Mr Sam Alan Bull

Secure Care Uk

Quality Report

Unit 1
Cubitt Way
St Leonards on Sea
East Sussex
TN38 9SU
Tel: 02035985938
Website: www.securecareuk.co.uk

Date of inspection visit: 17 and 25 October 2017
Date of publication: 18/12/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Secure Care Uk is operated by Mr Sam Alan Bull. Secure Care Uk predominantly provides transport for adults, children and young people (CYP) with mental health disorders, as well as the transport and supervision of people in section 136 suites whilst awaiting mental health assessment. The 136 suite is a place of safety for those detained under Section 136 of the Mental Health Act (1983) by the police following concerns that they are suffering from a mental disorder. The provider had contracts with NHS trusts and independent hospitals. They also provided bed watches on request. During a bed watch, staff observed the patient continuously to maintain their safety.

We inspected this service using our comprehensive inspection methodology. This was a partial inspection of the service. The physical inspection of vehicles, ambulance station and talking with staff all took place at the provider's address in Hastings. This inspection did not include the other sites the provider has in the North of England and in the Midlands.

We carried out the announced part of the inspection on 17 October 2017, along with an unannounced visit to the ambulance station on 25 October 2017.

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

We found the following areas of good practice:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff reported all forms of restraint as incidents.
- The registered manager had an understanding of the duty of candour regulation and there was guidance on its use within the service.
- Records showed vehicles at this ambulance station had appropriate safety checks, were maintained and checked daily.
- Staff could plan appropriately for patient journeys using the information provided by the booking system.
- There was good communication between the control staff, crews and external providers.
- Staff helped patients feel comfortable and safe. Staff respected the needs of patients, promoted their well-being and respected their individual needs.
- Staff we spoke with were committed and passionate about their roles. They provided excellent care.
- The service encouraged feedback from patients through satisfaction surveys.
- Leaflets were available in different languages and in easy read format.
- Staff we spoke with liked working for the service. There was a positive culture and staff were focused on providing person-centred care.
- All staff felt supported by the managers of the service and said the managers were approachable and accessible should they require any advice.
- All staff had received appraisals.

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

- Incidents were not adequately investigated and relevant learning was not shared with staff.
- Staff at this ambulance station did not always complete the cleaning and vehicle safety checklists.
- The external door to the ambulance station was open on arrival at the unannounced inspection.

Summary of findings

- The service did not have equipment for children and young people.
- Oxygen cylinders were stored incorrectly.
- Management lacked awareness of safeguarding children and adults at risk.
- There were ineffective storage of patient records.
- Some of the policies and guidance were not specific to the roles, responsibilities and type of service provided.
- There were no policies or guidance for the transport of children, monitoring at 136 suites and bed watches.
- Staff were unaware of how to contact the translation service.
- Staff were unaware of the organisation's visions and strategy for the service.
- Governance arrangements were not robust enough to identify and minimise risks. There was a lack of oversight and self-assurance to compliance with the fundamental standards.

Following the inspection, we told the provider of our intentions to place conditions on their registration for transporting children and young people (CYP). This action was taken in response to our significant concerns of the immediate risk to this patient group arising from the inadequate pre-employment checks, lack of policies, lack of equipment and lack of assurance that staff were suitable and safe to undertake this work. In response, the provider took voluntary suspension of this service until they had made all the necessary improvements. The provider submitted a statutory notification to remove under 18s from its registration.

We also used our legal powers to request information from the provider following inspection; however, the provider did not completely fulfil this request. Therefore, we have been unable to gain assurance about some aspects of staff training.

The service did not have established and effective systems and processes to assess, monitor and improve the quality and safety of the services. This was a breach of a regulation. You can read more about it at the end of this report.

We also told the provider it must take some action to comply with its registration 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 one requirement notice. Details are at the end of the report.

We informed the service of our serious concerns immediately after the inspection and took immediate action.

Amanda Stanford

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)		Secure Care Uk specialised in the transport of adults, children and young people (CYP) with mental health disorders. It also monitored service users in 136 suites and occasionally provided bed watches. The service operated from a single location in Hastings, but the service had micro bases throughout England.

Secure Care Uk

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Secure Care Uk

Secure Care Uk is operated by Mr Sam Alan Bull. The service opened in 2013. It is an independent ambulance service in Hastings, East Sussex. The service is available 24 hours per day, every day of the year.

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

The service provides secure patient transport for adults, children and young people (CYP) within the United Kingdom. The service initially worked with one NHS hospital trust within Sussex. However, Secure Care Uk now provides patient transport services to a number of NHS trusts and private providers across England, Scotland and Wales.

The types of transport provided includes transfers from secure mental health services to 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 provides bed watches on mental health wards and monitoring of patients at 136 suites.

The service has had a registered manager in post since 2013; this individual also became the Managing Director of the provider in 2014. We inspected this service on 17 October 2017. This was the first time that CQC have inspected this service.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, a CQC inspector, a CQC mental health inspector and a specialist advisor with expertise within the ambulance service and safeguarding. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- It is safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions formed the framework for the areas we looked at during the inspection. Before visiting Secure Care Uk, we reviewed information we held about the location and asked other organisations to share

Detailed findings

information and experiences of the service. This was a scheduled inspection carried out as part of our routine schedule of inspections. We carried out an announced comprehensive inspection visit on 17 October 2017 and an unannounced inspection on 25 October 2017.

During the inspection, we visited Hastings, East Sussex. We spoke with 11 staff including; patient transport drivers, escorts, call centre staff and management. We were unable to speak with patients during our inspection as there were no local transfers taking place. We also received five 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 16 booking forms and 10 employment records. We reviewed policies and procedures the service had in place. We checked to see if complaints were acted on and responded to. We also analysed data provided by the service both before and after the inspection.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the 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 main base station in Hastings. The service had recently moved into this building and was undergoing work to reconfigure the space. The downstairs area consisted of the control room, crew room, storage area and toilet. The upstairs consisted of offices and the staff kitchen. The ambulance station we inspected had 12 vehicles including specially adapted ambulances with a separate area for the patient.

The service took bookings from referring hospitals via email and telephone. Call centre staff completed a booking form with the help of the referrer to enable the service to complete a risk assessment for each patient. Using the risk assessment, the call centre staff assigned a crew and a suitable vehicle. Once dispatched, the crew called the control centre with updates during the journey. After completing the job, the crew returned to their base and handed in all completed documentation.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the first inspection since registration.

Activity (September 2016 to August 2017)

- The service completed 3165 adult and 68 Children and Young People (CYP) patient journeys.
- Information provided by the service in August 2017 reported the service employed 52 staff. This consisted of one director, six managers, five team leaders, three finance staff, five call centre staff and 32 driver and/or escort staff.

Track record on safety

- No never events
- Between May and August 2017, the whole service reported 56 incidents of which 98% resulted in no harm and in 2%, the level of harm was not identified.
- No serious injuries
- Four complaints

Patient transport services (PTS)

Summary of findings

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

We found the following issues:

- Incidents were not adequately investigated and relevant learning was not shared with staff.
- Staff at this ambulance station did not always complete the cleaning and vehicle safety checklists.
- The external door to the ambulance station was open on arrival at the unannounced inspection.
- The service did not have equipment for children and young people.
- Oxygen cylinders were stored incorrectly.
- There were ineffective storage of patient records.
- There were multiple versions of the booking form in use and service audits showed a consistent lack of clinical detail obtained at the referral stage.
- Employment records showed delayed reference checks, incomplete disclosure and barring checks (DBS) documentation and a lack of staff training records.

We found the following areas of good practice:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff reported all forms of restraint as incidents.
- The registered manager had an understanding of the duty of candour regulation and there was guidance on its use within the service.
- Records showed vehicles at this ambulance station had appropriate safety checks, were maintained and checked daily.
- Staff knew how to prevent the spread of infection.
- Staff completed a week of competency assessments whilst being mentored by another staff member.

Are the services effective?
We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff could plan appropriately for patient journeys using the information provided by the booking system.
- There was good communication between the control staff, crews and external providers. The call centre staff held a handover meeting daily.
- All staff had completed 'Mental Health & Capacity Act' training.
- All staff had received appraisals.
- The service monitored performance against response times and cancelled journeys.
- The service coordinated well with the NHS trusts they provided a service for, with police and with the section 136 suites.

We found the following issues:

- Some of the policies and guidance were not specific to the roles, responsibilities and type of service provided.
- Staff did not complete any specific training in relation to transporting children and young people.
- Staff did not complete comprehensive training or competencies on their role and responsibility within the 136 suites.

Are the services caring?
We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff helped patients feel comfortable and safe.
- Staff respected the needs of patients, promoted their well-being and respected their individual needs.
- Staff we spoke with were committed and passionate about their roles.
- Staff wanted to make a difference to patients' lives.
- Comments from patients and their relatives were very positive.

Are the services responsive to people's needs?
We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The service encouraged feedback from patients through satisfaction surveys.
- Leaflets were available in different languages and in easy read format.

Patient transport services (PTS)

- Staff had access to sensory aids which they used for patients living with dementia or patients with a learning disability.
- The service had patient leaflets on how to complain/ compliment the service.
- Staff communicated any expected delays and estimated time of arrival to the unit/hospital.
- There was evidence of joint working with other providers of healthcare to investigate complaints.

We found the following issues:

- Staff were unaware of how to contact the translation service.
- The service did not have patient eligibility criteria for call handlers to use.

Are the services well-led?
We do not currently have a legal duty to rate independent ambulance services.

We found the following issues:

- Management lacked awareness of safeguarding children and adults at risk.
- There were no policies or guidance for the transport of children, monitoring at 136 suites and bed watches.
- Some internal policies did not reflect the service provided.
- Staff were unaware of the organisation's visions and strategy for the service.
- Governance arrangements were not robust enough to identify and minimise risks. There was a lack of oversight and self-assurance to compliance with the fundamental standards.
- The service lacked robust action plans in light of audit outcomes.
- The 'Integrated Governance Committee' meeting was new and needed time to be embedded.
- Senior management staff were not held to account for meeting deadlines as the service did not review progress of actions plans following meetings.
- Only the registered manager was able to identify risks to the service .
- The service undertook new contracts without full consideration of the implications or ensuring effective systems and processes were fully embedded first.
- The service lacked understanding of its responsibilities in relation to medicines management.
- The service did not submit statutory notifications to the CQC in line with their registration.

We found the following areas of good practice:

- Staff we spoke with liked working for the service. There was a positive culture and staff were focused on providing person-centred care.
- All staff felt supported by the managers of the service and said the managers were approachable and accessible should they require any advice.
- Staff had access to a confidential whistleblowing helpline through a third party.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had an incident management policy that outlined the arrangements for reporting and investigating incidents.
- Staff reported they were encouraged to report incidents and felt they could raise concerns with the management team.
- Staff understood the requirement to report incidents and completed paper incident forms, which they gave to the senior operations manager. The senior operations manager discussed incidents at weekly management meetings.
- The service introduced a new incident form, which captured more information about incidents such as patient details and information about the alternative methods used prior to restraint. However, the incident forms did not contain any risk grading. This is not in line with the service's 'Incident Reporting' policy, which states, 'The person completing the form should grade the incident'.
- Part of the incident form allowed staff to reflect on their practice by identifying lessons learnt and what they would do differently. In the majority of cases, staff did not complete this section or wrote 'n/a'. Front line staff told us they were not aware of any lessons or changes implemented because of incidents.
- Staff could indicate on the incident form whether they wanted debriefing with the operations manager. Documentation of one completed debrief showed staff had discussed and reflected upon the incident. The documented lessons learnt included ensuring staff completed an in-depth patient risk assessment. There was no evidence of any action taken.
- We reviewed four internal investigations into staff practices, which showed an in-depth investigation took place. However, there were no completed actions plans or evidence of shared learning. Therefore, the service had no evidence to show they acted to lessen the risks and avoid the incidents happening again
- The service categorised all forms of restraint as a clinical incident and expected each member of the crew to complete an incident form when this occurred. We recognised this as best practice. In the five incident reports we reviewed, there was one occasion where this was not followed.
- The service undertook a monthly incident analysis and compared the results to the previous months. We reviewed the analysis for May, June, July and August 2017. We found only incidents involving mechanical restraint were analysed and there was no information about investigation outcomes or lessons learnt. This meant the service missed opportunities to learn from all incidents.
- The service reported no never events to CQC between September 2016 and August 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level and should have been implemented by all healthcare providers.
- The whole service reported 56 incidents between May and August 2017. The incident log showed in 84% of incidents, the comment in the action or outcome taken column was the same or similar. This demonstrated a lack of comprehensive investigation into each incident. This meant the service missed opportunities to learn from incidents.
- The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. The service had one incident where the duty of candour was triggered and the service responded appropriately.

Cleanliness, infection control and hygiene

- The organisation had an infection prevention and control policy that was in date and outlined standard operating procedures for decontamination of equipment/vehicles, management of patients with blood borne viruses and use of personal protective equipment (PPE).
- The vehicles and vehicle records we reviewed were for the vehicles based at the Hastings ambulance station only.
- The service introduced a new cleaning and vehicle safety checklist. Staff completed the paper checklists

before using the vehicle. The fleet manager noticed any omissions in checks when scanning the completed checklists into the computer to make an electronic record.

- We reviewed 72 checklists completed between July and August 2017 for vehicles in the South. We found 58% were fully completed, 18% had only vehicle checks completed, 19% had only cleaning checks completed and 5% were blank. There was one comment, whereby staff stated they could not clean the vehicle due to, 'no cleaning materials'. This meant the service did not always have assurance the vehicles were clean and ready for use.
- Staff did not complete cleaning and vehicle checklists at the end of each journey. However, staff reported to the fleet manager if they found a dirty vehicle. The fleet manager raised this with the previous crew.
- All vehicles had a recorded weekly deep clean by an external contractor. This was in addition to the cleaning of each vehicle by staff after each patient journey.
- The fleet manager undertook weekly spot checks on random vehicles to monitor staff compliance to the checklists. These spot checks were not recorded.
- The provider undertook a monthly vehicle audit, which included the standard of hygiene on board the vehicle. The October 2017 audit showed seven out of eight staff was aware of the hygiene posters and not wearing any jewellery on duty. All staff was aware of the importance of hand hygiene and the resources available.
- We inspected five vehicles and found they all contained alcohol hand rub dispensers, clinical waste bags, decontamination wipes, personal protective equipment such as gloves and body fluid spill kits. Staff could replace these items at the base when required.
- Two out of the five vehicles had torn fabric seating and the foam inside was exposed. We escalated this to the fleet manager who replaced the seats with wipe clean seating on the same day as the inspection.
- Staff put clinical waste into the small yellow bags on the vehicle and then disposed of this either in the large clinical waste bin back at base or whilst at the referring/receiving hospital. The clinical waste bin was unlocked and contained loose items such as gloves and cleaning cloths.
- An external contractor collected the clinical waste on an ad hoc basis when the service requested collection.
- Staff had access to a strong disinfectant, which was suitable to use for blood borne viruses and bacteria such as MRSA and E.coli). This is in line with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections.
- The job sheets documented whether patients had any blood borne viruses to ensure staff took the necessary precautions.
- Staff reported if a patient bit them and broke the skin, they would squeeze and clean the wound in the first instance. They would attend the nearest accident and emergency for tests and treatment. This is in line with the Health and Social Care Act (2008) Code of Practice.
- Staff wore visibly clean uniforms. They were responsible for washing their own uniforms. Staff told us they would return to base to change into clean uniform if theirs were soiled during a patient journey.
- Staff completed an e-learning infection prevention and control module. We requested the training rates for all staff but we did not receive this. The service did not carry out any face-to-face hand hygiene training or competency.

Environment and equipment

- The ambulance station was purpose built with space downstairs for equipment storage. During the inspection, the service was undergoing works to update their IT system and relocate the control room.
- The entrance to the station and the subsequent internal doors were open on arrival at the unannounced inspection. Despite there being internal CCTV cameras, this compromised security and posed a significant risk of theft of equipment and medical gases.
- Access to the control room was restricted to specific named people as shown on a list on the control room door. However, the door was unlocked and so restricting access to those named people depended on there being someone in the control room who would tell unauthorised person to leave. The fleet manager who was based in the control room was not on this list and staff told us the door could not be locked, as it was a fire escape. Therefore, the service could not fully enforce restricted access to this area. This posed a risk to data protection and access to confidential personal information.
- The service operated a fleet of unmarked cars, ambulances and celled ambulances. In each ambulance, a metal grid or panel separated the driver

from the other passengers. This protected the driver from being attacked and meant the vehicle could be driven safely regardless of any incident taking place in the passenger compartment.

- The service kept vehicles directly outside the base. Staff would attend the office to collect the designated vehicle keys. During the announced visit, the service kept the keys in an open plastic tray due to the ongoing works. However, during the later unannounced visit, there was a key safe on the wall with an access code in use.
- The fleet manager reported the service replaced older vehicles with newer models that were not more than five years old.
- Records showed completed and up-to-date vehicle maintenance and servicing schedules. All vehicles in use had an up-to-date MOT and road tax. The fleet manager told us there were two vehicles out of use due to expired MOTs. The insurance certificate showed all vehicles had insurance.
- Each vehicle had a clear plastic box with essential kit in it, which included items such as a first aid box, urine bottles and sick bags. Staff checked the content of the box daily before using the vehicle. The fleet manager monitored the expiry dates of the kits weekly using an electronic spreadsheet. We checked seven boxes and found one bandage out of date. Staff escalated this to the fleet manager who replaced the item immediately.
- The service had a system in place to ensure all equipment were maintained and the safety checks completed by an external provider. Records seen provided assurance the checks were carried out routinely.
- Staff reported any faulty equipment on front line vehicles to the fleet manager, who was a qualified mechanic, for immediate action.
- We asked the service what equipment they had for children and young people (CYP). The service told us they did not have any equipment. We had serious concerns the service were unable to cater for the needs of CYP in both emergency and non-emergency situations.
- The service did not use trolleys like traditional ambulances, patient sat in seats during the journey. The service did not have booster seats for children.
- There was fire safety equipment in the base station and records showed it had maintenance checks completed within the past 12 months.
- The service had bought defibrillators as two of their NHS contracts requested the service had these in every vehicle. Staff including senior management was unclear whether defibrillators were in use on the vehicles. We reviewed seven vehicles and found one defibrillator on board in a locked cupboard. We asked the service for the contents of the first aid training to determine if staff received training on defibrillators but the service did not provide this information. Therefore, we were unable to gain assurance staff were competent to use this equipment.
- We found specialist kit bags in the storeroom. Staff told us the provider had purchased maternity and airways kits. They told us the specialist kits were not in use and there was no intention of bringing them into service use. If the provider were to do this, it would be outside of its scope of registration.
- The service did not transport bariatric patients and therefore did not have modified vehicles or equipment.
- There was an unlocked cupboard containing hazardous substances such as de-icer, large cans of engine de greaser, anti-freeze and motor oil. The service had identified this as a risk during a health and safety audit on 12 October 2017. Actions included suitable cstorage; however the service had taken no immediate action to mitigate the risk. The storage is not in line with the Health and Safety Executive (HSE) guidance on the COSHH regulations (2002).
- The fleet manager carried out a weekly fire safety inspection. The latest inspection had two actions required which included signage and access to a fire extinguisher. The service was addressing these.
- Records showed the service checked the emergency lighting at the base station monthly and the fire alarms weekly.

Medicines

- The service did not have any stock medicines on site, nor did the ambulance crews administer any medications. Staff told us they stored patients own medication in the glove compartment during the journey.
- The medicines management policy covered the safe storage and transportation of patient own medication. The policy was not reflective of the service provided. It stated staff should record all transported medication except controlled drugs (CDs). No records for medicines existed.

- The service audited the storage of CDs during transit in the monthly vehicle audit. The October 2017 audit showed staff lacked understanding of their responsibility in relation to the patient's own CDs. The service planned to incorporate training into induction and ordered CD books to place in all vehicles. However, it was unclear why the service took this action as their medicines management policy stated staff should not store or record CDs.
- Oxygen cylinders at the ambulance station were stored individually in a fabric case, on a rack within a small storage room with no signage showing the presence of medical gas. Compressed gas storage arrangements did not comply with the British Compressed Gases Association Code of practice 44: The Storage of Gas Cylinders, 2016.
- The service had purchased oxygen as one of their NHS contracts requested the service had oxygen available in each ambulance. An external company provided a training programme for all drivers and escorts. At the time of inspection, the oxygen purchased was not for the providers operation in the South.

Records

- The call centre staff created electronic booking forms from the control room at the ambulance station. This ensured if paper versions of the completed booking form were lost, there were electronic copies.
- The call centre staff completed booking forms using information received from the referring person such as ward staff or the police.
- The service had two versions of the booking form in use. Staff told the service they had not shared the newer version with all providers and some providers had reverted to the older version.
- The newer version was comprehensive and captured more information around risk. However, it did not use a risk rating scale of low, medium and high. The provider's policy referred to this scale, which call centre staff used to decide on staffing numbers for each journey. For example, high risk required a minimum of one driver and two escorts. This meant there was a discrepancy between the policy and the new booking form.
- Drivers and escorts in the South picked up a printed copy of the booking form from the control room. Staff returned all completed paperwork to the control room after each journey.
- Staff kept the booking forms and invoices together and stored them in a locked room.
- We chose 16 booking forms from the locked room and asked to see the rest of the records associated with these journeys including body maps, observation charts, journey report forms and details of restraint (if used). The HR manager was unable to retrieve this information due to the processing and storage of completed records. This meant we had no assurance staff completed this paperwork or that the provider kept the records.
- The monthly booking form audit for August 2017 showed there was a consistent lack of clinical detail obtained by call centre staff. There was no formal action plan; however, the service recognised the need for further analysis to identify staff that would benefit from individual supervision and training.
- The service kept an electronic booking log detailing all jobs details such as date and time of referral, referrer contact details, patient details, journey details including start and finishing times.
- Drivers recorded the time in which they drove on each journey. This meant the provider could monitor driving hours and any risks drivers could be at due to being tired. Due to the ineffective storage, we were unable to review completed forms.
- When booking patient transfers, details of any patients with 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place would be recorded on each booking form. One booking form identified the patient had a DNACPR order. We requested to see evidence to show staff received copies of the DNACPR form prior to undertaking the journey as per the provider policy. However, we did not receive this information.
- The crew attending a 136 suite completed sections in an admissions logbook. The logbook recorded the time of the admission, assessment and the outcome of the assessment. The service discussed the logbook at performance review meetings with the NHS Trust.

Safeguarding

- The service had a 'Safeguarding Vulnerable Adults and Children' policy which was accessible to staff. It outlined responsibilities, types of abuse and contact details for local authorities. Best practice dictates this should be two separate policies.

Patient transport services (PTS)

- Staff we spoke with knew their responsibility to report safeguarding concerns. If they had a concern, they would report it to the control room or manager in the first instance and complete the appropriate referral forms. There were safeguarding referral forms in the vehicles we inspected.
- At the time of inspection, the operations manager was the safeguarding lead for the service.He had undertaken level two safeguarding children training. This is not in line with the ' intercollegiate document' (2014).
- The safeguarding lead had raised a safeguarding concern in July but did not alert the local safeguarding authority until nearly three weeks later. This demonstrated the safeguarding lead did not understand their duty to report safeguarding concerns to external bodies.
- CQC received no statutory notifications for allegations of abuse from the provider. However, the service reported one safeguarding alert. This meant the provider did not understand their duty to report allegations of abuse as part of its registration.
- The training manager had undertaken level three safeguarding children training. However, he was unaware of any national policy or documents relating to safeguarding. This was a significant concern, as he was delivering safeguarding training to staff. During the interview, he confirmed the operations manager was the safeguarding lead.
- The training manager reported staff received level three safeguarding training, whereas the safeguarding lead believed all staff received level two. The certificates we reviewed did not state the level of training, therefore we did not have assurance staff received level two training in line with the intercollegiate document.
- Data we received showed 100% of staff in the South had received safeguarding training. This is significantly better than the provider's target of 75%.
- We checked ten employment records chosen at random. We found delayed reference checks, incomplete disclosure and barring checks (DBS) documentation and a lack of staff training records. DBS checks were set up to prevent unsuitable people from working with children and adults at risk. This is discussed later in the report.
- The booking form captured information regarding safeguarding and personal protection plans. However, the booking form audit for August 2017 showed staff did not consistently obtain this data. Staff we spoke to did not understand what a personal protection plan was.

Mandatory training

- The service had a training manager who took responsibility for delivering training and training compliance. The training manager visited other bases to provide mandatory and refresher training to staff.
- New staff completed five days of induction training covering ten topics, including manual handling, conflict resolution, first aid and prevention and management of violence and aggression (PMVA) training. We spoke to the training manager who reported the PMVA training was one day and consisted of self-defence, handcuffing, de-escalation and breakaway techniques.
- We asked the service for information about the contents of their first aid mandatory training; however, the service did not provide this information. We saw the contents of the PMVA training but this information did not clarify whether it included any child specific content. Therefore, we did not have any assurances training reflected best practice in relation to children and young people (CYP) as outlined in the National Institute of Clinical Excellence (NICE) Guideline 10.
- The service told us staff also completed six mandatory e-learning modules during their induction and a further 29 modules during the year. The training matrix showed only 33% of staff in the South had completed all 35 e-learning modules. This is significantly worse than the provider's target of 75%.
- The service did not maintain accurate and complete staff training records. We reviewed 10 employment records and found a lack of training records and competencies. The training manager told us he issued training certificates when staff attended face to face training. The training certificates we did see, had the same date despite the training taking place on different days. We raised this concern to the training manager who reported this was a human error. This meant the service did not have accurate documentation of staff training.
- The service had a training matrix, which showed the dates of when staff completed training. Training highlighted in red indicated it was incomplete or expired. However, the training dates were the same for

multiple modules and staff. We raised this concern to the training manager who reported this was a human error. This meant the service did not have accurate oversight of staff compliance to training.
- Staff told as they received refresher training yearly but could also do training sooner if they felt it necessary.
- We noted 61% of staff in the South had completed first aid training. This is significantly worse than the provider's target of 75%. The service explained this was due to an influx of new starters who were scheduled to complete the first aid course.
- The service suitably trained and assessed drivers to carry out driving duties. Staff completed a week of competency assessments whilst being mentored by another staff member. There were completed driving competency assessments in the employment records.
- The training manager reported he observed staff while on duty on an ad hoc basis. However, there was no evidence of this within the employment records.

Assessing and responding to patient risk

- The call centre staff completed a booking form with the help of the referrer to enable the service to complete a risk assessment for each patient. The risk assessment included the risk of violence, suicide, self-harm and absconding. Using the outcome of the risk assessment, the call centre staff assigned a crew and a suitable vehicle.
- The service had a 'Vehicle and Transfer Policy and Procedure', which outlined the responsibilities of staff if a medical emergency occurred. Staff were aware of this policy and told us they would the administer first aid, contact control and make the decision to take the patient to the nearest emergency department or call 999.
- Staff received first aid training yearly. We asked the service to provide information on the contents of this training but we did not receive this. Therefore, we were unable to gain assurance staff what level of training staff received and whether this training included child specific content.
- The service reported it had never used blue lights to convey a patient to hospital.
- The service did not transport bariatric patients; however, the call handlers did not request the patient's weight at the time of booking and so did not assess the risk to the patient or staff if the journey is completed.
- The service had a 'Mechanical Restraint' and 'Restrictive Interventions' policy, which reflected best practice for adults. However, it failed to establish the procedures to follow for restraining children. Staff told us they were not allowed to use handcuffs on CYP as they had been told not to. However, NICE Guideline 10 states staff can consider using mechanical restraint, such as handcuffs, when transferring CYP. This demonstrated staff did not have an understanding of their role and responsibilities in relation to restraining CYP.
- Staff told us any form of restraint they used was the minimum amount necessary for the shortest possible time, and as a last resort. This complied with guidance by the Department of Health (DoH) entitled 'Positive and Proactive Care: reducing the need for restrictive interventions' (2014) and NICE Guideline 25.
- The service was unable to assure itself staff followed restraint policy and procedures. The service did not keep completed paperwork such as body maps and observations following restraint together with incident forms. Therefore, the process could not be scrutinised.
- Between May and August 2017, the whole service reported 6% of all patient journeys resulted in restraint.
- Between May and August 2017, the service reported the use of handcuffs on three occasions and prone restraint on two occasions. Prone restraint or face down restraint is when someone is pinned on a surface and is physically prevented from moving out of this position. We were unable to determine from the incident report whether staff used prone restraint in line with the DoH (2014) guidance, which states it can be used in exceptional circumstances.

Staffing

- Information provided by the service in August 2017 reported the service employed 52 staff at its Hasting's location. This consisted of one director, six managers, five team leaders, three finance staff, five call centre staff and 32 drivers and/or escort staff.
- Drivers and/or escorts worked on an on call basis and so only attended the location for training or support and when allocated to a job.
- Call handlers staffed the control room 24 hours a day, 365 days a year.
- The operations manager developed the monthly rotas for staff, taking into account staffing levels and skill mix. The call centre had access to the electronic rotas so they could allocate staff appropriately.

- There were no staff on a zero hours contract and at the time of inspection the service in the South did not employ qualified healthcare professionals.
- One of the service's contracts in the North required the service to provide a registered mental health nurse (RMN) on 90% of all patient journeys. The service used a healthcare agency to meet this demand but had also recently recruited two RMNs. We did not speak to these nurses as part of this inspection.
- Data submitted by the service showed staff turnover rate for the whole service was 41% for the last 12 months. The service reported some staff completed the training then left the service. In order to address this, the service provided a financial incentive to encourage staff to stay and introduced an agreement with employees that they will pay a fee for training if they leave the service within a specified period.
- Data submitted by the service showed staff sickness rate was 0.9% for the whole service in the last 12 months.
- During the inspection, we observed staff calling into the control room because they were concerned about the lack of work to meet their contracted hours. These staff were paid by the number of hours they worked. The registered manager explained employee contracts were due to change. The changes meant staff would follow a set rota, for example four days working followed by four rest days. Therefore, they would always meet their contracted hours.
- Within the vehicle and transfer policy and procedure document, the service had an aggregated staffing tool, which call handlers used to assign the correct number of staff unless otherwise specified by the referrer. If staff identified a high or medium risk transfers the minimum staffing level was one driver and two escorts. For low risk, it was one driver and one escort.
- The service provided a minimum of two staff to monitor patients whilst at a 136 suite as stated in the contract.

Response to major incidents

- A major incident is any emergency that requires the implementation of special arrangements by one or all of the emergency services. It would generally include the involvement, either directly or indirectly, of large numbers of people. As an independent ambulance service, the provider was not part of the NHS major incident planning.
- Each ambulance carried details of a 24 hours a day, seven days a week, breakdown recovery service. Staff told us if the vehicle broke down whilst a patient was on board, they would call the control room and request another crew to continue the patient journey.
- There was a comprehensive policy for business continuity, which was overdue for review (September 2016). It outlined the organisations response to major incidents such as IT failure and fire.
- The service carried out bi-annual fire drills. The last recorded fire drill was in March 2017.

Are patient transport services effective?

Evidence-based care and treatment

- All except one of the policies we looked at was within its review date. A third party advisor wrote and reviewed policies and procedures. The registered manager updated staff about new policies and procedures via a closed social media group.
- Staff accessed policies via the computer system and the policies folder held at the base station. There were plans in place to have a staff intranet so staff could access policies more readily.
- The resuscitation and medicines management policies did not reflect best practice and did not reflect the service provided.We raised our concerns with the registered manager post inspection. They reported the service would seek clinical advice from regulatory bodies and amend the policies as necessary.
- The service monitored staff knowledge of policies through audit. The vehicle audit dated August 2017 showed staff lacked knowledge around the management of controlled drugs. The booking form audit dated August 2017 showed the majority of staff followed its aggregated staffing tool.
- Staff signed signature lists to say they had read the organisation's policies. However, there were new policies introduced over the past few months. We asked to see the signature list for these. The compliance manager told us these were on the shared drive but we were not shown this.

Assessment and planning of care

- Following a referral, the call handler made the booking form available to the crew. The form included whether

or not the patient was detained under the Mental Health Act (1983). This meant the crew were aware of their patient's condition at the onset of their journey so they could plan the transport appropriately.
- At the time of inspection, 100% of staff in the South had completed 'Mental Health & Capacity Act' training. This is significantly better than the provider's target of 75%. Although, we noted the provider's target to be low given the specialist mental health service it provides to vulnerable adults and children.
- The call handlers held a 15-minute handover meeting daily between shifts. Staff discussed the activity for the day including jobs and crew availability using the details on the whiteboards within the control room.
- The call handlers updated the whiteboards throughout the day to reflect the pre booked journeys for the following day.

Response times and patient outcomes

- Between September 2016 and August 2017, the service completed 3233 patient journeys.
- The service monitored performance against response times by reviewing the booking forms, on which staff logged the times calls were received and the time the patient was received into their care. The service also monitored the number of cancelled patient transfers.
- The service reviewed its performance against its two-hour response time target at weekly management meetings. We reviewed five weeks of monitoring reports for the South which showed the below
- 2 July 2017: 89% of transfers were completed of these 83% met the response time.
- 9 July 2017: 92% of transfers were completed of these 77% met the response time.
- 16 July 2017: 78% of transfers were completed of these 81% met the response time.
- 23 July 2017: 71% of transfers were completed of these 82% met the response time.
- 6 August 2017: 83% of transfers were completed of these 68% met the response time.
- The service aimed to meet their two hour response time in 100% of cases. No discussions around reasons for missing the target were recorded and there were no action plans.
- The service had a key performance indicator (KPI) as part of one contract with a NHS Trust in the South. The service had to attend to 90% of incidents within 30 minutes of the police detention. The service submitted monthly activity reports and discussed any breaches to the KPI at performance review meetings.
- Feedback received by the CQC showed the NHS Trust raised no concerns about the service's ability to fulfil the requirements of the contract.
- The service fully investigated any breaches of its contract with the NHS Trust. We reviewed correspondence and action plans dated September 2017 following contract breaches. Actions included having an out of hours call centre manager, appointing a service delivery manager to work solely on the contract and the recruitment of 12 staff.

Competent staff

- All new starters to the service completed five days of mandatory training followed by five days of shadowing as part of their induction process. This consisted of first aid, restraint, moving and handling, conflict resolution, safeguarding, 'Mental Health & Capacity Act' and health and safety at work.
- Staff had a good understanding of how to manage challenging behaviour and told us they always tried de-escalation tactics in the first instance.
- Staff did not complete any specific training in relation to transporting children and young people (CYP). This posed a significant risk to staff and CYP.
- Staff did not complete any competencies following induction. This meant the service lacked assurance about the effectiveness of training and the competence of staff to undertake the role.
- The service did not require staff to have previous healthcare experience. The training manager who delivered all internal training did not have any previous experience of healthcare or teaching prior to this role. He told us he does his own research to enable him to teach and attended a train the trainer day for PMVA training.
- The service provided new starters with an induction workbook and an employee handbook. Staff completed the workbook within the first three months of employment. The workbook contained 33 questions in relation to four topics such as protecting patients and other people. Each new starter had an assessor who would review their answers and sign off the workbook.

- All staff received a yearly appraisal with their line manager. Completed appraisal documents were kept in the employment records. At the time of inspection, 100% of staff had received their yearly appraisal.
- Staff had one to one supervision with their line manager every three months. The agenda included progression, challenges and training needs. There was an inconsistent approach in the completeness of supervision documents. At the time of inspection, 81% of staff had received supervision.
- The Integrated Governance Meeting Minutes (October 2017) showed themes from appraisals and supervisions included refresher and additional training. Actions taken included offering training to staff where needed.
- We identified that between May and October 2017, the service attended the 136 suite on 35 occasions and bed watches at local hospitals on seven occasions. Although a standard operating procedure by the NHS Trust existed for the 136 suite provision, there was no evidence to show staff underwent comprehensive training, completed competencies or attended external training to enable them to provide these types of services.

Coordination with other providers and multi-disciplinary working

- Staff told us hospital staff who were caring for the patient being transferred were able to travel with the patient if they needed to.
- There was good communication between the control staff and crews, however call handlers stated they felt there should be clearer guidance on how to assign crews so there was a universal approach which was fair.
- Feedback from external stakeholders demonstrated staff had good rapport with healthcare professionals and law enforcement agencies. One comment received was, “I even got a phone call to let me know how my patient was on the journey and that she had arrived at hospital safely”.
- There was coordination with the NHS trusts they provided a service for, with police and with the section 136 suites. This ensured the police and the patient were not kept waiting whilst staff arrived to take the patient into the 136 suite.
- There were no patient records available to show if staff recorded a handover from the transferring unit.
- Staff did not attend meetings or training at other hospitals or units. This was a missed opportunity to improve multi-disciplinary working.

Access to information

- Patient records were stored securely on vehicles during transfers in lockable carry cases.
- Due to the storage of records, we were unable to gain assurance the service obtained essential paperwork such as do not attempt resuscitation (DNACPR) prior to transferring a patient as per the service’s policy.
- All vehicles had up to date satellite navigation systems.
- Call handlers completed booking forms electronically but printed these for drivers and escorts so they could review the information before leaving the base station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a policy for mental capacity, which summarised key principles of the Mental Capacity Act (2005). However it did not outline the responsibilities of staff when transferring a patients who lacked capacity. It also did not provide any guidance specific to children and young people (CYP).
- The service had standard operating guidelines for the Deprivation of Liberty safeguards (DoLs). DoLs was 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 guidelines stated crew must request to see the DoLs order to ensure that it is valid.
- The new booking form requested information from the referrer about whether there was any DoLs in place. Due to the storage of records, we were unable to gain assurances staff recorded viewing the DoLs order.
- The service had a ‘Restrictive Practice Intervention Policy’, which embodied the Mental Health Act Code of Practice (2015) and the Mental Capacity Act (2005) both of which are applicable in the conveyance of patients under the Mental Health act (1983). However, there was no reference to using force with the elderly, children and young people and people with learning disabilities.
- At the time of inspection, 100% of staff had completed “mental health and capacity act” mandatory training.

Patient transport services (PTS)

- The booking form requested information from the referrer about whether informal patients have consented to the transfer. If not the call handler would not proceed with the transfer.

Are patient transport services caring?

Compassionate care

- We reviewed the folder of compliments, which the service received from patients and their relatives, which included positive and appreciative comments about the service they had received and the caring attitude of staff.
- Feedback from patients demonstrated staff were kind and compassionate. Patients said, "She was an inspiration to me", "Staff were great to me" and "They have made me feel at ease".
- The service gave every patient the opportunity to complete a feedback questionnaire. The survey for May 2017 had a 32% response rate. The feedback report showed the majority of patients who responded thought the service was either 'excellent' or 'good'. Patients felt the crew showed them dignity and respect, understood their needs and allowed them to ask questions.
- The service used unmarked vehicles and staff wore uniforms with minimal logos or writing. The vehicles had CCTV in them but this used infrequently to respect patient privacy and dignity.
- There were times when staff had gone beyond their role to meet the needs of the patient. In one example, the crew had bought the young person crayons for colouring because hospital staff had taken away their pens for safety reasons.
- Staff took the necessary time to engage with patients. They communicated in a respectful and caring way, taking into account the wishes of the patient at all times.
- Vulnerable patients, such as children and young people (CYP) and those living with dementia or a disability, could have a relative or carer with them while being transported wherever possible. If there was no seat available within the vehicle due to the number of staff, relatives or carers could follow in their own vehicles.
- All staff were passionate about their roles and were dedicated in providing a service where the patient came first. Staff enjoyed their roles as they felt they were making a difference to the patients' lives.
- The 'Vehicle and Transfer Policy & Procedure' stated patients can travel for a maximum of two-and-a-half hours before they must be offered a comfort break, although this may be reduced accordingly to meet individual needs. Staff told us they routinely offered patients comfort breaks during long journeys.

Understanding and involvement of patients and those close to them

- Staff told us they were respectful and encouraged the input of family members. They asked family members about the patient's likes/dislikes and how best to interact with the patient. This meant staff could provide a more personalised approach to transporting the patient.
- Due to the storage of patient records, we were unable to review examples of where staff had used an personalised approach to meet the needs of the patient.

Emotional support

- Patient and external stakeholder feedback showed staff provided emotional support to patients in distress. Comments included, "The staff have made my stay at the 136 suite as minimally stressful as possible", "Staff made the patient feel very at ease" and "They are my heroes for making me smile".
- One compliment showed a member of crew spoke to the patient throughout their journey about their life experiences and previous employment, which inspired the patient to focus on their career prospects. The patient wrote to the service months later to invite the member of staff to their passing out parade.

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

Service planning and delivery to meet the needs of local people

- Secure Care Uk had a contract with a local NHS trust for the provision of transport and observations of patients held in a 136 suite. The police informed a third party of the 136 detention who liaised with the service. The

service conveyed the patient to a place of safety for assessment by a registered mental health nurse. Following assessment, the crew would either convey the patient to their home or to a mental health unit.
- The service monitored its performance through monthly reports submitted to the NHS Trust before the monthly contract meetings. During these meetings, the service discussed its compliance with the contract.
- Some call handlers also trained as escorts; this meant during high levels of activity, the service could utilise this dual role.
- Feedback from external stakeholders demonstrated staff were professional and respectful to the patients. Stakeholders said, "Staff introduced themselves to the patient", "Staff are very attentive and kind" and "The crew were sensitive to the individuals' needs showing flexibility, a calm demeanour and professionalism".
- The service did not transport bariatric patients; however, the call handlers did not request the patient's weight at the time of booking. Therefore, it was unclear how they would identify this patient need.

Meeting people's individual needs

- There was telephone translation support available for patients who had limited ability to speak and understand English. However, we asked the call handlers to contact the translation service and they did not know how to do this.
- The service had a brief welcome leaflet written in a variety of languages to give to patients whose first language was not English.
- One member of staff could communicate using Makaton and had employed this skill at work. Makaton uses signs and symbols to help any person with communication challenges to communicate more effectively.
- Call handlers asked the referrer if the patient had a diagnosis of dementia or learning disability. Staff had access to sensory aids such as fidget spinners and a twiddle cushion.
- The service had patient leaflets on how to complain/compliment the service. This was also available in easy read format for patients with learning disabilities.
- Patient's individual needs were noted when the booking was taken and arrangements made to meet those needs. For example, spiritual needs, triggers to challenging behaviour and de-escalation techniques the patient was responsive to.
- The service did not currently have facilities to transport bariatric patients.
- The vehicles had male urinal bottles for patients to use if they needed the toilet. Alternatively, the escort called the control room who liaised with a place of safety such as a police station or local hospital and advised the crew accordingly.
- Patients could request that a relative/friend travelled with them. Staff told us they would position the relative diagonally opposite the patient so they could maintain eye contact. However, no policies we reviewed outlined specific guidance in relation to relatives/friends.
- Newer vehicles had air conditioning and dimmer lighting to suit the preference of the patient.
- The service did not supply food for patients during transfer; however, patients could bring their own food to eat. The service did not check whether patients had eaten prior to transfer. Bottled water was available for patients on all vehicles.
- Call handlers asked the referrer if the patient had any physical health conditions such as reduced mobility, limited hearing or visual impairments. The service had accessible vehicles for patients with reduced mobility.

Access and flow

- Between September 2016 and August 2017, the service completed 3165 adult patient journeys and 68 children and young people (CYP) patient journeys.
- During inspection, we observed call handlers at the ambulance station answering calls promptly and organised crews dependent on patient need in a timely way.
- There was no answerphone facility for telephone calls, however the call centre was staffed 24 hours a day every day of the year and bookings were also taken by email.
- The service provided planned and unplanned patient transfers. Whiteboards in the control room showed details of the pre-booked patient journeys including the names of the assigned crew. The whiteboards contained no identifiable patient details.
- The call handlers confirmed that no emergency transfers took place and patients transported were clinically stable. If they had any concerns, they would speak to their line manager. However, we saw a booking form whereby it was recorded the patient had swelling of the brain and the service conveyed the patient. The service did not have patient eligibility criteria for call handlers to use.

Patient transport services (PTS)

- The service had not needed to make any emergency transfers to a hospital for acute care in the 12 months preceding the inspection.
- The service provided patients with timely transfers. Crew called into the control room to report departure, journey and arrival times. They also documented this on the transfer sheet. These figures were analysed by the service and findings discussed at weekly management meetings.
- Call centre staff informed the receiving hospital/service if there were any expected delays and provided an estimated time of arrival.
- All vehicles had a tracking function, which linked to the control room's IT system. This meant the call centre could see where vehicles were at all times on a map.

Learning from complaints and concerns

- According to the services' complaint log, between March and October 2017, Secure Care Uk received four complaints.
- Two complaints we reviewed dated February and April 2017 involved the transporting of female patients by an all-male crew. The service investigated both complaints and actions included communicating learning through team meetings and call handlers to use the phrase 'gender specific' in relation to patient preference. The new booking form incorporated this question. The allocation of jobs during the inspection met the patients' requests.
- However, regardless of patient preference, call handlers did not offer all female patients a female escort. The service did not have a formal process in place for call handlers to follow when a female member of staff was not available.
- The service had a complaints policy, which outlined the process for verbal and written complaints.
- Although we did not see posters within the vehicles to show patients how to raise concerns or compliments, staff told us feedback/complaint forms were available in the patient records carry case.
- The service kept a complaints log to monitor trends and themes. We reviewed the complaints log, which showed the service fully investigated complaints. The service acknowledged all complaints within five days and sent final responses within 20 days in line with their policy. However, we noted an error where the recorded date of the final response was the day after receiving the complaint.
- There was evidence of joint working with other providers of healthcare to investigate complaints. However, the service did not capture all complaints on the complaints log. For example, a complaint raised about Secure Care Uk in May 2017 and discussed at the June performance review meeting was not on the log. This meant data was insufficient to provide assurance.
- The management team discussed complaints at their weekly and monthly meetings.

Are patient transport services well-led?

Leadership

- The Chief Executive Officer (CEO) was supported by the Chief Operating Officer (COO) and Senior Operations Manager (SOM).
- Transport staff reported to team leaders and senior team leaders, while call centre staff reported to the call centre manager.
- Senior team leaders received half a day's report and management training internally prior to commencing the role.
- Although the senior management team told us that the service did not have staff meetings, senior team leaders told us they held staff meetings monthly. However, these meetings were not recorded.
- Staff told us they could refuse to work additional hours over their contracted hours if they felt it would affect their wellbeing. Staff felt this was supported and encouraged by managers. Staff had the option to sign a disclaimer regarding the European Working Time Directive so they could work over 48 hours per week.
- The call centre manager, fleet manager, training manager and IT manager reported to the compliance manager who fedback to the registered manager. The HR and finance managers also fedback to the registered manager.
- All transport staff and administrative staff we spoke to were able to identify the different managers and their roles.
- The management team worked at the Hastings location and therefore were highly visible to staff during normal working hours. Staff told us the registered manager was always contactable by phone 24 hours a day.
- The service did not collect any Workforce Race Equality Standard (WRES) data.

Patient transport services (PTS)

Vision and strategy for this this core service

- In this service, the registered manager was also the owner and chief operating officer.
- The service had a 'Performance Management Strategy', which outlined it's responsibly to ensure effective systems are in place to provide assurance to stakeholders. However, the provider's action plan to implement this strategy was incomplete and contained no review date or a completion date.
- The registered manager developed the company's vision, which was, 'Big enough to cope, small enough to care'. There were five core values of 'open, honest, least restrictive, patient first and team approach', which were outlined on keychains for staff. However, none of the staff we spoke to knew these. Staff appraisals and supervisions did not incorporate the visions or values.

Governance, risk management and quality measurement

- The senior management team had their first 'Integrated Governance Committee' meeting the day before the inspection. The agenda items were comprehensive and included incidents, safeguarding, risk register and feedback from external stakeholders. However, the meeting lasted only 65 minutes, which suggested there was not a thorough, and in depth discussion of each item.
- The attendees of this meeting included the CEO, SOM, COO, the training manager, the health and safety manager, the human resources manager and an external consultant. However, two attendees of the meeting were unable to recall discussions that occurred despite having actions to take forward assigned to them. This demonstrated the governance systems in place were insufficiently developed to provide the assurance that the service was operating safely and effectively.
- We reviewed eight sets of minutes for the weekly management meeting. Standing agenda items included due diligence, staffing, training and compliance. The due diligence section reflected service activity in the previous week. This enabled the senior management team to have single oversight of performance against the service's key performance indicators (KPIs).
- Although, the team discussed and agreed actions during meetings, there was no evidence to show staff were held to account for meeting deadlines as they did not review progress of actions at the following meeting.
- The operations manager had managerial oversight for incidents. We reviewed the incident log and incident analysis reports, which demonstrated a lack of comprehensive investigation into each incident.There was also no evidence of learning in response to incidents and minimal action taken to prevent recurrence.
- The service had a risk register, which contained nine risks including IT failure, failure in meeting contract requirements, service expansion and recruitment. Each risk was assessed and graded as either low, medium or high risk. The risk register was a standing agenda for the monthly Integrated Governance Committee meeting. However, during the inspection only the registered manager was able to identify risks to the service.
- The risk register was inadequate, as it did not include the risks identified during inspection such as a lack of training records, oxygen storage and storage of records to allow easy retrieval.
- The service was undertaking new contracts without full consideration of the implications or ensuring effective systems and processes were fully embedded first. For example, one contract required oxygen to be available on the ambulance. In response, the service had started to train staff and had obtained the oxygen. The service had no policy in place to guide staff on the use of oxygen. When asked about medicines, the registered manager informed us the service kept no medicines on site. However, within the storeroom we found oxygen cylinders. This demonstrated the service did not recognise oxygen as a medicine or the strict regulations in relation to its transport, storage and administration.
- It was evident, some internal policies were from another source but had not been adapted to reflect the service provided. For example, the resuscitation policy referred to emergency equipment and staff roles, which did not exist within this service.
- Internal policies did not always contain clear and coherent information. For example, the medicines management policy made differentiations between the management of patient controlled drugs and

non-controlled drugs. However, all patient medicines should be treated the same. The service did not transport more than one patient within the same vehicle; therefore, risk assessments were not required.

- The vehicle audit dated October 2017 highlighted staff were unclear about how to store and transport controlled drugs. The action taken, to buy controlled drug books is conflicting as the medicine management policy stated staff should not store or record controlled drugs. This demonstrated the service lacked knowledge over its responsibilities, as an independent ambulance provider, in handling patient medicines.
- The service had multiple versions of documents in use such as booking forms and incident reports. This demonstrated the service had not removed the old versions from circulation when introducing the newer versions.
- The service did not maintain complete records for staff training. We reviewed 10 employment records selected at random. There was a lack of training records and no competency frameworks with the exception of driving assessments. Where staff did have certificates for training, we noted these had the same completion date. We also saw the same practice used within the training matrix. We raised this concern to the training manager who reported this was a human error. Therefore, the service did not have accurate records to use for monitoring. There were no training risks identified on the risk register.
- The service recognised that prior to August 2017, there were failings in it processes in obtaining employment checks before staff commenced work. The service reported a new system was in place, which had improved compliance. However, during the inspection we still found 50% of the employment records reviewed contained incomplete DBS documentation or references despite the new system. This was not in line with their recruitment policy, which stated, “No candidate may start employment during the recruitment process until the Director has received an enhanced satisfactory DBS certificate and two satisfactory references”.
- We raised this concern with the provider who acknowledged prior to August 2017, staff were working with children and young people before completed DBS checks. However, the provider
- failed to recognise the significant risk posed to all service users, regardless of age by having staff who had not completed DBS checks working within the service.
- The provider reported since August 2017, all employment records for new starters’ contained full documentation of recruitment checks. However, this change only extended to newly appointed staff. This meant the provider could not gain assurance about all staff, regardless of their start date.
- During the unannounced inspection, we asked to see the documentation for 16 patient journeys. The service was unable to provide these documents due to ineffective storage systems. Staff explained they separated completed patient records and sent them to three departments, for example booking forms went to the finance department for invoicing purposes.
- The analysis of patient records were done in isolation, for example the operations manager reviewed incident reports and the governance lead reviewed booking forms. Therefore, the service lacked single oversight for each stage of the patient’s journey; from referral through to completed journey and patient feedback. The service missed opportunities to identify themes and trends as well as valuable insight into each patient journey. Staff we spoke to were unaware of the results of monthly audits or actions taken.
- CQC received no statutory notifications during the reporting period; however, there were incidents that met the requirement for statutory notifications such as allegations of abuse and incidents reported to the police. This meant the provider did not understand its duty to report such incidents. Not submitting statutory notifications to the Commission is a breach of its registration.
- The fleet manager was a trained mechanic so had the correct knowledge and skills for the role. He monitored and updated the vehicle data sheet daily which included service schedules, maintenance intervals and MOT dates. He also monitored the driving performance of staff using data from the electronic monitoring device fitted to each of the vehicles.
- The CEO told us they were not recruiting registered mental health nurses (RMNs). However, in the Integrated Governance Committee meeting minutes (October 2017) the service had offered posts to two RMNs.

Culture of service

- There was a positive culture between staff and the senior management team. Staff told us they felt well supported and were encouraged to raise concerns.

Patient transport services (PTS)

- A 'You said, we did' board was displayed in the crew room. Issues raised included the length of the induction programme. Actions taken included discussing a 14-day induction programme. However, management had not updated the board since May 2017.
- A few members of staff had very recently joined the service and they felt comfortable working for the organisation and really enjoyed their job.
- Staff had access to a confidential whistleblowing helpline through a third party. We saw the telephone number displayed around the base. The service was updating their whistleblowing policy at the time of the inspection.

Public and staff engagement

- After each transfer, staff asked the patient to complete a patient experience survey in order to gain feedback about the service. The feedback report dated May 2017 showed 32% of patients completed the survey that month and the majority of the patients who responded stated that overall they thought the service was either 'excellent' or 'good'. The service did not monitor response rates to these surveys.
- At the time of inspection, the service was not having formal staff meetings and had stopped the monthly newsletter. The service communicated with staff via a secure social media application. We reviewed this page and saw staff used it primarily to pass on praise. There were no personal identifiable details of patients posted.
- The service carried out staff surveys. The feedback report dated August 2017, showed 14 members of staff completed the survey. Actions developed to address the issues raised included producing a Mental Health Act (1983) booklet and developing a lessons learnt log which is accessible for all staff.
- Staff had free access to an employee assistance programme where staff could call a telephone number for advice on personal problems that might adversely affect their work performance, health and well-being.
- There were no formal systems in place to engage with the public.
- The service sponsored a local rugby club and donated to local charities.

Innovation, improvement and sustainability

- The senior management team shared the same aspirations for the business: to continue to grow steadily while maintaining the same service and family atmosphere.
- The service won the Health Care Supplier of the year award at the secure and specialist IHA awards in October 2016.
- The service worked alongside the Police, a NHS Trust and approved mental health professionals to streamline the process of patients attending a 136 suite. The crew collected the patient from police custody, transferred the patient to the 136 suite then transported the patient to the required destination following assessment. This meant patients had continuity of care and the same crew were involved in the whole process.
- The service was investing in new IT systems including a staff intranet and a new dispatch and logistics system. These systems will enable better organisational communication and improve data collection.
- The registered manager told us the service was requesting through their contract to have bases at hospital sites in order to improve response times.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The registered manager MUST notify the Commission without delay of any incidents as specified in paragraph 2 of Regulation 18.
- The provider MUST have effective governance, including assurance and auditing systems or processes. These must assess, monitor and drive improvement in the quality and safety of the services provided.
- The provider MUST ensure all staff have DBS and reference checks prior to commencement of employment.
- The provider MUST ensure the safeguarding level has undertaken the correct level of safeguarding training.
- The provider MUST ensure staff receive specific training in relation to the transport of children and young people.
- The provider MUST ensure it has sufficient equipment for the transport of children and young people.
- The provider MUST have clinical input when developing policies and procedures.
- The provider MUST review its management of patient records.

Action the hospital SHOULD take to improve

- The provider SHOULD ensure staff complete vehicle and cleaning checks prior to vehicle use.
- The provider SHOULD ensure it keeps external doors locked at all times.
- The provider SHOULD ensure staff know how to access the translation service.
- The provider SHOULD amend policies to ensure they are evidence based and reflect the service provided.
- The provider SHOULD ensure incidents are fully investigated and relevant learning shared with staff.
- The provider SHOULD ensure the storage room has signage to show the presence of medical gases.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents The Commission has not received any statutory notifications from the registered manager. The registered manager must notify the Commission without delay of any incidents as specified in paragraph 2 of the regulation. Regulation 18 (1)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure all staff had an enhanced DBS check prior to commencement of employment to safeguard patients. The provider did not ensure the safeguarding lead had the correct level of training and knowledge to fulfil this role. Regulation 13 (1)(2)(3)

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance The provider did not keep complete and accurate records in respect of each patient. The provider did not properly analyse incidents and did not communicate the results or share learning across the service. The provider did not develop action plans following audit and did not monitor progress against actions taken. The provider did not ensure its policies and procedures reflected the roles, responsibilities and type of service provided. The provider did not maintain employment and training records for all staff. The provider must have effective governance, assurance, auditing systems and processes in place. These must assess, monitor and drive improvement in the quality and safety of the services provided. Regulation 17 (1)