Care Quality Commission

Secure Care UK Limited

Secure Care UK Headquarters

Inspection report

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

Ratings

Overall rating for this location	Good ●
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Good** ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	**Good** ●

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment and assessed patients' food and drink requirements. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Patient transport services	Good	🟢	Our rating of this service improved. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Secure Care UK Headquarters

Secure Care UK Headquarters is operated by Secure Care UK Limited. This service offers secure transport for patients with mental health conditions including patients detained under the Mental Health Act. They collect patients from their own homes, hospitals, and custodial settings. They transport patients to hospitals or other facilities to receive treatment for their mental health conditions. In the past 12 months, the service transported 8,523 patients. Operations were run from seven sites with over-all control from their headquarters. The headquarters was the registered location and housed the control centre. The control centre operated 24-hours a day. The location was registered to provide the following regulated activities

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

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. They have legal responsibilities for meeting the requirements set out in the Health and Social Care Act 2008.

This location registered with the Care Quality Commission in December 2018 and this was their third inspection. We carried out a comprehensive inspection on 19 January 2022 after we gave the service 24-hours notice.

How we carried out this inspection

How we carried out the inspection
The team that inspected the service comprised a CQC lead inspector, and a CQC inspector. An additional inspector completed staff interviews remotely. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

During the inspection, we visited the company headquarters in Hastings. We spoke with 19 staff, which included managers and senior managers. We looked at five records of patient care, two vehicles, five staff records, five complaints, logs of incidents, minutes of meetings, board reports, training records and various audits and policies.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

- Staff worked with other agencies to meet the patient's needs. They worked with the clinical commissioning group for one of their main clients, to develop their bespoke risk assessment tool. The tool was used to determine the safest number of crew and vehicle type for each patient transfer. This included the information provided by clinical staff or the police, dependant on the location they collected patients from.
- Their education lead had developed a weekly podcast. Staff felt it was helpful to refresh on a certain subject while driving to collect a patient. Staff were encouraged to suggest topics for future podcasts.
- The service developed and launched an NVQ programme in January 2021. This was for a secure patient transport accredited module with a Level 3 qualification.

Summary of this inspection

- Staff planned the journey to help support the patient's emotional needs. For example, an autistic patient was anxious about being transported by staff they had never met. The service sent photographs of the allocated crew and some information about them. Hospital staff shared the photographs and information with the patient, and this helped to relieve their anxiety before meeting them. Another patient was very anxious about their dog prior to transfer. A member of staff walked their dog and settled the dog into bed prior to the journey.
- Management had engaged with a service-user panel at an NHS trust they held a contract with. This was to receive feedback about choice of uniform colour. They took samples of uniforms in different colours and discussed their choices. The service changed their uniform to silver grey as the user-panel considered this to be the most calming colour.
- The service was trialling the use of silicone mood bands for patients. This meant patients who were unable to talk or did not feel like talking, could still communicate how they felt. One side of the wrist band said ''Leave me alone,'' the other side said ''happy to talk.''

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should consider the suitability of using a police station for patients who are not high-risk and need a comfort break during their transportation.
- The service should consider the suitability of calling the secure area a cell.
- The service should ensure they adhere to relevant guidance on retention of patient records and update their policy accordingly.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Good	☆ Outstanding	Good	Good
Overall	Good	Good	Good	☆ Outstanding	Good	Good

Patient transport services

Good 🟢

Safe	**Good**	🟢
Effective	**Good**	🟢
Caring	**Good**	🟢
Responsive	**Outstanding**	☆
Well-led	**Good**	🟢

Are Patient transport services safe?

Good 🟢

Our rating of safe improved. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. It was comprehensive and met the needs of patients and staff. Training included, but was not limited to, person centred care, conflict resolution, distressed signs, the Mental Care Act and Deprivation of Liberty Safeguards. Overall compliance rates for all mandatory training was 93%.

Staff received additional training that was specific to their role. For example, team leaders and managers received training on safer recruitment, interviewing skills, completing appraisals and managing complaints.

Staff were expected to attend yearly refresher training in the prevention and management of violence and aggression. All other training modules were repeated every two years.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff could not work shifts if they did not attend their re-fresher training. This was communicated during their induction and across their electronic communication channel.

Safeguarding

Staff understood how to protect patients from abuse Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific to their role on how to recognise and report abuse. Records showed 92% of all staff had completed safeguarding adults' level 2 training, and 92% of staff had completed safeguarding children level 2 training. Managers made sure staff completed safeguarding training and monitored staff compliance.

There was a dedicated safeguarding lead for the company who maintained oversight of all safeguarding matters. and produced a monthly safeguarding report to the board. The safeguarding lead was trained to safeguarding level 5. The deputy safeguarding lead and registered manager were trained to safeguarding level 4. All managers were scheduled to complete additional level 4 safeguarding training, the week following our inspection.

Patient transport services

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could explain how they would respond if they witnessed or suspected abuse. They knew who their safeguarding lead was, who to inform if they had concerns, and how and why to make a referral. Staff completed safeguarding referrals on their electronic tablet which alerted all managers, including the safeguarding lead and their deputy. Staff had access to support with safeguarding matters, this included out of hours support.

The booking team discussed any transfers of a young person (under 18 years of age), with the safeguarding lead or their deputy. This was to ensure the correct approach was used. There was a laminated poster in the control room to remind staff that informing the safeguarding leads was mandatory. Staff encouraged a parent or guardian to accompany transfers for young people, unless they were declared as a trigger. Staff were familiar with their safeguarding policy and knew how to keep patients safe.

Disclosure and Barring Service (DBS) checks were completed for every member of staff as part of the recruitment process. New starters were not offered a start date until their DBS was reviewed. If a new starter did not have two references, human resources completed a risk assessment before a decision was made to offer employment.

A member of the human resources team and a manager conducted interviews. They had completed training in safer recruitment and interview techniques. The provider completed pre-employment checks to determine the applicant's suitability for the role.

Cleanliness, infection control and hygiene

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

The headquarters were clean and had suitable furnishings which were clean and well-maintained. The service performed enhanced and more frequent cleaning of all areas to prevent the spread of COVID-19 in line with national guidance.

Hand washing posters demonstrating best practice in hand washing techniques were on display above sinks. Staff completed training on hand hygiene principles during their induction. Practice was observed during clinical supervision and monitored as part of their appraisal process.

Vehicles were visibly clean and had suitable furnishings which were clean and well-maintained. Vehicle checklists were completed at the start of each shift. This included ensuring vehicles were clean. Audit results for vehicle cleanliness were 100% in October 2021 and 97% in December 2021(due to one missing record).

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All vehicles were deep cleaned every eight weeks by an external cleaning company. The provider maintained an electronic log to monitor compliance. This included vehicle registration numbers, dates of previous deep cleans, date of next deep clean and evidence of cleaning certificates.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was stored in equipment bags which were taken on every patient transfer. Staff used PPE and followed national COVID-19 guidance.

Patient transport services

Environment and equipment

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

The service had designed the environment to keep people safe. The service managed day to day work from their headquarters. There were areas for staff to take breaks, make drinks and hold meetings. The headquarters had signs to remind staff to keep socially distanced and wear face masks. The service had removed some chairs to reduce the number of people sitting in each space. There were separate toilets for male and female staff.

The finance manager was responsible for monitoring all vehicles to ensure that DVLA requirements, insurance, MOTs and services were up-to-date. They maintained an electronic database and alerted team leaders of any maintenance that was required and by when.

Staff that transported patients were required to have a full UK driving licence and report any endorsements to their line manager. The service maintained a copy of all employee driving licences on staff files. Team leaders completed driving assessments for all staff during their probationary period. Their assessment details were stored in their files. The service deployed software to monitor staff driving behaviour such as vehicle speed and harsh braking.

Child seats were available for young children, although the service had not needed to use one yet. There was a poster next to the seats, to remind staff on how to choose the correct size. They were able to offer wheelchair accessible vehicles for patients with mobility issues.

Staff completed moving and handling training and use of equipment such as handcuffs. Vehicle keys were stored securely in a locked cupboard which was password protected. Staff restocked vehicles and equipment bags regularly. There were laminated posters in the control room which confirmed what should be in each vehicle and equipment bag. This included diagrams to confirm where each item should be stored. Equipment bags were secured with tamper evident seals. The service developed an equipment checklist which they shared with us following inspection. This included the date and time the bag was checked/restocked, including the bag identification number.

The service had enough suitable equipment to help them to safely care for patients. Electrical equipment had yearly electrical checks to ensure they were safe to use. They maintained copies of the safety certificates.

Staff disposed of clinical waste safely. Staff stored clinical waste securely on vehicles and their base, until it was collected by a third party. They maintained copies of their waste disposal certificates.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. They were trained in first aid and basic life support. They identified deteriorating patients and escalated them appropriately. Staff took patients to the nearest accident and emergency department or called 999 if they needed emergency care.

Staff completed risk assessments following each patient referral. The control operator took as much clinical information as possible from their main carer or asked the referrer to use the patient's care plan. This included medical history, medicines, anything that triggered the patient, physical aggression, history of self-harm or suicidal thoughts, sensory impairments and learning difficulties.

Patient transport services

The replies generated a score for each category and an aggregated score was used to plan the safe transport of the patient. This included the number of staff and the type of vehicle. The transfer was assigned a driver plus one escort if the risk assessment was low. A vehicle with a secure area was assigned to high risk transfers, with a driver plus three escorts. The service only used the secure area or other restrictive interventions if this was requested by the referrer, and a clear rationale provided.

The service did not transfer the patient without the clinical support of a qualified nurse if the patient needed sedation during transfer or had other medical needs. The service declined requests if they did not have enough staff, the right skill mix or enough information to complete the risk assessment in full.

Staff shared key information to keep patients safe when handing over their care to others. We looked at five patient records. They were all fully completed.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and all staff received a full induction.

The service had enough staff to keep patients safe. The service employed 260 members of staff at the time of inspection. They did not use agency staff. The service ensured all staff were trained, before allocated to any patient transfer. The booking team refused transfer requests if they did not have enough trained staff available.

Staff notified the control operator if they were late finishing a shift by two hours or more. They were advised to start their next shift later, to ensure they had a minimum break of 11 hours in-between shifts. The control operator emailed an end of shift report to the senior management team, after every shift. Shift over runs were usually due to unforeseen circumstances such as heavy traffic. They were reported as incidents and reviewed at the weekly clinical review committee. This helped to ensure they had oversight of staffing issues.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Records were stored securely. Staff had individual electronic tablets which were password protected. The service had introduced an electronic record system nine months earlier. Staff were familiar with the system and reported positive feedback. The service was registered with the NHS data protection toolkit to ensure records were stored securely.

Staff carried blank paper records in case there were connection issues during a transfer. They stored them in sealed opaque envelopes. Staff returned them to the control operators who checked for completeness and ensured any incidents were reported.

Patient notes were comprehensive, and all staff could access them easily. They recorded mandatory information in the electronic records. This included the patient's risk assessment, if they used any form of restraint, details of the patient's search on collection and handover, patient's property and medicines, and how this was stored during the journey.

Staff recorded notes contemporaneously. We reviewed five records and they were fully completed. Entries included names of the crew, times, dates and signatures.

Patient transport services

Staff recorded the patient's presentation at the start of the journey and at handover. Staff updated the records during the transfer by recording regular observations of the patient's mood and behaviour. The electronic records calculated an overall summary of the patient's presentation during the transfer. This included the percentage of time the patient was calm, anxious or aggressive. The records also calculated a summary of any time that restraint or de-escalation techniques were used during the transfer.

Medicines

The service followed best practice when recording and storing medicines.

Due to the nature of this service, crew did not administer or have access to on-board medicines. The provider's medicine management policy was up-to-date. gave clear guidance to staff on their role and responsibilities. It was appropriate for the service provided.

Control room staff asked the referrer if the patient had taken any medicines prior to transport. They required written and signed confirmation that a patient was medically fit to travel when any potentially sedative drug was given within three hours of transportation. They also required a qualified nurse to support such transfer. If a qualified nurse could not support the journey, they insisted on a three-hour delay before collecting the patient.

Staff ensured medicines travelling with the patient were recorded and stored correctly. They stored patient's medicines in a sealed bag, with an identification tag within a locked vehicle. The bags were not used for any other purpose. Staff handed medicine over to the nurse in charge and recorded this on arrival.

If a patient had controlled drugs, staff stored them in the drugs bag with a sealed tag. This was stored in a spare pocket in their equipment bag which was also sealed. Staff stored medicine securely during journeys and the service audited compliance of their medicine policy for further assurance.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff we spoke to had reported incidents and were clear about what type of incidents to report and how. They received an alert on their electronic tablet to confirm what incidents had to be reported. For example: safeguarding concerns, use of restraint, if a crew member were hurt or if staff were late off duty by more than two hours. Their IT system also included a feature which sent an immediate text message to the leadership team when a significant incident occurred.

Managers investigated incidents thoroughly. The quality manager and managing director, had experience and training in root cause analysis. Management completed mandatory training in fact finding following an incident. This helped them understand any underlying issues related to incidents and ensured they were effectively investigated. All incidents were reviewed at their weekly incident review committee. This ensured they were categorised correctly, investigated and external organisations such as the CQC were notified as required.

Staff received feedback from investigation of incidents. They discussed incidents and related learning at bi-monthly team meetings. Learning from incidents was a standing agenda item at team meetings.

Patient transport services

There was evidence that changes were made as a result of learning from incidents. Staff of all grades were able to give us examples. For example, they identified an increased number of crew being hurt when collecting a patient. They completed a deep dive into the incidents and identified that staff were not always aware of situational risks. The service developed mandatory training for all staff in situational awareness and they measured the effectiveness of this by monitoring the number of similar incidents, which had decreased since the training.

Managers debriefed and supported staff after incidents. The service offered counselling to those affected by stressful incidents. Staff told us they were well supported.

Staff understood the duty of candour (DoC) They were open and transparent and gave patients and families a full explanation when things went wrong. Staff explained what had happened and apologised to patients. They assessed the application of the DoC against all incidents and maintained a DoC log to monitor compliance.

Are Patient transport services effective?

Good ●

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment
The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers regularly reviewed policies and procedures to ensure they were up-to-date. We were told paper records were scanned, stored for seven years and then destroyed as confidential waste. This was in case there were any related complaints or investigations. However, their policy did not reflect that storage period.

Policies referenced national guidance and legislation. For example, the National Institute for Health and Care Excellence. The quality lead was a member of the Social Care Institute for Excellence Standards. They received notifications when national guidelines were updated. The training lead also received notifications through associations they were accredited to. Polices were updated swiftly in response to changes in national guidance.

Staff received training regarding the Mental Health Act 1983. Training compliance was 95% at the time of inspection. Staff were aware of their role and responsibilities in relation to patients who were detained under the Mental Health Act.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs prior to a journey. The service made adjustments for patients' religious, cultural and other needs.
Staff checked when the patient had last eaten and drank as part of their booking process and handover. They asked the referrer to provide something for the patient to eat and drink if a journey was likely to be two hours or more. The service did not provide food during a transfer, due to concerns about potential allergies.

Patient transport services

They encouraged patients to use the bathroom before a transfer. They called the control room and asked them to identify the nearest place of safety if a patient needed a comfort break during a transfer. This would either be the nearest accident and emergency department, or police station.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

The service received bookings from NHS trusts they had contracts with. They had time targets for collecting patients. It was dependant on the type of booking, although they aimed to collect patients as soon as practicable. Staff recorded the time they arrived to pick up patients, the time they left the pick-up location, and when they reached their destination.

Delays were communicated in a timely way. If a journey was unexpectedly delayed on route, staff communicated this to the control operator. The control operator then communicated the delay to staff expecting to receive the patient. Managers tracked the location of the vehicle and provided an updated estimated time of arrival if the crew were delayed and not contactable.

The service's strategic objective was to collect a patient from any location within the UK within two hours. The pandemic had made this aspiration more challenging but 83% of patients were collected within two hours from October to December 2021.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The provider had a thorough recruitment process which was managed by a member of the human resource (HR) team. Applicants had an initial telephone interview to explain the role and determine suitability before progressing to a second stage face-to-face interview.

Managers gave all new staff a full induction before they started work. This was tailored to their role. New starters were assigned a buddy. They made contact as soon as the applicant accepted their job-offer. They had to complete some mandatory e-learning before starting their induction. New starters had a probation period of three to six months, following their induction. During this time, they shadowed colleagues until their competencies were signed off, and their knowledge of policies and procedures assessed formally.

Managers supported staff to develop through regular, constructive clinical supervision of their work. They reviewed staff understanding of best practices during clinical supervision and appraisals. Staff were given extra training sessions if they required additional support. They ensured any gaps in staff knowledge were reviewed and updated.

Appraisals were every six months with a staff 'MOT' in between. The MOTs were less in-depth. They used the company values to align any objectives and training requests during appraisals. Managers notified HR when appraisals were completed, and HR monitored overall compliance. Most staff had a recent appraisal, or a date secured to complete by the end of February 2022.

Staff told us appraisals/MOTs were meaningful and used to look at their strengths and opportunities and areas for development. Staff reported that Secure Care UK was now a company where they could grow and develop.

Patient transport services

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, a member of the HR team was given funding and study time to complete a diploma in people practice, people management and learning and development.

Managers received specialist training for their role. This included conduct management, managing harassment and bullying, safer recruitment and completing appraisals for managers and team leaders.

The training lead and deputy training lead had completed a train the trainers' course in prevention and management of violence and aggression. All staff completed this training and training was maintained throughout the pandemic.

Multidisciplinary Working

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.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. They employed a client liaison and quality lead who worked with their head of quality to focus on standards of care, safety and compliance in a transparent fashion with their NHS clients. Their safeguarding and search policies were multi-agency and written in collaboration with other relevant agencies.

We saw positive feedback from other agencies that demonstrated effective communication and working relations. For example, we saw staff had recently received praise from an NHS trust after they shared information of concern. We also saw that an approved mental health professional had written the following at the time of our inspection: "I'd like to compliment the 3 person-only team on their calm handling of the situation, which facilitated a dignified and respectful conveyance and helped me feel safe. They were all fantastic."

They worked with other healthcare professionals including clinical staff to make sure patients' needs were met. They communicated effectively with staff when they collected patients to ensure journeys were undertaken to meet the needs of the patients and in line with legislation when patients were detained under the Mental Health Act.

Staff received a handover when collecting patients and recorded the date and time of handover. They also recorded the patient's mood and behaviour at all handovers. Staff signed to confirm their handovers. The crew signed to confirm they had collected the patient and dated and signed their electronic record. They provided a handover to staff at the receiving destination. They tried to ring ahead of their arrival. This was to ensure staff were ready to meet the patient when they arrived.

The service was a member of the British Ambulance Association and they participated in knowledge forums and committees in order to benefit their patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They had a clear understanding of the principals of the Mental Capacity Act. Staff gained consent from patients for their care in line with legislation and guidance. Staff told us they would talk to patients and explain the reasons for their journey. This helped patients to understand what was happening and to provide informed consent.

Patient transport services

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff would support patients to make decisions. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of our inspection training compliance for this was 95%.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They had access to policies from their electronic tablets. The service monitored the use of restraint and tried to avoid restrictive interventions. They had a restraint reduction strategy. They recorded the number of restraints, use of handcuffs and use of the secure area within the vehicle. Use of restraint was a key focus at their weekly incident review committee and monthly governance meetings. They completed an immediate 'deep dive' if they identified an increased use.

Leaders were committed to continued reductions of restraint and restrictive interventions. Staff understood they must always use the least restrictive option and only use restraint in the best interest of the patient. Restraint was clearly recorded, and all episodes were reported as incidents for further scrutiny and learning.

Are Patient transport services caring?

Good ●

Caring was not rated at our previous inspection. We now rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Control operators asked if patients had anything they liked to talk, such as a hobby or interest. They also asked if the patient had any triggers. For example, one patient got anxious when they saw a white van. The referrer advised the patient found silver and grey to be the most calming colours, so the crew transported the patient in a silver vehicle. Control operators shared relevant information with the crew. This helped prepare them and connect with the patient.

Staff carried a clean blanket and a set of new clothing and slippers in every equipment bag. Patients kept any used items. They were used to maintain a patient's privacy and dignity and keep them comfortable. Vehicles used for high secure transfers had black-out windows to protect patients' privacy and dignity.

Staff described various situations where patients had been very distressed at the start of, or during a journey. They told us how colleagues had built a rapport with the patient, reassured them and reduced their anxiety and distress. One staff member told us "If a member of my family needed this type of service, I would recommend the service. I wouldn't work here if I couldn't do that."

Patient transport services

A member of staff had shared their most rewarding moment working for the service in a monthly staff newsletter as: 'taking patient X to their new home. After the most emotionally, physically and mentally intense care, the sight of them settling in, with a smile on their face, was worth more than words can describe'.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when discussing patients' mental health needs with us. All staff understood how vulnerable patients were during their transfer. Staff described transfers as getting the patient ready to receive care on arrival. They all referred to the importance of reducing any anxiety or distress during the transfer and the importance of details such as what the patient liked to be called, what they liked to drink and handed over this information on arrival.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us patients were all individuals with different needs. Control operators routinely asked if the patient had any requests or needs to improve their experience during the transfer. They talked to them, tried to develop a good rapport and understand what they needed. We saw evidence that staff sang, joked and prayed with patients to provide emotional support during transfers.

Staff told us they always explained the reason for transport to their patients and tried to reassure them as much as possible. Control room staff tried to allocate repeat patient journeys to the same crew to ensure continuity. Staff supported patients when they were referred or transferred between services.

The service had adopted the Hampshire Mental Health Charter for people on the autism spectrum. They promoted its principles. For example, an autistic patient was anxious about being transported by staff they had never met. The service sent photographs of the allocated crew and some information about each crew member in advance. Hospital staff shared the photographs and information with the patient, and this helped to relieve their anxiety before meeting them. They planned the journey to help support the patient's emotional needs.

Another patient was very anxious about their dog prior to transfer. A member of staff walked their dog and settled the dog into bed prior to the journey

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. They would take time to calmly explain their role and where they were taking the patient when they were collecting patients from their own home. They reassured families and friends that they would be supporting their relative during their transport.

Staff told us they would transport a relative with a patient if this could help to provide emotional support of both the patient and the relative. They completed an assessment to ensure this was suitable and safe for the patient. If family were unavailable to support a transfer, they would ask control operators to call a chosen family member. This was so they could talk with the patient during the journey.

Patients and their families could give feedback on the service and their care. Staff supported them to do this. They provided an information leaflet which outlined how patients could give feedback. Staff discussed whether it was

suitable to give this to patients with the service receiving the patient. For example, the nurse in charge, or the police. The crew asked staff to encourage feedback and provide the information leaflet to support this, as it was often not appropriate when they handed the patient over. The service gathered feedback from their patients even though this was challenging due to the nature of their conditions.

Are Patient transport services responsive?

Outstanding ☆

Our rating of responsive improved. We rated it as outstanding.

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. There was a proactive approach to understanding the needs of different groups of people and to delivering care in a way that met these needs, was accessible and promoted equality.

Managers planned and organised services, so they met the changing needs of the local population. The service had opened a new headquarters in Kent to meet their increased demand. Facilities and premises were appropriate for the services being delivered. The headquarters had toilets, well organised storage areas and space to store the vehicles. The base also had facilities to hold staff meetings and complete paperwork. The service covered the whole nation to accommodate the needs of patients that needed to transfer to and from anywhere in England, Scotland, and Wales.

The service collected patients from mental health units, police stations, custodial settings, and people's own homes. They had five permanent contracts with NHS trusts and completed individual journeys for other local and national providers. Managers monitored and took action to minimise delays to patients. Managers dispatched another vehicle when the assigned vehicle broke down. This was to reduce the delay experienced by patients.

Leaders had purchased additional vehicles to increase their capacity in line with an increase in demand for their services. The service had five categories of vehicle. They had also increased staffing numbers to manage increased demand.

The service transported one patient per vehicle. All staff we spoke to were aware they were only to transport one patient at a time. The low secure vehicles were smaller vehicles used for patient discharges and were more like a taxi in design. The mobility vehicles were designed for patients with reduced mobility. The high secure vehicle had a seating area and a secure area. This was only used when indicated by their risk assessment. Some staff called this area the 'calm space' but some staff called it the cell. It was locked to protect patients and staff, but had two lights and a hatch, so staff could still talk to patients face to face. Staff tailored lighting and music selection to the patient's preferences. This included silence.

Control operators checked the patient's correct pronouns (consistent with how they identified), and chosen names. Staff used information that was gender neutral and accessible to transgender and non-binary patients. They promoted equality and demonstrated respect and validation.

Meeting people's individual needs.

The service was inclusive. Patient's individual needs and preferences were central to their transport service. There were innovative approaches to providing person-centred care that involved other service providers.

Patient transport services

Key information was requested of the referrer. For example, they routinely asked if the patient had a gender preference for the crew, or if the patient had mobility issues. Control operators then allocated resources to ensure those needs were met and equipment was available. Special requests were recorded on the booking form.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Control operators requested information on additional care needs. This included their mental health, physical health, learning disabilities, and dementia. Patient records showed consideration of how to meet specific needs of each patient. Staff training compliance for person centre care was 99%. Staff were provided with training to help them meet the individual needs of their patients. Staff compliance for dementia awareness training was 95%. Vehicles were designed to meet the needs of patients living with dementia. Flooring in the vehicles were one neutral tone. Patients living with dementia can perceive changes in colouring on floors as holes in the floor.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment. They identified if patients needed an interpreter or signer at the time of booking appointments. They had access to an interpreting service day and night and google translate was installed on all their devices.

Staff had access to communication aids to help patients become partners in their care and treatment. Patients with hearing or sight impairments were identified during booking. They ensured patients could access information according to their needs. Staff carried Makaton cards in their equipment bags. The cards used symbols and signs for patients who were unable to communicate with speech.

The service was trialling the use of silicone mood bands. This meant patients who were unable to talk or did not feel like talking, could still communicate how they felt. One side of the wrist band said ''leave me alone,'' the other side said ''happy to talk.''

Management had engaged with a service user panel at an NHS trust they held a contract with. This was to receive feedback from the panel about choice of uniform colour. They took samples of uniforms in different colours and discussed their choices. The service changed their uniform to silver grey as the user panel considered this to be the most calming colour.

Users also provided feedback on the importance of knowing team members names. This caused them to adopt the "hello my name is" badge convention in response to a campaign founded by Dr Kate Granger (MBE), to promote the importance of introductions within the healthcare community.

They worked with the clinical commissioning group of their main clients, to develop their bespoke risk assessment tool. The tool was used to determine the safest number of crew and vehicle type, for each patient transfer. This included the information provided by clinical staff or the police, dependant on the location they collected patients from.

They worked with a medical company to devise their equipment bags and ensure they were tailored specifically for secure patient transfers.

Patient transport services

Good 🟢

Access and flow

People could access the service in a way and time that suited them.

Managers monitored waiting times and made sure patients could access services when needed and within agreed timeframes. The service ran 24 hours a day, seven days a week. The service had targets for collecting patients from time of referral and managers monitored their compliance with these targets. The service monitored the number of patients transported each month and analysed this to look for trends. This showed they had increased the number of patients being transported over the last year with this trend continuing this year.

In 2021, the service transported 8523 patients. Bookings were received through their call centre where staff completed an electronic booking form. Control operators reviewed the referrals and assigned staff and a vehicle to collect the patient. Referrals contained information of the individual needs of the patient including number of staff required, equipment needed, and type of vehicle requested. The control operator provided an estimated time of arrival for the referrer and communicated any delays.

Control operators routinely asked if the patient had any requests or needs to improve their experience during the transfer. They considered the journey pick up and drop off time to meet the patient's individual preferences. For example, if a patient wanted to pray at a particular time. One patient loved to watch a television series at 7pm so they arranged to collect them after the programme had finished.

Managers kept the number of cancelled transfers to a minimum. They had additional crews which they dispatched when the initial crew were unable to attend. Staff checked the reason for transporting patients and confirmed this was in the patient's best interest and in line with the Mental Health Act section relevant to the patient.

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.

Patients, relatives and carers knew how to complain or raise concerns. They gave patients/family an information leaflet which outlined how they could provide feedback or make a complaint. They discussed whether it was suitable to give the patient the leaflet when a patient was transferred to a place of safety. If it was not appropriate at the time of handover, it was kept with their belongings and given on discharge.

Managers investigated complaints and monitored them to identify themes. For example, they identified a theme regarding unprofessional communication. This included challenging clinicians inappropriately. Management rolled out training in professional communication and were monitoring the number of similar complaints to assess the effectiveness of the training.

We looked at five recent complaints which had been investigated. Fact finding included interviews with staff and record reviews. They all had a swift acknowledgement, with an explanation of actions taken to reduce the risk of this happening again. They managed complaints in line with their complaints policy.

Complaints were monitored and reported on the managers' monthly compliance reports and were a standing agenda item at team meetings. Management maintained contact with complainants until issues were resolved and complaints closed.

Patient transport services

Managers shared feedback from complaints with staff and learning was used to improve the service. They discussed complaints with staff involved and then shared learning with the wider team during team meetings.

Managers told us it could be challenging to get feedback from patients, but when they did, they used it to improve the service. For example, a patient had complained about the use of handcuffs during their journey. Management had explained their risk assessment and how and why the handcuffs had been used to keep them safe during the journey. The patient agreed to be interviewed about their experience and this feedback was used to contribute to staff training. Management maintained contact with complainants until issues were resolved and complaints closed.

Are Patient transport services well-led?

Good ●

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service opened in 2013 and a board of directors invested in the company in October 2017. They established a new management team in March 2019. This included the managing director, the registered manager, the operations managers, regional managers, the quality and governance manager, the human resources (HR) manager for strategy and communication, the HR manager for operations and the finance and IT manager.

Leaders had the skills and abilities to run the service. For example, the managing director had significant experience in change management. The head of quality and governance was a registered nurse with a master's degree in health and social care management. They had oversight at strategic level.

They understood and managed the priorities and issues the service faced. The leadership team held weekly calls to discuss current priorities and latest updates. Any issues were highlighted and escalated to ensure improvements were made. This included monitoring the use of restraint and restrictive interventions. Their key performance indicators were reviewed at every board meeting and every monthly leadership team meeting to inform short, medium, and longer-term activity.

Leaders had a good understanding of the service's challenges. Their key focus was managing the impact of COVID-19 and responding positively to the challenge. This included challenges with recruitment and retention. Recruitment had significantly slowed down due to Brexit and the COVID-19 pandemic.

Management encouraged staff to complete exit interviews to determine their reason for leaving. Previous feedback had confirmed that staff often left because of pay and shift over runs. The service had introduced the NVQ. This was an accredited programme for secure patient transfers. It was developed to inspire staff and support career progression and included a pay increase. Forty-six members of staff were completing the course at the time of our inspection

Staff said they were encouraged and supported to step into management roles and become training champions, with additional training and support. They felt well supported, valued and motivated by leaders.

Patient transport services

They also developed secondment opportunities. For example, a member of staff had a six-month secondment to focus on vehicle management. This included management of vehicle safety and cleaning with a focus on vehicle adaptations. The service strived to continually improve the patient's experience.

All managers and the leadership team completed the staff induction programme. The Managing Director regularly visited bases and supported the local crew with patient transfers. This helped them to understand the role of the crew and challenging aspects of their work. Staff felt well supported and were clear about the management structure. Staff felt managers were visible and approachable. There was an on-call rota for management support out-of-hours. Staff told us they responded swiftly and were supportive. One member of staff told us, ''even if they are not around, they are always available.''

The service had made significant improvements since our inspections in April and November 2019. Staff described the organisation as unrecognisable in terms of the improvement made in the last two to three years. It was a service that was focused on patients, constantly improving, developing their staff and nurturing talent. Staff felt this was mainly due to the leadership of the managing director. They were consistently described as inspirational, supportive, a great motivator and role model, who always upheld the company values.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The company philosophy had been to expand and develop once safety and quality had improved. Leaders had focused on reducing the use of restrictive interventions, embedding their governance and improving the patient's experience.

Their vision was to improve the lives of vulnerable patients by providing safe and responsive mental health care. They had a leadership charter which defined the role of the business leaders. The charter also included the company values. They were patient first, openness, respect, unity and determination. This was on their electronic platform, with a mechanism which permitted staff to show they had read and acknowledged the charter. Their values were also placed around their headquarters to ensure they were always displayed.

The service had a strategy to address recruitment and retention and were focused on marketing and exploring different ways of recruiting. The head of human resources produced a monthly board report to monitor progress and maintain oversight and they reviewed their strategy every six months.

Culture

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

Staff were consistently positive when they described the culture within the service. They felt supported by all leaders and colleagues. Staff felt respected and valued. They were happy in their role, and stated the service was a good place to work. Staff interacted and engaged with each other with a positive and supportive manner.

Patient transport services

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and various disciplines. They described healthy working relationships, where they felt respected, and able to raise concerns without fear. The culture was one of learning, not blame. They were encouraged to be open and honest with service users and staff, when things went wrong. Staff told us they were able to speak up about concerns and were supported by managers to do this. We were given several examples of how staff had felt able and supported to raise concerns. This included junior members of staff.

A whistleblowing and duty of candour policy supported staff to be open and honest. Their whistleblowing helpline was advertised at the base and on staff key rings. There was a dedicated section on their monthly newsletter which highlighted the whistleblowing helpline number. It confirmed the information was confidential, available to all staff and how to use it.

A member of staff had been appointed as the freedom to speak up guardian. This was to ensure staff could raise concerns in a safe and supportive way. The guardian was scheduled to complete training in February 2022, in advance of starting this role.

There was good communication in the service, from local managers and at senior level. Staff were kept informed by various means. This included newsletters, team meetings, emails and podcasts. Staff were encouraged to share relevant information and suggest useful topics for future podcasts. Management shared lessons learnt and hot tips through all their communication channels.

The service promoted equality and diversity. They were a member of the National Equality Register which provided members with access to up to date information and details of the organisation's current equality status. Staff completed mandatory training in equality and diversity. At the time of inspection, compliance was 90.5%. Two staff were completing it during our visit and the remaining staff who had not completed it had future training dates secured.

There was a focus on staff wellbeing. Mental health first aiders were promoted to support staff. There was an external counselling service available, and they had a confidential and professional life management service.

The service had implemented staff recognition nominations and awards every quarter. The awards were nominated by co-workers to the team member they believed to have demonstrated their CARE competencies the most.

Governance

Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.

Staff at all levels were clear about their roles and accountabilities. They had regular opportunities to meet, discuss and learn from the performance of the service.

The clinical governance committee met monthly. Meeting minutes showed evidence of audit results, incidents and complaints, information security, policies, the risk register and business continuity being discussed. Subcommittee reports, such as those from safeguarding, human resources, quality, and health and safety fed into the corporate governance meetings.

Shift overruns were monitored and reported to the board monthly. There was a process to ensure that staff always had an 11-hour break in between shifts. There were regular, bi-monthly, staff meetings. They were recorded and used to discuss key topics, such as safeguarding, staffing, quality and risk, and learning from incidents.

Patient transport services

They had a rolling audit programme and policy review programme which were monitored and managed by the quality manager. For example, they monitored compliance with their Duty of Candour (DoC) policy. The audit results for November 2021 confirmed that 89% of staff felt the policy was easy to follow and DoC was applied. Staff were reminded that they also needed to complete their DoC register to confirm when it did not need to be applied.

Recommendations following audits were recorded and monitored on an improvement register. This included the date the required action was identified, the issue, the required action, the staff member responsible for the action, if the action was effective and the date the action was closed. The service ensured recommendations were completed and evaluated to drive service improvements.

The service assessed every patient's calmness at the start and end of each journey. They monitored and recorded this throughout the journey. Clinical teams in the NHS also assessed the patient's level of calmness on handover. Data showed that this consistently improved. For example,19% of patients were calmer following their transfer between October and December 2021.

The provider had developed bitesize training packages for various leadership levels to improve the quality, consistency and accuracy of documentation, reflection and incident investigation.

The service commissioned an external company to monitor their effectiveness and gain further assurance of their governance in 2021.

The service managed and monitored contracts and service level agreements with partners and third-party providers. Contracts were reviewed on a yearly basis and awarded for between 3-5 years. This included a review of quality indicators and feedback, where appropriate. All NHS contracts with Secure Care had been renewed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Leaders and staff used systems to manage performance effectively. The service reviewed their performance with stakeholders, including their main contract provider. They held meetings with their NHS mental health trust commissioners every three months and reviewed their key performance indicators. This included the number of patients transferred, the use of the secure area, the number of incidents of restraint, and the number of complaints received. Management engaged with partnership organisations to build better working relationships.

Leaders identified and escalated risks and issues and identified actions to reduce their impact. The service had an up to date risk register. Each risk entry was reviewed and had actions recorded to reduce the risk. These risks were assessed for likelihood and severity which produced a risk score with most risks recorded as 'low' or 'medium'. They did not have any risks rated as 'high'.

The service was committed to reducing their use of restraint and required people with the right temperament and competencies supported by effective training, induction and probation. Managers effectively dealt with staff who did not uphold their values.

Patient transport services

Staff attended mandatory training in situational awareness. This was to help ensure they did not put themselves in positions of increased risk. Management had recently implemented a process for crews to use reflective practice following restraint, unplanned use of the secure area, or any significant incident where there was an opportunity for learning.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

All computer systems were password protected and staff locked computer screens when leaving their workstation. Staff knew their responsibilities regarding data protection, where the data protection policy was stored and how to keep records safe. Staff files for current employees were held in a locked filing system.

Managers submitted notifications to the Care Quality Commission and external organisations when required. The service responded quickly to our requests for information.

The service had invested heavily in developing and launching its own mental health specific patient care coordination system (SCIPS). This included resource planning and vehicle management software. Managers had access to up-to-date information. The data available on SCIPS was accurate, up-to-date, and easy to access. The system contained a wide range of information. This included journey completion times, staff rotas, staff engagement, and the difference in the patients' level of calmness at the start and end of their journeys

Engagement

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

The provider had contracts with five NHS trusts. Communication and partnership working had improved between hospital staff and approved mental health practitioners There was representation from the service at multi-agency meetings, a single point of contact for incident reporting and sharing of information. They met with their main NHS clients every three months.

Staff felt included and involved. Communication was described as open and transparent about changes. There was a visual rolling display of key messages at their headquarters. Managers communicated to staff through their internal communication platform, meetings, podcasts and newsletters.

Staff were invited to their open board meetings. Communication channels were discussed as part of the appraisal process. This was to determine what staff found effective. Staff had been consulted for their views on their IT platform and in advance of any updates to the software

Staff had access to an electronic application on their phones. They used it to communicate with each other. Staff could review rotas and allocations, find out about upcoming events and information, send confidential messages to the management team or post general messages to all staff. They had the opportunity to feedback on their experiences of working at the service, including through anonymous staff surveys.

Patient transport services

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation. Improvement was seen as the way to deal with performance and for the organisation to learn.

All staff were committed to continually learning and improving services. Staff committed to learning from incidents and complaints. They understood this was the focus of their leaders when reporting concerns.

Leaders encouraged innovation and supported staff to identify opportunities for learning and improvement. For example, a member of staff shared an idea for customising silicone mood bands. This meant patients who were unable to talk or did not feel like talking, could still communicate how they felt. One side of the wrist band said ''Leave me alone,'' the other side said ''happy to talk.'' The member of staff had been encouraged and supported to progress the idea and the mood bands were being trialled when we visited.

They developed an NVQ training programme for mental health training assistants. It was optional but developed in response to staff feedback around career progression. There would be a pay increase for completing the training and it was expected that staff who successfully completed the course would become a champion in a specific subject. For example, safeguarding or a mental health first aider.

They developed a podcast for staff during the pandemic. It was a way of connecting with staff during heightened restrictions. They had been maintained following positive feedback. Staff described them as 'learning on the go.' They could listen to a podcast on the way to collect a patient and found the information and advice useful.

The service employed a psychiatrist as a clinical advisor. They were a registered psychiatrist who specialised in training teams on secure patient transfers. They attended the board quarterly meetings to advise on clinical topics. They were also available for ad-hoc clinical questions related to transfers.