary working internally and externally.

- The control room staff worked with the referrer to assess and develop a risk management plan for the patient as part of the booking process. This considered the advice from the healthcare professional and included whether there was a do not resuscitate order for the patient and whether the patient was under section. Staff requested to view the documentation before starting the patient journey.
- There was effective communication between the control room, crew and external stakeholders. The crew always informed the control room of any concerns or delays which were then communicated to the stakeholder. External stakeholders confirmed this happened.
- Although staff had access to local hospital policies, staff did not attend any training at the local hospital in relation to the management of 136 suites. Hospital staff told us they had arranged a training day for Secure Care UK staff but there was no attendance. This was a missed opportunity to improve multi-disciplinary working.
- External stakeholders reported they received clear, comprehensive handovers by Secure Care UK staff upon receiving a patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not assess whether a patient had the capacity to make decisions about their care. There was limited assurance staff knew how to support patients experiencing mental illness.

- The provider's, 'Mental Capacity Act' policy was up to date and included definitions of capacity, key principles, responsibilities of staff and practical principles. The policy reflected national guidance for adults and children. However, the policy referred to staff completing a mental capacity assessment, which did not exist within the service.
- During the booking process there was no consideration of the patient's capacity or their deprivation of liberty safeguards. Information about these were not sought from the referrer. Deprivation of liberty safeguards were introduced as legislation within the Mental Capacity Act when rewritten in 2007. These safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.
- The provider's 'Mental Capacity Act' policy referred to the deprivation of liberty safeguards but did not define it or outline staff responsibilities in relation to it.
- The provider's 'Restrictive Practice Intervention Policy', was overdue for review (November 2017). It embodied the Mental Health Act Revised Code of Practice (2015), the Mental Capacity Act (2005) and the Human Rights Act (1998). However, there was limited assurance staff followed this policy as documentation of restraint was poor.

Patient transport services (PTS)

- As of 10 June 2019, 95% of mental health transport assistants had completed online training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was much better than the provider's compliance target of 80%.
- As of 10 June 2019, 95% of mental health transport assistants had completed online training in the Mental Health Act. This was much better than the provider's compliance target of 80%.
- External stakeholders felt Secure Care UK staff did not have a good level of understanding around relevant mental health legislation. The external stakeholder had raised this with the senior management team and they were working together to make improvements.

Are patient transport services caring?

We rated CARING as **not rated.**

Compassionate care

Staff cared for patients with compassion.

- There was a focus on supporting patients' privacy and dignity. For example, the service only transported one patient per vehicle and CCTV recording of the patient journey was not routinely used. The service also used unmarked vehicles and staff wore plain uniforms so there was no sign they were from a mental health service.
- Feedback from patients showed staff cared for them with compassion. We reviewed two completed patient feedback forms which showed a high level of satisfaction from both patients.
- We were unable to see any direct staff and patient interactions at either site; however, we sought feedback from external stakeholders. Comments included; "Some staff are amazing, they are able to use de-escalation techniques well and build a good rapport with the patient". However, the team did report this depended on the member of staff as some were exceptional and others were less compassionate.
- We saw a sample of comments and feedback messages received by the service from healthcare professionals. These messages were shared within the monthly newsletter called 'Stories from the front line'. The comments included, "…your team was able to form a bond with him and they calmed the whole situation down really well, establishing a very trusting rapport" and "They managed the situation with great sensitivity and fortitude."
- All staff we spoke with were passionate about the service they provided and were dedicated in providing compassionate care. All staff took pride in their work and upon reflection told us they did their job because it was rewarding as they felt they made a difference to the lives of patients and their families.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Crew told us they encouraged the patient to ask questions during the patient journey and answered them to the best of their ability. This helped to ease the patient's anxiety and develop a rapport with the patient.
- Staff gave patient centred care. Crew tried to engage with the patient whilst they awaited an assessment at the 136 suites. One crew member told us they encouraged a patient to write a letter to pass the time, whilst another played cards with the patient.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care.

- There was an overarching focus on communication and engagement with patients rather than restricting them or limiting their independence. Staff were encouraged to talk with the patient and use de-escalation techniques in the first instance. Staff we spoke with reflected this approach.
- The referrer was asked about any de-escalation techniques that work for the patient and any triggers that escorting staff needed to be aware of as part of the booking process. This enabled staff to tailor their management plan to meet the needs of the patient.
- Vulnerable patients, such as children and young people (CYP) and those living with dementia or a disability, can

have a relative or carer with them while being transported, providing this was agreed by the control room. Relatives or carers could also follow in their own vehicles.

Are patient transport services responsive to people's needs?

Good

We rated RESPONSIVE as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- The service offered a national wide service to accommodate the needs of those patients who needed transfers to mental health units in any area. Secure Care UK had contracts with two NHS trusts and two clinical commissioning groups.
- The service's section 136 suites were based in Hampshire. To meet local demand, the Hampshire ambulance station had the most vehicles on site compared to other sites.
- The service did not transfer bariatric patients; however, the patient's weight was not requested during the booking process. Therefore, it was unclear how the service identified this patient need.

Meeting people's individual needs

The service took account of patients' individual needs.

- The service had specific vehicles for the transport of patients with mental health disorders. These vehicles were unmarked and had secure cells. The secure cell was only indicated by the clinical risk assessment or recommended by the referrer.
- Mental health transport assistants completed online training in dementia awareness. As of 10 June 2019, 48% of staff had undertaken this training. This was much worse than the provider's compliance target of 80%.
- Staff completed online training in person centred care. As of 10 June 2019, 51% of staff had undertaken this training. This was much worse than the provider's compliance target of 80%.
- During the booking process, the refer was asked if the patient had any spiritual needs. The service told us it tried to make provisions to accommodate spiritual needs.
- In Sussex and Hampshire, the most common ethnic groups were Indian, Pakistani and African and Caribbean. The provider had an interpretation service for patients who were not able to communicate in English. Although crew had not used the service, they were aware of its existence.
- We saw a language chart, whereby patients showed their preferred language from a choice of 14 languages. However, this was not available on all vehicles which meant not all crew could identify the patient's language required for interpreting.
- Crew told us if a patient needed to go to the toilet during the journey, they coordinated this with the control room who found a place of safety for example a police station, for the crew and patient to stop. They also encouraged the patient to use the toilet before the journey.
- The service had booster seats and toys stored at each hub station for the transport of children and young people.

Access and flow

People could access the service when they needed it.

- The service ran 24 hours a day, seven days a week.
- Each referral was risk assessed jointly between the service and the referring provider to show the individual requirements for the journey, including staffing, equipment and type of vehicle. An estimated time of arrival was provided to the referrer and any delays were communicated.
- Most bookings were pre-planned and made over the telephone or by email (through the control room at Sussex site). The management team told us there were plans for referrers to be able to make bookings electronically and send these to the control room for progressing

Patient transport services (PTS)

- On the day bookings were normally for patients who had been detained by the police under section 136. A third party, often an approved mental health professional, contacted the service to book patient transport. The service transported the patient to a 136 suite. Whilst waiting for the patient to be assessed by a registered mental health professional, the crew stayed with the patient and ensured their safety. Following the assessment, the crew took the patient home or to a mental health unit for admission.

Learning from complaints and concerns

The service treated concerns and complaints seriously. We did not see evidence of complaint investigations. There was no evidence to demonstrate the service learned lessons from complaints.

- The provider's 'Complaint's Policy', was up to date and outlined the procedure for verbal and written complaints, the duty of candour and learning from complaints. The aim of the policy was to ensure complaints were dealt with seriously and service users feel confident their complaints are listened to and acted upon.
- Staff were encouraged to resolve each complaint independently but if support was needed they escalated to their team leader.
- Staff signposted patients and their relatives to raise complaints through the service's website, by telephone, email or post. All complaints were managed by the control room team leader who recorded any complaints within a central database. Team leaders initially dealt with complaints relating to their sites. The registered manager dealt with any complaints that needed escalation.
- The target time for first acknowledgement of a complaint was stated as five working days by letter, followed by another letter within 20 working days which outlined the investigation outcomes. Staff knew their responsibilities around complaints.
- If a patient or their relative were dissatisfied by the provider's response, they were directed to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) within the provider's complaints policy but directed to the Care Quality Commission on their website.
- The provider had received no complaints in the 12 months prior to inspection.

Are patient transport services well-led?

Requires improvement

We rated WELL LED as **requires improvement.**

Leadership of service

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The service was initially set up by the previous director in 2013. A board of directors invested in the company in July 2018 and have since set up a new management team.
- The new management team consisted of the managing director, the registered manager, the operations manager (North) and regional manager (South and Control Room).
- Day to day operations at all sites were managed by team leaders who reported to the operations manager (North) and regional manager (South and Control Room).
- The service had recently employed a new managing director who had significant experience of working in the independent healthcare industry. At the time of inspection, the managing director had been in post for 12 days.
- Staff reported seeing their managers most days and told us managers were available to contact via telephone 24 hour a day. Staff felt well supported and were clear on the leadership of the service.
- The provider had one location in Sussex registered with the Care Quality Commission and hub stations in five other regions. The registered manager was based in Birmingham for most of the working week and only visited the Sussex site once a week. We escalated our concerns with the management team as registered managers need to take day to day charge of the regulated activity at the location. We were told although the registered manager was in daily contact with the control room at Sussex, they would review their management arrangements.

Patient transport services (PTS)

Vision and strategy for this service

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff.

- Within the past 18 months the service had successfully obtained three new NHS contracts. The provider had a clear vision; to be the market leader in secure transport.
- All staff were engaged with the provider's vision to deliver patient centred care. All staff we spoke with told us they put the patient at the heart of everything they do.
- Behind this vision was a strong business strategy which focused on the next three years. It showed the provider's awareness of its challenges in achieving its vision. The strategy found three areas which were key in obtaining the vision. These included recruitment and retention of staff, utilising resources and embedding compliance throughout the organisation.
- The provider had an innovation plan for 2019 which focused on two strategic initiatives; technology and service. Goals for each initiative were set for each quarter of this year. This included the launch of an internal mobile phone application which was due to go live between 21 and 23 May 2019.
- The provider had recently revisited and renewed its core values with the engagement of staff. The chairman told us a meeting with 12 members of staff was held and these staff were invited to put suggestions forward for core values. A discussion took place and the core values were set up.

Culture within the service

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had an open culture and staff worked with mutual respect. Staff reported management promoted staff wellbeing by ensuring rest breaks were taken and management called staff to check on their wellbeing following serious incidents.
- All staff were encouraged to report incidents. Although management of incidents was ineffective at the time of the inspection, there was a clear drive to deliver service improvements through learning from incidents. Examples of good practice was shared throughout the organisation in 'Stories from the frontline' newsletter which was available on the internal mobile application.
- The management team told us there were many changes occurring throughout the organisation which affected all staff. This included the implementation of the patient care record on 20 May 2019. The managing director arranged workshops prior to the implementation to help the transition and support staff with adopting the new ways of working. Staff received a 'how to guide' on completing the new patient care record.
- The provider held its first open board meeting in April 2019. The meeting was open to all staff and external stakeholders. The meeting minutes show discussions were inclusive and demonstrated an open culture.
- The provider's, 'Whistleblowing- policy statement', was up to date and effectively signposted staff in how to raise concerns.
- Regulation 20 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014 is a regulation introduced in November 2014. This Duty of Candour regulation requires the organisation to notify relevant persons (often a patient or close relative) that an incident has occurred, to provide reasonable support to the relevant person in relation to the incident and to offer an apology.
- The provider's, 'Being Open and Duty of Candour Policy', was up to date and named the registered manager as the lead person responsible for the duty of candour. The policy explained the process for ensuring where service users had been harmed whilst under the provider's care, the regulatory requirement to ensure regulation 20 was discharged. The management team showed an awareness of the duty of candour policy.
- During this inspection, we did not see any records to show the service had or had not discharged its responsibility of the duty of candour. The incident log did not hold this information and despite a request for the investigation of an incident, this was not provided by the service.

Patient transport services (PTS)

Governance

Although there were systems of accountability to support good governance, processes were not embedded and required reviewing. Staff were aware of governance systems and how to escalate concerns.

- The Secure Care UK governance committee had terms of reference. The document outlined aims of the group and clear responsibilities for each member.
- The provider had a corporate governance strategic plan which set out the key responsibilities of the governance team for the year ahead to drive improvement and steer the business in the direction of its overall vision.
- Evidence from the provider showed for quarter one of 2019, it had completed the first two actions. The first aim was to improve information flow between frontline staff and the board in both directions. A new governance structure was implemented to strengthen the escalation processes for raising and managing concerns.
- The second aim was improved staff awareness of policies and align policies with operational realities. Although, the management team was confident it had achieved this aim, during inspection we found issues with policies that had been ratified and updated using the new method. This suggested the ratification process was ineffective and the system used to gain feedback led to false assurance.
- The third aim was improved and audited incident management process. The management team reported this aim was not met by the deadline.
- Quarterly board meetings were attended by the chairman, the managing director, the nominated individual, the human resources manager and the registered manager. We reviewed the minutes for November 2018 and January 2019. The standing agenda included compliance, contract review, recruitment, training and actions from the board meeting.
- Monthly corporate governance meetings were attended by the managing director, the nominated individual, the registered manager, the operations manager (North) and regional manager (South and Control Room). The latest meeting minutes for April 2019, used a new minute's template which incorporated three meetings: the corporate governance meeting, the open board meeting and the operations meeting which were held sequentially. The template outlined actions agreed, actions to take forward, comments by attendees categorised into benefits or concerns.
- We reviewed the minutes for the weekly calls between the registered manager and the nominated individual between 1 October 2018 and 4 February 2019. The standing agenda included review of actions from last meeting, review of action plan, serious incidents, compliance and activity.
- The provider also implemented weekly regional calls and weekly team meetings where the day to day operations of the service were discussed and key messages from managers were given.

Management of risk, issues and performance

The service had ineffective systems to identify risks and plan to eliminate or reduce them.

- The risk register was comprehensive with an outline of each risk, rating and mitigating actions. The provider added 10 new risks to its risk register between May 2018 and April 2019. Of these three were completed and seven were ongoing.
- Actions taken to mitigate risk were not always effective. Although the risks on the register were aligned to the concerns found during this inspection, we found an ineffective incident management processes which had been marked as complete on the risk register.
- The management team had acted at once following feedback from this inspection regarding the review process for policies. They had reviewed all policies within the service and streamlined these into three sub groups: people, resources and clinical. They had undertaken a risk assessment for the prioritisation of policy rewrites. Policies with the highest priority would be reviewed with clinical input and implemented within two weeks. The management team aimed to complete this process for all policies by the end of June 2019.
- The provider undertook an audit of all incidents reported by the Hampshire site between October and December 2018. The audit found incident reports lacked detail and contained inappropriate language. Actions to improve this included increased support for staff to complete incident forms, team leaders to discuss any issues in the quality of the incident report with the

reporter and to give time to staff after each shift to complete the incident forms. However, during our inspection we saw staff still used inappropriate language to describe restraint, this included, 'heavily man handled' and 'wrestle him to the ground'.

- We escalated our concerns about the lack of documentation around restraint to the management team. They reported they had developed a patient record form which captured the level of detail needed for the use of restraint and remove the need for subjective statements. The new patient care record went live across the organisation on 20 May 2019 following workshops held by the managing director to all teams.
- The management team had developed continency plans until the new patient record form was implemented. The medical director had instructed all regional managers and team leaders to ensure that all incidents, and particularly those involving restraint are reported. A service wide message was also posted on the internal mobile application to act as a reminder for all staff.
- The provider did not have an audit schedule which meant it was unable to obtain assurance around compliance to policies and national guidance. However, the provider had undertaken some ad-hoc audits, but these were not co-ordinated in a way that allowed the management team to have oversight of the quality of care delivery or compliance with its policies.
- The 'Secure Care Business Continuity Plan' was updated in January 2019 but did not have a planned review date. The policy outlined actions to be taken by named staff in a variety of emergency situations such as fire, flood or loss of broadband/telephone lines.
- The management team informed us that they had discovered a substantial number of training records were not kept. This meant there was limited evidence to show staff attendance at mandatory training and support the figures calculated on the central tracker. To rectify this, the training manager planned to retrain all the teams in the areas where there were no clear records of attendance. There were initially three days of training booked for the week beginning 6 May 2019 which more dates to be scheduled. The management team believed there would be a correct record of all mandatory training by the end of June 2019.

Information Management

The service collected, analysed, managed and used information well to support all its activities.

- The provider monitored, managed and reported on its quality and performance to key stakeholders. It recognised it needed to improve in its ability to analyse data. It had invested in an internal mobile application which captured real time information, improved key performance indicator reporting and create audit trails for trend analysis. This platform was not to be fully operational until June 2019.
- In the meantime, key performance indicators were extracted manually from databases. All information surrounding performance such as response times were manually inputted into a database by control room staff and then extracted for reporting purposes.
- As of 10 June 2019, 46% of staff had completed training on the Data Protection Act. This was much worse than the provider's compliance target of 80%.

Public and staff engagement

The service engaged well with patients, staff and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

- Staff fedback to the management team through staff meetings. The management team had recognised there was a disconnect between management and frontline staff. Frontline staff felt they were not made aware of progress on issues that affected them directly.
- Following this feedback, the provider had a strong focus on improving communication across the organisation. The implementation of a governance structure and regular meetings had improved the two-way flow of information between frontline staff and the board.

Patient transport services (PTS)

- All staff used the internal mobile application to ask questions, share best practice and receive updates about the business. The management team had more administration controls, so they monitored the information uploaded onto the platform.
- The management were committed to being visible amongst frontline staff. The new managing director had visited all sites across the organisation to speak with staff and understand their day to day roles and the frustrations associated with this. He had also attended the new starter induction to review the quality of the training and gain feedback from new starters.
- Staff felt listened to and that their views mattered. They gave us examples of when their feedback had led to changes in practice. The length of induction for the Hampshire team was increased from two to three days to take account of their other role in section 136 suites. Staff had fedback to management that they believed their navy-blue uniform was too like the police which can agitate patients. Managers were in discussions about changing the colour of uniforms.
- The provider launched a staff survey on 16 April 2019. The results of this were not available at the time of reporting. However, the management team were keen to use the results to develop a 'you said, we did' tool.
- Patient feedback was captured by a survey undertaken by the patient with or without the help of staff after the patient journey (where appropriate). The survey was included in the patient journey record and consisted of five questions rated by stars (1 star for poor, five stars for excellent). The service did not have a system to monitor response rates or satisfaction scores.

Innovation, improvement and sustainability

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The service had introduced Mental Health Transport Assistant leads in January 2019. The purpose of this new way of working was to allow individual staff to take more responsibility when working as a team. Staff volunteered monthly to act as the leads on transfers and had overall responsibility to ensure correct procedures are followed and the patient receives compassionate care.
- The service was in the early stages of engaging with other transport providers to share ideas and exchange best working practice. No meetings were scheduled at the time of this inspection. This showed a commitment to improving the care and treatment patients with mental health receive.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must complete a clinical risk assessment for every patient to ensure a proper management plan is developed.
- The provider must ensure incidents that affect the health, safety and welfare of people using services are reviewed and thoroughly investigated by competent staff and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.
- The provider must make sure that staff have the qualifications, competence, skills and experience to keep people safe.
- The provider must securely maintain accurate, complete and detailed records relating to employed staff including referencing checks, training records and driving assessments.
- The provider must prevent and control the spread of infection in relation to the cleaning of vehicles.
- The provider must have systems and processes such as regular audits of the service and must assess, monitor and improve the quality and safety of the service.
- The provider must keep accurate, complete and detailed records for the use of restraint.
- The provider must continue to develop and embed effective governance systems.

Action the hospital SHOULD take to improve

- The provider should read, consult and implement nationally recognised guidance.
- The provider should analyse and use patient feedback to drive improvement to the quality and safety of services and the experience of engaging with the provider.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The clinical risk assessment at booking stage was not always complete which could lead to an inappropriate management plan for the patient. Not all incidents that affected the health, safety and welfare of people using services were investigated. This meant opportunities to learn from the incident and prevent further occurrences were missed. Staff compliance to mandatory training varied between 48% and 98%. This meant staff may not have the correct skills to carry out their roles. Records of cleaning vehicles were poor, and we found vehicles were visually dirty and untidy. Staff did not always have access to hand sanitiser to promote good hand hygiene. Regulation 12 (1)(2)(a)(c)(h)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have an audit schedule, instead audits were performed on an ad hoc basis. This meant management did not monitor compliance to standard operating procedures, national guidance and policies.

This section is primarily information for the provider

Requirement notices

There was poor record keeping for patient transfers. This included risk assessments and documentation of restraint. Although management were aware of this, there had been little appreciation of the associated and substantial risks.

There was poor record keeping for mandatory training. The central tracker and evidence of attendance in staff records did not complement each other.

Serious concerns from the previous inspections still existed at this inspection. This suggested governance systems and arrangements were ineffective. New governance frameworks need time to be embedded.

Regulation 17(1)(2)(a)(c)(f)