

Personal Security Service Limited

Personal Security Service

Quality Report

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

Ratings

**Overall rating for this
ambulance location**

Requires improvement



Patient transport services (PTS)

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Personal Security Service is operated by Personal Security Service Limited. The service provides patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced visit to the hospital on 6 June 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 main service provided by this service was patients transport service.

This is a first time we rate this service. We rated it as **requires improvement** overall because:

- Leaders had limited awareness of their responsibilities in relation to the provision of service governed by the Mental Health Act 1983.
- Staff did not always complete comprehensive risk assessments for each patient to remove or minimise risks.
- Staff did not always keep detailed records of patients' care and treatment.
- Systems and processes for reporting and reviewing incidents were relatively new and not yet fully embedded into practice.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- Staff did not follow national guidance to gain patients' consent or to ensure care and treatment were in line with it.
- Not all staff received mandatory training in key skills.

However, we also found:

- The service had enough staff to meet the demands of the service.
- Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well.
- The design, maintenance and use of facilities, premises, vehicles, and equipment kept people safe.
- The service had measures to meet patients' nutrition and hydration needs.
- The service routinely collected and monitored key information including response times. People could access the service when they needed it, in line with national standards, and received the right care in a timely way.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- It was easy for people to give feedback and raise concerns about care received.
- Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

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 notices that affected transport services, triage and medical advice provided remotely. Details are at the end of the report.

Nigel Acheson

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

Requires improvement 

Personal Security Service

Detailed findings

Services we looked at

Patient transport services (PTS)

Detailed findings

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Background to Personal Security Service

Personal Security Service is operated by Personal Security Service Limited. It is a private independent ambulance service operating in Southgate, North London. The service primarily serves the communities of North London. It also accepts patient transport requests from outside this area. The service registered with CQC in 2013 and this was their fifth inspection.

Personal Security Service provides a secure patient transport service to vulnerable adults with mental health problems. This includes transporting a patient sectioned under the Mental Health Act 1983. Most journeys involve

the transport of a patient from one hospital to another. Depending on patient's needs and associated risks the transport is carried out in low secure or high secure vehicles fitted with a secure area (cell) in the rear section of the vehicle. The service provides a driver, escorts, and registered mental health nurse (RMN) if requested by hospital staff.

The service has had a registered manager in post since 2013. At the time of inspection, they were registered to provide regulated activities of transport services, triage and medical advice provided remotely.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two specialist advisors with expertise in mental health.

The inspection team was overseen by Terri Salt, Head of Hospital Inspection.

Facts and data about Personal Security Service

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the provider's office. We spoke with six staff including; the registered manager, patient transport drivers and management. We spoke with no patients or relatives as they were not available to

speak with us. During our inspection, we reviewed 10 sets of patient records (records of conveyance) and numerous other documents related to the day to day management of the service.

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 four times, and the most recent inspection took place in June 2017, which found that the service was not meeting all standards of quality

Detailed findings

and safety it was inspected against. We identified regulatory breaches related to good governance (Regulation 17 HSCA (RA) Regulations 2014) and to fit and proper persons employed (Regulation 19 HSCA (RA) Regulations 2014).

In 2017 we said that the provider needed to take prompt action to address several significant concerns identified during the inspection in relation to safeguarding, incident recording and reporting, and the governance of the service. We asked them to ensure care and treatment was provided in a safe way for service users and to ensure all equipment used was suitable for the purpose for which they were being used and was properly maintained. On this inspection we found that the provider had improved and had developed new governance systems and processes to ensure these issues were addressed.

In 2017 we found that the provider did not ensure fit and proper persons were employed for a purpose of caring

out the regulated activity. During this inspection we found that they had systems to ensure all staff undergo suitable recruitment checks and appropriate records were available for inspection.

Activity

- The provider undertook between 250 and 350 patient journeys each month.
- The service did not keep a breakdown of number of total high secure and low secure journeys. They did not collect data on NHS and non-NHS journey numbers
- The provider used 18 vehicles to provide the service

Track record on safety

- No never events
- No serious incidents
- No serious injuries
- No incidences of service acquired infections
- Ten complaints in 2018

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	Not rated	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Not rated	Good	Requires improvement	Requires improvement

Patient transport services (PTS)

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

Information about the service

Personal Security Service provides a secure patient transport service to vulnerable adults with mental health problems. This includes transporting a patient sectioned under the Mental Health Act 1983. Most journeys involve the transport of a patient from one hospital to another. Depending on patient's needs and associated risks the transport is carried out in low secure or high secure vehicles fitted with a secure area (cell) in the rear section of the vehicle. The service provides a driver, escorts, and registered mental health nurse (RMN) if requested by hospital staff.

Summary of findings

This is a first time we rate this service. We rated it as **requires improvement** overall because:

- Leaders had limited awareness of their responsibilities in relation to the provision of service governed by the Mental Health Act 1983.
- Staff did not always complete comprehensive risk assessments for each patient to remove or minimise risks.
- Staff did not always keep detailed records of patients' care and treatment.
- Systems and processes for reporting and reviewing incidents were relatively new and not yet fully embedded into practice.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- Staff did not follow national guidance to gain patients' consent or to ensure care and treatment were in line with it.
- Not all staff received mandatory training in key skills.

However, we also found:

- The service had enough staff to meet the demands of the service.
- Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well.
- The design, maintenance and use of facilities, premises, vehicles, and equipment kept people safe.

Patient transport services (PTS)

- The service had measures to meet patients' nutrition and hydration needs.
- The service routinely collected and monitored key information including response times. People could access the service when they needed it, in line with national standards, and received the right care in a timely way.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- It was easy for people to give feedback and raise concerns about care received.
- Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

Are patient transport services safe?

Requires improvement



This is the first time we have rated this service. We rated it as **requires improvement**.

Incidents

Although the service generally managed patient safety incidents well, systems and processes for reporting and reviewing incidents were relatively new and not yet fully embedded into practice. There was evidence of changes to practice following incidents.

- The provider told us they did not have enough serious incident reports to identify reliable trends and to monitor the service from previous incidents. Overall the number of incidents being reported was low. They acknowledged reporting of incidents needed improving. Learning from incidents was a standing agenda at team meeting. Information was also disseminated through staff supervision and any de-briefing sessions.
- Records indicated 28 incidents from January 2018 to May 2019. The majority referred to use of handcuffs or other forms of restrain, which were routinely recorded by staff. The investigating manager recorded lessons learnt and outcomes of the investigation when appropriate. Staff also recorded any other potentially harmful behaviour such as patient's attempt to self-harm.
- The service did not have any action plan for incidents of restraint as they reported only "low level restraints" (hand holds to place handcuffs on the patient as required). They told us that they organised a team debrief after each restraint and that each case patient was informed of reasons for restraint and reassured. Incident and restraint forms were completed and sent to clinical service manager within 12 hours from incident taking place.
- The service had a policy for staff on reporting serious incidents. The provider's policy outlined types of incidents and, responsibilities of staff. However, it did not describe the reporting process and how incident would be investigated or graded. It failed to address how learning from incidents would be identified and taken forward. This policy was not based on the standard health service incidents reporting framework

Patient transport services (PTS)

and did not refer to standard Reporting of Injuries, Diseases and Dangerous Occurrences practice as prescribed by health and safety at work legislation. Furthermore, it did not reference principles set by the national guidance that covered the short-term management of violence and aggression in adults, young people, and children. This guidance is relevant for mental health, health, and community settings. After the inspection, the provider submitted an updated incident reporting and management policy which described the reporting process and how incident would be investigated. They have also provided us with occupational health policy which was guided by relevant health and safety legislation.

- The 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 complaints or incidents management policy did not name anyone as the lead person responsible for the duty of candour and it did not explain 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. Both policies encouraged culture of being open and transparent. During this inspection, we did not see any records to show how the service had considered its responsibility of the duty of candour. The incident log did not hold this information, however, we noted there were no serious incidents reported by the service that would trigger it.
- The service reported no never events or serious incidents. Never events are serious incidents that are 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 staff but did not make sure everyone completed it.

- When joining the service staff were required to complete training based on individual job roles; data protection, equality and diversity, safeguarding adults, safeguarding children, risk assessment, moving and handling of

people, physical restraint, infection control, manual handling, mental health, mental capacity and deprivation of liberty, managing hazardous substances (COSHH), health and safety, fire safety, dementia awareness, basic life support, oxygen therapy, and first aid. Staff also completed additional training such as training related to behaviours that challenge, lone working, food essentials, use of handcuffs, incident reporting, customer care, patient care and consent, complaints handling, Counter-terrorism (Prevent). Provider used both online training and delivered face to face training on site. Some mental health nurses (RMN) worked also for an NHS service which provided them with their mandatory training. The provider would obtain their training records and monitor frequency to ensure this training was meeting their requirement.

- Managers had good oversight over their team's compliance to mandatory online training as they had access to the training compliance log which was up to date. The clinical service manager took responsibility to remind staff when their training was due, and this was monitored during staff meetings.
- Drivers and mental health nurse mandatory compliance rates varied between 50% and 83%. The low compliance rate was related to new staff joining the provider and delays with receiving training from another organisation staff were working for. The service did not have specified minimum compliance rate target. The manager told us that staff, who were to complete their training but did not attempt to do it, were stopped from working until their minimum training requirement was met.

Safeguarding

Staff had training on how to recognise and report abuse, and they knew how to apply it. They understood how to protect patients from abuse. All bookings for patients under 18 years old were reviewed by the safeguarding lead.

- Staff had access to a transport record form which helped them to determine if a known safeguarding concern was identified prior transport taking place. The provider told us as part of the risk assessment on arrival to convey a patient, the conveyance crew asked if there were any potential safeguarding concerns, this was noted on the driver's conveyance record sheet. On

Patient transport services (PTS)

arrival at the destination information was handed over to the receiving hospital. Staff we spoke to knew who the safeguarding lead was for the organisation and told us how they escalated concerns in the first instance.

- Staff were provided with a safeguarding adults and children training up to level 2. This training was completed annually online. Safeguarding training completion rates varied between 50% and 73% amongst RMNs and drivers.
- There were nominated leads for adults and children safeguarding. Both the children safeguarding lead and adults lead was trained up to level 3 the adults training was an online training and safeguarding children training was face to face training.
- The provider has made no safeguarding referrals to the local authority in the 12 months prior to inspection.
- Disclosure and Barring Service (DBS) checks were carried out for every member of staff as part of the recruitment process. We reviewed staff files and saw completed enhanced DBS checks in each.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Vehicles were visibly clean and tidy. Cleaning checklists were completed by drivers and infection control practice was monitored by managers.

- Drivers maintained a cleaning log which was audited by office staff. The provider had an agreement with an external company that provided regular monthly deep clean of vehicles. Office staff took responsibility to ensure crew were aware when vehicles needed deep cleaning or a valet.
- Vehicles we inspected had personal protective equipment and decontamination wipes. They also had hand gel for staff to use before and after direct patient contact.
- The provider's infection control policy provided guidance to staff regarding frequency of cleaning and disposal of bodily fluids. However, it did not inform staff how to manage potential infectious diseases, open injuries, or what arrangements were in place to dispose of clinical waste. The provider told us that any clinical waste, should there be a need, would be handed over at the location the patient was transported to.
- The transport booking form completed at the time of booking did not specifically asked the referrer whether the patient was 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, the crew wore personal protective clothing. The form referred to illness the service should be aware of and prompted for more information should there be any.

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 maintained a vehicle maintenance record which was regularly audited. Records indicated that all vehicles used for the patient transport were regularly serviced and had required documents as required by legislation.
- All vehicles were fitted with a GPS tracking system. This enabled control room staff to locate vehicles and see if the vehicle was stationary or moving. They were also fitted with numerous cameras, aimed to improve patient's and staff's safety. They were operational at the time of conveyance. In case of any incident, should there be a need, recorded footage could be reviewed.
- There was standardised list for vehicle equipment. We inspected vehicles and found that they had the same equipment stored in them. The equipment checklist referenced the equipment stored. Equipment such as first aid kit, defibrillator, oxygen canister amongst others was tested and within the expiry date and fit for purpose.
- When a vehicle was faulty, it was taken off the road and the fault recorded and reported. Each vehicle had a service agreement arranged and staff knew who to contact should there be a need to arrange service.
- Although staff were present at all times when transferring patients and would be able to intervene should patient be at risk of self-harm, the vehicles used for transport and their physical environment were not assessed for risks related to self-harm or ligatures.

Assessing and responding to patient risk

Staff did not always complete comprehensive risk assessments for each patient to remove or minimise risks.

Patient transport services (PTS)

- All staff providing direct support to patients received restraint training (Level 2) annually. They also received training in use of handcuffs, basic life support, oxygen therapy, and first aid.
- The provider told us that in response to an incident they introduced changes to the booking process and the way individual risk was assessed where the level of risk scale used by staff was changed. We noted that this change was not formalised and there was no up to date written protocol to standardise the practice of assessing individual risk.
- Initial individual risk was assessed by the booking staff who completed a standard booking form which prompted questions in relation to patient's mental state and any other social, emotional, or clinical needs. Drivers were able to contact the person requesting the transport to confirm any information and ask additional questions. The service relied on the referrer's assessment of whether the patient was fit to travel. Staff trusted that "the hospital would not convey if the patient was not fit to travel". There was no record of verification of this risk assessment and to confirm if it was accurate.
- Staff reported if they experienced any problems during a patient transfer they would contact the control room for advice, or to request more resources. Staff told us if a patient became unwell during a transfer staff would carry out basic life support if needed and call 999 for an emergency ambulance. Crew also informed the control room and completed an incident form.
- Drivers and RMNs received basic life support training during their induction and then every three years. Records for March 2019 indicated 67% of drivers and 50% of RMNs were up to date with this training. The provider told us that this had improved across April and May as newly appointed staff completed it.
- Patients with serious medical conditions were not transported as the service could not provide appropriate level of clinical care. During the booking process, staff asked the referrer about the patient's physical conditions. If the control room staff had concerns they discussed this with a senior member of the team before accepting the booking.
- There were no journeys cancelled because of staff being unavailable in the period of 12 months prior to the inspection.
- Documents indicated that in all cases crew numbers were enough and as requested by the call handler and the referrer.
- 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.
- The provider told us a constant recruitment drive was underway aiming to recruit long term staff members. Alternative working rotas were being trialled in a bid to offer more consistency with hours, to enable both the staff and the service, to have set schedules in place for a better work life balance for staff and consistency of staff cover for the provider.
- There was high turnover of staff over the course of the 12 months prior the inspection.
- Whilst the turnover of staffing had been high it was for a variety of reasons. There was in total 24 changes over the period. The provider was aware it required improving and they said they were working towards reducing the workload and improving training opportunities within the company.
- The provider told us the sickness rates were low with majority of staff not taking any sickness for the full year prior to our inspection.

Records

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

- Information needed to deliver safe care and treatment was in general available to relevant staff in a timely and accessible way. However, it was not mandatory for staff to see documents that justified deprivation of patient's liberty during transport and staff occasionally relied on information passed on to them verbally.
- Staff did not always record what the actual mental state of the patient was at the time when they were supported with transport and if it correlated to the initial assessment. The call handler did not record the exact reasons for use of secure transport therefore it was not always clear if it was justified.
- The seven incident forms we looked at, completed when handcuffs were used, did not record the length of time the patient spent in handcuffs.

Staffing

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

Patient transport services (PTS)

- The service stored records securely. When crew returned to base, they placed all patient record in secure storage with restricted access. All patient and staff records were stored in a locked cupboard within a locked room at the head office.
- Most records were paper based. Each vehicle was issued with an electronic tablet and staff could use this or their mobile phone to also access documents, sent to them, electronically.

Medicines

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

- The provider's, medicines management policy, outlined the responsibilities of staff in relation to the transportation of patient's medicines. It was carried in a sealed, protective container and staff were required to complete a 'transportation of belongings form' which was signed on collection of the medicines and again at destination location by the person receiving the medicine container.

Are patient transport services effective?

Requires improvement



This is the first time we have rated this service. We rated it as **requires improvement**.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

- Policies were not always based on national guidelines or standards. For example, a policy for staff on reporting serious incidents was not based on the standard health service incidents reporting framework and did not refer to standard Reporting of Injuries, Diseases and Dangerous Occurrences practice as prescribed by health and safety at work legislation. It did not reference principles set by the national guidance that covered the short-term management of violence and aggression in adults, young people, and children.

Nutrition and hydration

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

- Staff assessed patients' food and drink requirements to meet their needs during a journey. The service made adjustments for patients' religious, cultural, and other 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.

Response times / Patient outcomes

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

- At the time of the inspection the service did not take part in national audits or accreditation processes as there were limited opportunities and no national data collection initiatives for this type of service.
- The control room recorded the time of booking, time of arrival at collection, time of arrival at destination. This enabled the provider to monitor key performance indicators.
- The service monitored number of journeys and bookings. They had not had any aborted journeys in January to April 2019. The service achieved a maximum response time of 90 minutes in 100% of journeys in the same period.
- They monitored and recorded if restraint and handcuffs were used during transport as well as use of secure vehicles. However, records were not sufficiently detailed to assess if use of restraint was justified. The service did not record for how long time restraint was applied for. Records lacked detail on patient's preference of preventive strategies and potential de-escalation techniques that had been tried to promote positive behaviour support. The service did not keep record of the patient's physical and psychological wellbeing which should be monitored after restraining was used.

Competent staff

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

Patient transport services (PTS)

- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- The provider obtained a copy of the driver's licence from each driver. All vehicles were not larger than as prescribed by the licence category B1 therefore all staff who held a valid manual drivers' licence (Category B1) were licensed to drive vehicles. A check was carried out on driver's licences to ensure there were no offences and drivers were able to drive safely.
- Staff were offered training relating to behaviours that challenge, lone working, restraint, and customer care amongst other subjects. Staff told us that the quality of training was good.
- The provider monitored compliance with Nursing and Midwifery Council's registration requirements for RMNs.
- The job descriptions for drivers; 'responsible for driving or assisting on a non-emergency transport', and for support workers; 'responsible for escorting or assisting on a non-emergency patient' were very generic. They did not give detail regarding the roles and responsibilities of each staff member and staff were guided by other protocols or training provided at the time of induction to understand their roles.
- Staff supervision covered staff wellbeing, personal development and training and competencies amongst other standard agenda items. Supervision was offered at eight weekly intervals.
- Although staff protected the rights of patients in their care, managers did not check to make sure staff followed guidance and protected the rights of patients subjected to the Mental Health Act 1983. The Mental Capacity Act 1983 policy was generic and did not give any guidance to employees as to operational standards.
- Staff responsible for transport did not always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. The call centre staff worked with the referrer to assess the risk for the patient and staff as part of the booking process. They considered the advice from the healthcare professional and checked whether the patient was treated under section of the Mental Health Act 1983. However, the information was handed over verbally and records did not mention which section was used to justify detention of the patient. We were not assured, because of the provider not keeping sufficiently detailed records, staff always acted in accordance with the Mental Capacity Act 2005, or if care and treatment were provided with the consent of the relevant person.
- The information collected was not sufficiently detailed to demonstrate that staff kept patient and themselves safe at all times. The booking sheet prompted staff to ask basic questions such as 'risk of aggression'. There was no free text to ascertain or to explain to others what the actual current mental state of the patient was, and no detail on the risk (i.e. specific risk posed to males, females; only when unwell). When the referrer asked for use of a secure cell, the call handler did not record the exact reasons for it.
- Senior staff did not recognise that use of secure cell was a form of restraint and that it should only be used where absolutely necessary, based on a documented risk assessment. Senior staff had limited awareness of the relevant legalisation and Mental Health Act Code of Practice (2008).
- The seven incident forms we looked at, completed when handcuffs were used, did not record the length of time the patient spent in handcuffs. The provider's restraint policy allowed the use of more than one set of handcuffs, but it was imprecise on what would justify its use. The policy said that it was "allowed in situations where one pair of handcuffs did not appear sufficient to restrain the individual or may cause unreasonable discomfort due to the person's size". The Mental Health

Multi-disciplinary working

There was evidence of effective multidisciplinary working internally and externally.

- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- There was effective communication between the office staff, crew, call centre and external referrer. The crew informed the control room of any concerns or delays which were then communicated to the referrer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. However, they did not follow national guidance to gain patients' consent or to ensure care and treatment were in line with it.

Patient transport services (PTS)

Act Code of Practice 2008 mentions that use of mechanical restraint should be exceptional. If any forms of mechanical restraint are to be employed a clear policy should be in place governing its use.

Are patient transport services caring?

Not sufficient evidence to rate

We were unable to rate this domain because of the limited evidence gathered to inform our findings.

Compassionate care

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

- Patients satisfaction surveys we reviewed, for three months prior the inspection, indicated positive feedback was provided by majority of patients. Patient satisfaction surveys were carried out on all journeys with survey forms being provided to patients who were able to provide written feedback. This enabled the service to obtain patients feedback for most journeys.
- There was a focus on supporting patients' privacy and dignity. For example, the service only transported one patient per vehicle. The service also used unmarked vehicles and staff wore plain uniforms so there was no sign they were from a mental health service.
- Staff we spoke with were passionate about the service they provided, they were dedicated in providing compassionate care, and took pride in their work.

Emotional support

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

- Staff 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. The provider told us that they were proud that crews were able to deescalate and potential anxieties by their personal friendly and informal approach.

Understanding and involvement of patients and those close to them

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

- Staff were focused on communication and engagement with patients and promoting their independence. They were encouraged to talk with the patient and use de-escalation techniques when necessary. Staff we spoke with reflected this approach.
- The referrer was asked about any de-escalation techniques that work for the patient. This information enabled staff to tailor their management plan to meet the needs of the patient.

Are patient transport services responsive to people's needs?

Good

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

Service delivery to meet the needs of local people

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

- The service offered a nationwide service to accommodate the needs of those patients who needed transfers to and from mental health units in any area. The provider had a permanent contract with one NHS trust but the service was used by many other local and national health service providers.
- The service specialised in providing secure transport. They had specific vehicles for the transport of patients with mental health conditions. Some of these vehicles were fitted with secure cells, which were used accordingly to the risk assessment or when recommended by the referrer.
- The service also had low security vehicles that were used for informal patients and the conveyance of children. Data for May 2019 indicated that out of 150 ambulance requests, 100 of the people requesting the booking said the secure cell was required.

Patient transport services (PTS)

Meeting people's individual needs

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

- Because of the nature of the service and their short and limited engagement with the patient they did not complete individual care plans.
- All staff were issued with an electronic tablet with a translator application installed. This application was able to provide written translation and verbal interpretation and could be used to assist where a patient had any visual or hearing impairments.
- Special requests of the patient were relayed to the service at the time of booking and staff were aware of them. Staff were provided with customer care training, as well as training in dementia awareness, and mental health needs. It helped to ensure they were aware of and helped them to look out for various individual needs.
- We were advised the service took account of 'gender sensitivities' however there was no evidence to confirm this was the case as patient's preference was not recorded on the booking form.
- Staff told us if a patient needed to go to the toilet during the journey, they 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.
- Records indicated patient's needs were always assessed during conveyance this included hydration, pain, anxiety, and personal hygiene.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

- Transport was booked through the call centre and staff logged the details, delegated the job and then drivers assisted by other staff collect patients and offered transfer between sites. Most bookings were pre-planned.
- The service ran 24 hours a day, seven days a week.

- Each referral was assessed to agree 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.
- The service did not keep a breakdown of number of total numbers of high secure and low secure journeys. They did not collect data on NHS and non-NHS journey numbers. This meant they could not analyse patterns and trends.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

- The service logged 10 complaints in 2018 and three in 2019. Twelve complaints were made by referrers and one by a member of staff who had problems with accessing a vehicle. Three of those complaints referred to journey cancellation, one to poor staff conduct and one to use of handcuffs. Other complaints concerned late arrival times. The investigating manager recorded actions taken in response and how improvements were to be achieved and lessons learnt communicated with staff.
- The service aimed to acknowledge receipt of a formal complaint in writing within seven working days and provide details of actions they have taken within 28 working days of the complaint received. They participated in the complaints adjudication service for independent healthcare providers which could be contacted should the complainant feel there was a need.
- There were complaints leaflets and laminated posters available in all vehicles.
- Formal complaints were received by one of the directors and they usually acknowledged receipt within 48 hours and informed of a period for a full response. The complaint was usually investigated by the clinical service managers who prepared a draft copy of the response.
- Learning from complaints was a standing agenda at team meeting. Information was also disseminated through staff supervision.

Patient transport services (PTS)

Are patient transport services well-led?

Requires improvement



This is the first time we have rated this service. We rated it as **requires improvement**.

Leadership of service

They were visible and approachable in the service for patients and staff. They supported staff to develop their skills. However, they had limited awareness of their responsibilities in relation to provision of service governed by the Mental Health Act 1983.

- The leadership of the service consisted of a nominated individual who was responsible for the operational side of the business, including vehicles and invoicing, and a registered manager who was responsible for staff and responding to complaints. In addition, there was a clinical service manager whose role was to offer support to staff and overseeing the auditing process.
- Since our last inspection, the service had introduced a senior leaders meeting. They met quarterly as a minimum. They were looking to review the company structure to ensure it was meeting business needs.
- There were managers responsible for human resources, training, compliance with legal and regulatory requirement management of accounts and contracts.
- Leaders had limited awareness of their responsibilities in relation to provision of services that were governed by Mental Health Act 1983. They saw the service as a transport provision service and not service that provided a mental health support to vulnerable patients often in mental health crisis.

Vision and strategy for this service

The service had a vision for what it wanted to achieve. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

- The provider took pride in providing “prompt and safe customer care”. Their care objective was to treat patients with compassion, kindness, dignity, and respect. Their values were: “safety first” and “compassion and dignity”.

- Since our last inspection, the provider increased the number of vehicles to ensure there was sufficient resources to meet patients’ needs and ensure potential growth.
- The service’s vision was to be “a leading patient transport service providing tailored conveyance to clients that is safe and calm, through skilled and professional staff”. They had set objectives that aimed to support its delivery.
- Managers focused on day to day business, they developed plans for company growth, but this was not directly related to provision of patients transport services.
- Since our last inspection, the provider focused on new practices and procedures with all members of staff through staff meetings and correspondence.

Culture within the service

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Managers openly talked about challenges faced by the service and acknowledged potential areas for improvement. They promoted a positive culture that supported and valued staff, creating a sense of common purpose.
- The provider had whistleblowing procedure which invited staff to raise any concerns with senior management or commissioners of the service or regulators.
- There was a drive to deliver service improvements through learning from incidents and complaints and by accessing external advice and resources.
- The service had a duty of candour policy that encouraged staff to be open about incidents and concerns and to discuss patient safety events promptly, fully, and compassionately with patients and/or their carers or relatives.
- Staff demonstrated person centred approach, they aimed to provide personalised service driven by patient’s needs. The provider understood the role they played in patients care and treatment and considered patient’s individual needs each time they participated in patient’s journey.

Governance

Patient transport services (PTS)

Although the service had systems of accountability to manage and review service performance, governance processes did not fully reflect the provider's needs and support the services being provided.

- Two company directors and two managers met for a quarterly board meeting. They discussed service quality metrics, staffing issues, financial performance related issues as well as new business opportunities and any risks highlighted on the risk register. The service used a standard agenda which was not service specific and did not reflect all the provider's needs. For example, it referred to board assurance framework and report from the quality and safety committee, but the service did not operate these.
- The services had introduced number of new policies and were in the process of developing others. However, some of the policies were not up to date with regulations, and industry best practices and therefore were not effective. Policies were not informed by standard operating procedures or step-by-step instructions. Standard operating procedures help staff to carry out complex routine operations such as control infection, manage risks, or report and investigate serious incident.
- The service was monitoring the quality of its delivery including; use of oxygen in a vehicle, duty of candour responsibilities, fire safety availability of medical equipment and devices' checks.
- The service had regular staff meetings where good practice sharing could take place and any concerns could be discussed.
- The service held records that confirmed staff were fit to provide the service and that they were of good character and had the required skills. This included Disclosure and Barring Services (DBS) checks, staff references and documents that confirmed staff were eligible to work in the UK.
- Managers had a good understanding of the role of the safeguarding lead and they had completed safeguarding training to the required levels.

Management of risk, issues, and performance

Systems and processes for identifying and reviewing risks were not fully embedded within the wider governance processes. The provider's risk register did not reflect risks identified during the inspection.

- The service used an external consultant who carried out assessment of the service every three months so that any areas requiring improvement may be addressed. This consultant was also responsible for reviewing regulatory compliance and ensuring the service managers were aware of any changes within the legislation and were compliant with them. They provided assistance in ensuring policies and procedures were in line with legislation and any relevant guidance. However, we found that some of the policies lacked detail and did not refer for to national guidance and the provider was not fully aware of their obligation under the Mental Health Act 1983.
- The provider had an incident and complaints reporting system and staff knew how to report incidents. There was a good understanding of what constituted an incident and that incidents were to be reported. Incidents and complaints were investigated and actions in response to them recorded on the incident log. The provider did not report any serious incidents therefore we were unable to assess the quality of investigation and ability to implement changes in response.
- The service had a risk register which addressed organisational risks and listed potential risks related to individual patient's transport such as violence or absconson. These risks were related to day to day business provision and business continuity or organisational resilience. They have not changed since 2016 and it was not clear how new risks were identified or if risks were to be removed from the register once mitigation measures were implemented. The provider used a grading scale that allowed them to rate risks accordingly to likelihood and its impact. The service had a business continuity policy that also addressed some of the issues listed on the risk register for example staff shortage or vehicle breakdown.
- Since our last inspection, the service developed more systematic approach to monitoring performance and quality with number of audits being carried out and data being collected to inform senior leader in decision making process.

Information Management

The service collected data and analysed it. The information systems were integrated and secure.

Patient transport services (PTS)

- Staff were provided with training on data protection and were required to complete it every two years. Although all office staff completed this training only 66% of drivers and 50% of mental health nurses were up to date with this requirement.
- The provider assured us that only authorised staff had access to information management systems. Systems were regularly updated and backed up to ensure information was available in the event of local equipment or network failure.
- The service had a staff engagement strategy that referred to staff survey results from 2018 and identified key development areas. Five target areas aimed to enhance the level of employee engagement within the company.
- Staff encouraged patients and their carers or relatives to complete feedback forms and they used it to monitor staff conduct or improve the service. We noted that feedback provided by patients on survey forms was overwhelmingly positive (April and May 2019).

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The service carried out a staff survey in 2018 but it was not clear what actions were to be taken in response to it. The manager told us that they were looking for ways to recognise long term staff contributions and their individual achievements. Staff told us they felt supported by management, however, they were not always consulted when decisions related to their job were taken by senior management. For example, some staff did not feel sufficient information was shared when the management reduced their hourly pay rate.

Innovation, improvement, and sustainability

All staff were committed to continually learning and improving services. Leaders encouraged innovation and supported staff to identify opportunities for learning and improvement.

- The service had invested in five new vehicles.
- The service was working towards implementation of a bespoke booking system which would enable them to capture all information in one system and become a partially paper free organisation.
- The service had an external independent support to help with service monitoring and auditing the quality.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The provider must ensure staff responsible for care and treatment have access to suitable documents justifying use of Mental Health Act and Deprivation of Liberty prior to delivering the service.
- The provider must keep detailed records of patients' care and treatment.
- The provider must develop effective system for managing risks. It includes comprehensive risk assessments for each patient.

Action the hospital **SHOULD** take to improve

- The provider should ensure staff complete mandatory training.
- The provider should implement effective governance structure that is reflective of service needs.
- The provider should ensure their policies are reflecting suitable legislation, regulation, and other national guidance relevant to the service.
- The provider should ensure the vehicles are risk assessed to guarantee they meet patients' and the service's needs.
- The provider should ensure the risk register is up to date and reflective of the service's needs.

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	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <ol style="list-style-type: none">1. Care and treatment of service users must only be provided with the consent of the relevant person.2. Paragraph (1) is subject to paragraphs (3) and (4).3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*.4. But if Part 4 or 4A of the 1983 Act** applies to a service user, the registered person must act in accordance with the provisions of that Act.5. Nothing in this regulation affects the operation of section 5 of the 2005 Act*, as read with section 6 of that Act (acts in connection with care or treatment). <p>* Mental Capacity Act 2005</p> <p>** Mental Health Act 1983</p> <p>Staff responsible for care and treatment did not always have access to suitable documents justifying use of Mental Health Act and Deprivation of Liberty prior to delivering the service.</p>
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <ol style="list-style-type: none">1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

Requirement notices

2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—
 - a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
 - b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
 - c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;
 - d. maintain securely such other records as are necessary to be kept in relation to—
 - i. persons employed in the carrying on of the regulated activity, and
 - ii. the management of the regulated activity;
 - e. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;
 - f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

The service did not manage risks well. There was insufficient guidance on how to recognise and assess risks.

Records of patient's care and treatment were not detailed and lacked information in relation to use of restrain.