Secure Care UK Headquarters

Quality Report

Unit 1, Cubitt Way,
St Leonards-on-Sea,
East Sussex,
TN38 9SU
Tel: 0203 598 5938
Website: www.securecareuk.co.uk

Date of inspection visit: 25 November 2019
Date of publication: 03/03/2020

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services well-led?	Good

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Secure Care UK Headquarters is operated by Secure Care UK Limited. The service provides a patient transport service for adults and children with mental health disorders. They also observe people in section 136 suites while they are awaiting a mental health assessment. A 136 suite is a place of safety for people who have been detained under Section 136 of the Mental Health Act 1983, due to concerns about their mental wellbeing and safety.

We carried out an unannounced inspection of Secure Care UK Headquarters on 25 November 2019. This was in response to information of concern. We considered the findings of our previous inspection on 2 April and 3 April 2019, when this information was relevant to the concerns raised, or our findings from this inspection. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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.

We focused our inspection on the questions of safe and well led because this is what the information of concern related to.

To see the most up-to-date rating for the questions of effective and responsive, please see the inspection report published on 26 June 2019. The question of caring has not previously been rated due to insufficient evidence to be able to rate this question.

The service is rated Requires Improvement overall.

Our rating of this service stayed the same. We rated it as Requires improvement overall.

- The provider did not have effective pre-employment checks to assess the suitability of new staff. They did not always use reference checks to determine if new employees were suitable to employ.
- Although the provider had implemented a coordinated programme for reviewing all polices, practice did not always reflect their policy related to recruitment checks.
- The provider considered the duty of candour when reviewing complaints. The current process for reviewing incidents, did not routinely consider if the duty of candour applied.
- The provider did not ensure all staff had a meaningful annual appraisal.

However:

- The provider had strong leadership. They were visible, proactive and engaged with staff.
- Staff spoke positively about the culture of the service. They felt valued, listened to, and able to raise concerns as well as ideas.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm, and to provide the right care and treatment.
- The provider had improved its training compliance since the inspection in April 2019. As a group of staff, training compliance had exceeded 80% in all modules apart from the practical element of moving and handling. All staff attended annual training updates.
- The shift patterns had been reviewed and changed to ensure all staff had a minimum break of 11 hours between consecutive shifts. This was largely in response to staff feedback.

Summary of findings

- The provider controlled infection prevention well. They had recently established a contract with an external cleaning company to complete deep cleans. This included all their vehicles used for regulated activity.
- The provider had systems to ensure vehicles were maintained to keep them roadworthy. We saw evidence of up-to date tax, MOTs, insurance and servicing for all vehicles used to carry-out regulated activity.
- The provider had introduced patient care records. We saw they were recording more detailed information of patients' care than when we inspected in April 2019. However, records were not always stored securely.
- The provider had introduced a process for coordinating the review of all incidents and disseminating learning to staff that were involved. While this learning had not been shared with all staff, the provider had plans to share the learning across the service.

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

Name of signatory

Nigel Acheson Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Requires improvement 	Secure Care UK specialised in the transport of adults, children and young people with ill mental health. They also supervised patients in section 136 suites when they were waiting for a mental health assessment. The service ran from a single location based in Sussex but had four additional sites across England. Although there was evidence that the service had made changes since the last inspection, we found pre-employment checks to assess the suitability of staff were not always effective. There was evidence the duty of candour was applied as part of the complaints process. We could not find evidence that it was considered following incidents.

Summary of findings

Contents

Requires improvement

Secure Care UK Headquarters

Services we looked at:
Patient transport services

Summary of this inspection

Background to Secure Care UK Headquarters

Secure Care UK Headquarters is operated by Secure Care UK Limited. The service opened in 2013 as a sole trader. This was changed to a limited company in December 2018. It is an independent ambulance service and has one location registered with the CQC in Hastings in East Sussex. The service also provided satellites in Birmingham, Leeds, Lincoln and Hampshire.

There was no registered manager at the time of the inspection. The provider had submitted an application to us to register a new registered manager. This application was processed on 29 November 2019. The provider confirmed that the new registered manager would be based at the organisations' headquarters.

The service provided patient transport for three NHS foundation trusts and two clinical commissioning groups across England. On average, the provider completed 432 patient journeys a month.

The type of transport provided included: 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 address to a mental inpatient setting and transfers for patients using community mental health services and learning disability services. The service also provided one to one observations of patients on mental health wards and monitored patients at section 136 suites. A section 136 suite is a dedicated unit for patients waiting for a mental health assessment.

We have previously carried out three inspections of the service. This included an unannounced inspection of the service on 2 April 2019 followed by a short announced visit to the service on 3 April 2019. Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached. This was to help the service improve. We also issued the provider with two requirement notices, where fundamental standards had not been met in relation to its patient transport services.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, an inspection manager and an assistant inspector. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection

Requires improvement

Patient transport services

Safe	Requires improvement
Well-led	Good

Information about the service

The service is registered to provide the following regulated activities:

- Patient transport services
- Treatment of disease, disorder or injury

During the inspection, we visited the providers headquarters in Sussex. We spoke with 11 staff including team leaders, control room staff, one mental health transport assistant and management. We were unable to speak with any mental health transport assistants (MHTAs), on the day of the inspection. We asked for our telephone number to be shared with all staff and offered two days when they could call us to give us feedback. We only received one call from a MHTA. We did not try to speak with any patients or relatives due to the areas we focused on.

We reviewed five sets of patient records, 80 records of patient restraint, five staff files, 25 vehicle records, minutes of the last five incident review meetings, the risk register, the training database, minutes of meetings and policies and procedures.

There were no special reviews or investigations by us 12 months before this inspection. The service had been inspected three times before and the most recent inspection took place in April 2019. This inspection found that the service was not meeting all standards of quality and safety it was inspected against. The service was rated overall as Requires Improvement.

- There were 4,322 patient transport journeys undertaken between 1 January 2019 to 31 October 2019.

The service employed 156 MHTAs, eight control room staff, 19 team leaders, three staff in human resources, one finance director, one trainer and 10 mental health nurses at the Birmingham site. Are patient transport services safe?

Are patient transport services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory training

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

We saw improvement in mandatory training since the last inspection. At the April 2019 inspection the service provided training in key skills, but they did not ensure that staff completed it. None of the mandatory modules met their compliance target of 80% and compliance varied between 17% and 65%. At this inspection, staff completion of mandatory training was higher than 80% in all modules except 'moving and handing practical' which was 77%.

The providers, 'Induction and Training Policy' was last updated on 24 July 2019. The policy outlined the three-phase mandatory induction. All staff had to complete this before they could commence any work that involved contact with patients.

The first part of the induction training was classroom based over two days. This covered the Mental Health Act, the Mental Capacity Act, the Deprivation of Liberty Safeguards, dementia awareness and safeguarding. Staff completed the majority of this by e-learning. Senior managers also completed the induction training. One senior manager had not completed it, but they were scheduled to complete it December 2019.

An internal trainer facilitated most of the face-face training. They had the right qualifications and skills and maintained a training database. Each site had a champion who was authorised to update the training spreadsheet with names and dates of new starters or leavers.

The internal trainer attended annual refresher training in subjects such as prevention and management of violence and aggression (PMVA), conflict management, and mechanical restraint to maintain their training skills. An

external trainer could be used to complete some modules if the in-house trainer did not have capacity, but this was unusual. The provider was in the process of up-skilling two members of staff to become trainers. This was to support training across the bases.

New starters were all given an induction checklist and employee handbook. The checklist had to be completed within their first few days of employment. This was completed with their team leader. It included a discussion about company culture and values and ensured they understood their terms and conditions. They were required to read their company polices, discuss health and safety regulations, familiarise themselves with their location, contact details and discuss any training requirements.

New starters were given a competency handbook. They had a three-month probation period and were expected to complete their induction programme and have their competencies signed off during this period. Competencies were signed off by colleagues/team leaders during episodes of patient care. We did not ask to see evidence of this, but staff told us it happened.

Staff were expected to attend annual refresher training in PMVA. All other training modules had to be repeated every two years. Staff could not work shifts if they did not attend their re-fresher training. This was communicated during their induction and across their internal electronic communication channel.

Human resources (HR), ran tailored training for team leaders on management skills such as performance management, managing appraisals and interview skills. We did not ask to see evidence of this. However, a team leader confirmed that they received additional training from HR and the training manager. They told us they could not attend one training date due to leave, but they were offered a date to suit them on return.

Safeguarding

Staff had training on how to recognise and report abuse, but we were unable to speak with staff to determine if they knew how to apply it. The provider did not always complete the necessary recruitment checks in advance of new starters commencing employment. This meant that they could not assure themselves that staff were always suitable.

At the April 2019 inspection the safeguarding lead was the registered manager. We saw that the quality manager had recently been appointed as the lead. They had a background in nursing and were trained in safeguarding to level four. Their deputy had also completed training to level four. This was in line with Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document (July 2018), and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document (January 2019).

The safeguarding lead had responsibility for notifying any safeguarding alerts to the Local Authority. They also reported safeguarding notifications to us, Commissioners, Providers and Clinical Commissioning Groups. The provider had made no safeguarding referrals to the Local Authority since the last inspection in April 2019.

During the April 2019 inspection we saw the provider's 'Safeguarding Vulnerable Adults and Children Policy' did not include the referral form for children and did not provide clear guidance to staff regarding their responsibility and the escalation process.

We reviewed the policy during the inspection and saw it had been reviewed on 3 April 2019. The policy now included clear roles and responsibilities, updated contact details for who to escalate concerns to and an adult referral form. It still did not include an electronic or paper referral form for children. However, we saw relevant information on the notice board in the control room. This reminded staff that any bookings for patients under the age of 18 had to be reported to the safeguarding lead.

We saw that 92.9% of staff had completed the safeguarding training for adults and 90.9% had completed the safeguarding training for children. Front line staff and control room staff completed safeguarding training level 2 as part of their induction. This was mandatory on-line training. The training lead also included the referral process as part of the induction.

A team leader gave us an example of a safeguarding matter which they had identified, escalated and reported to the safeguarding lead. They told us they had received positive feedback and the lessons learnt had been shared at their team meeting. However, it had not been disseminated outside of the team to share learning across the organisation.

Requires improvement

Patient transport services

Management told us that Disclosure and Barring Service checks (DBS) were completed for every member of staff as part of the recruitment process. We were told new starters were not offered a start date until any DBS was reviewed and the risk was assessed before a decision was made to offer employment. We reviewed five staff files and saw two staff had begun working for the service before the DBS check had been completed. There were also no references on file for these two employees. However, management told us staff were not allowed to work with patients until after their DBS has been received. They told us a small number of staff started employment before the DBS had been fully completed. These staff could complete training whilst they waited for the DBS to be returned and reviewed. However, they were not allowed any contact with patients until this was completed. This was not in line with their 'Recruitment and Selection Policy' which was reviewed on 19 September 2019.

Cleanliness, infection control and hygiene

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

The provider had updated and improved their infection control policy since our previous inspection. We noted that the 'Infection Control Policy' (January 2019), did not provide clear guidance and did not reflect the service provided when we inspected in April 2019. We saw the policy was updated on 6 June 2019. The update provided clear guidance to staff regarding their roles and responsibility. At the inspection in April 2019 there was no regular cleaning schedule and no process for deep cleaning vehicles. We saw a cleaning regime had now been introduced. This was part of a rolling audit programme.

A contract had been established with an external provider with an arrangement for all vehicles to have a deep clean every 6-8 weeks. We saw evidence that vehicles had recently been deep cleaned and further deep cleans were planned. They used a backup fleet of older vehicles when vehicle(s) were being deep cleaned. The provider had made improvements in the system and was now auditing the process to determine the effectiveness and provide further assurance.

There were two vehicles at the headquarters when we inspected. They were visibly clean internally and externally. However, they both had plastic boxes in the hatch. They contained unused gloves, tissues and paper towels. They also contained an empty water bottle which had been used. We highlighted this to a manager who told us they would remove them immediately.

At the April 2019 inspection, there was no evidence for the management of waste. At this inspection staff told us clinical waste was disposed of in yellow clinical waste bags (stored in the equipment bags). The yellow bags were disposed of either at hospital or in clinical waste bins on site. The provider arranged for clinical waste to be collected as required. We were told that this was audited as part of the rolling audit programme to ensure clinical waste was disposed safely. We did not ask to see evidence of this during the inspection.

Environment and equipment

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

The premises at the Sussex headquarters was the same as when we inspected in April 2019. This included staff offices, a meeting room, a training room which could also be used for meetings, a stock room, a kitchen and a control room where all bookings were received and managed.

At the inspection in April 2019 we saw that the provider did not take a proactive approach in maintaining vehicle safety. We saw that the finance manager now had oversight of the vehicle maintenance. They maintained an electronic database which they updated and disseminated to team leaders to action. The electronic database was stored on a central system.

The spreadsheet included the vehicle registration number, breakdown cover, the date the road fund licence expired, insurance details, MOT expiry date, how frequently vehicles should be serviced, next service due date, and current mileage to flag if a vehicle should be serviced sooner. The team leader used the spreadsheet as an aide memoir. For example, we saw that an MOT was highlighted in yellow to alert the team leader that it was due in two months. The team leader took responsibility for organising any maintenance or repair work.

We saw one incident of a missing MOT. They had kept the vehicle off the road until the MOT had been completed. We saw evidence of mechanical work completed on each vehicle. For example, replacement of brake pads and cambelt and repair of a seat belt to maintain vehicle safety.

Only materials provided by the organisation were permitted to be used for vehicle care and maintenance. This was to comply with control of substances hazardous to health regulations. We saw child seats were available for young children with different weight requirements, although they had not needed to use them yet.

Staff had maintained vehicle inspections prior to the completion of any patient journeys, since the inspection in April 2019. We saw a specific vehicle checklist which they used to check vehicles before and after journey. This was in line with their 'Vehicle Safety Policy' which was reviewed on 12 June 2019.

At the April 2019 inspection the vehicle equipment varied because there was no checklist for staff to refer to. We saw that the 'Equipment Policy' now included a list of items that should be carried on all journeys. The policy had been approved on 29 August 2019.

Vehicle equipment bags had been introduced approximately four weeks prior to this inspection. These were bags which included all the equipment staff should need to complete the patient transfer. We were told the service delivery manager was responsible for ensuring staff were trained to use the equipment. However, the policy did not outline how this training would be rolled out, or when to use items.

The equipment bags were provided as complete packs. They were sealed using a green seal tag by a team leader. These confirmed items were complete and unused. If any items were used, they were returned to the relevant site for restocking by a team leader. Bags included a seatbelt extension, first aid box, disposable overall (one medium and one extra-large), seat pads, seat covers, vomit bags, a fluid spill kit, yellow clinical waste bags, shoe covers, face masks, clear bags, blue roll and hand cuffs.

There were three categories of equipment. This included personal equipment, vehicle equipment bags, and specialist equipment bags. Personal equipment was provided as part of induction training. Staff were always expected to carry it. It included a ligature cutter, personal face mask for cardiopulmonary resuscitation, safety scissors and soft cuffs.

We saw specialist equipment bags in the control room. They included a defibrillator. Staff told us this was for patients at increased risk of heart attack. For example, someone with a history of a previous heart attack. The defibrillator was not listed in the 'Equipment Policy'. However, we saw there was text on the booking form (highlighted in red), to remind staff to take the defibrillator if a patient had a physical condition.

Assessing and responding to patient risk

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

Patient transfers were risk assessed as part of the booking procedure. The control operator took as much clinical information as possible. The information was entered onto an electronic booking form. This included an aggregated risk assessment tool based on specific questions such as 'history of risk of self-harm.' The replies generated specific scores and once all the questions were completed, an aggregated score was used to plan the safe transport of the patient.

If the assessment was scored as low risk, the journey was assigned to a driver plus one escort. If it was assessed as high risk, the journey was allocated to a driver plus three escorts and a cell vehicle would be assigned. A cell vehicle is a vehicle fitted with a secure cell for transporting high risk patients as safely as possible, protecting staff and patients. We observed this in action in the control room. The team leader in the control room reviewed all assignments. They could also discuss the allocation with the quality manager or training manager.

If a medical risk was identified such as a patient needed sedation during transfer, they would not transfer without the clinical support of a qualified nurse. The control room could also book an interpreter for transfers with an external company that was available 24 hours a day, 365 days a year.

The control room were also responsible for dispatching an appropriate crew to section 135 and section 136 transfers. A

section 135 allowed the police to enter someone's home so that a mental health assessment could be completed in their home, or so that they could be moved to a place of safety to complete the assessment. The mental health assessments were carried out by mental health professions. They informed the crew of the risk assessment (when known). They also advised them of any other information provided by the police when they took the call such as in circumstances of detention, severe intoxication or overdose.

At the inspection in April 2019 we saw the provider's 'Resuscitation Policy' did not reflect current practice. It stated, 'all operational staff will also ensure that the resuscitation equipment is functional and clean'. The vehicles did not contain resuscitation equipment. At this inspection first aid and resuscitation was part of 'Patient Safety and Care Policy'. However, it did not outline the standard operating procedure for resuscitation.

We only spoke with one crew member due to the lack of activity. They knew what to do if a patient became unwell.

All mental health transport assistants received basic life support training during their induction and annual mandatory updates. At the April inspection 95% of staff had completed this. The compliance rate was now 97%

We saw the safe and caring use of manual restraint for adults and children was part of their 'Patient Safety and Care Policy' This was an improvement from our previous inspection when we found the provider did not have assurance that the crew correctly applied restraint. The 'Mechanical Restraint Policy for Adults and Children' was overdue a review and the paper records we reviewed did not comply with the level of detail outlined in their policy.

This was reviewed on 6 June 2019. The policy made clear that staff must 'ensure that the use of restrictive interventions does not impose restrictions that amount to deprivation of liberty outlined'. The provider did not train any prevention and management of violence and aggression restraint techniques which involve the use of pain. This is in line with NICE guideline 10: Violence and aggression: short-term management in mental health, health and community settings (May 2015). Their training and policy encouraged de-escalation techniques and gave clear guidance around their role and responsibilities. The guidance made clear that any form of restraint was a reportable incident which had to be recorded in the patient care record.

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 staff working flexible hours were given a full induction.

The provider employed staff on either a flexible, part time or full-time contract. All staff, regardless of their contract type had to complete the same induction programme and refresher training.

Team Leaders took responsibility for rostering shifts and the control room had access to them. The provider had recently introduced a new shift system referred to as the 'watch' structure. This was to avoid shift over runs and ensure all staff had a minimum break of 11 hours between consecutive shifts.

They now operated four days on, four days off 'watch' or shift pattern, with four teams or 'watches'. The teams were colour coded as red, yellow, blue and green. Each watch worked an equal share of day and night shifts.

At the inspection in April 2019 the day shift ran from 6am to 6pm and the night shift ran from 6pm to 6am. Staff worked on an on-call basis and were expected to answer a call from the control room within 15 minutes and arrive at base within 40 minutes of the answered call. However, shifts often ran over due to unforeseen circumstances, such as traffic delays. This meant staff often did not get enough time off in between shifts. This may have compromised their health and wellbeing and affected their ability to work safely.

The management team had restructured the shift patterns and the way the teams were aligned in response to staff feedback and their own concerns about health and safety. The day shift ran from 6am to 8pm and the night shift from 7pm to 7am. Management ensured staff received a one-hour unpaid lunch break to comply with health and

safety regulations. Although the day shift ran for 14 hours staff were asked to attend at either 6am or 7am and would finish at either 7pm or 8pm to reduce the shift length and to ensure a clear 11-hour break between shifts.

The new shift patterns had also been extended to staff working in the control room. This meant they followed the same pattern of working four days followed by four days off. They were aligned to the operational teams. For example, when red team were on duty in Hampshire the corresponding red team were on duty in the control room. This was to support continuity and promote better working relations. Each 'watch' had a team leader who also worked the same shift patterns.

A 'cross over' shift had also been introduced to make opportunities for a small number of flexible colleagues to be paid a fee to be on call. They came to work if they were busy and needed additional cover. For example, if a transfer was likely to require a team working across a shift change.

If a crew member was late off duty, because of unpredictable circumstances, they reported this to the control room at the shift handover. They were advised to come in late on their next shift to ensure they had a minimum break of 11 hours in-between shifts. The control room staff also kept in touch with staff who were with patients in s136 suites. They stayed in contact to ensure they received their breaks. They allocated a crew of three to s136 suites to ensure they could relieve each other for breaks.

The control staff completed an end of shift report which was emailed to the senior management team after every shift. Any shift over runs were discussed as part of the management calls which took place every week. This helped to ensure that they had oversight of the service and ensured they monitored the new shift system.

Information provided by the managing director since September 2019 showed shifts over-runs were less frequent. They happened due to unforeseen circumstances. They ensured that when shifts over ran the crew were given an 11-hour break before they started their next shift.

Records

Staff kept more detailed records of patients' care and treatment than the previous inspection in April 2019.

At the inspection in April 2019 we saw staff did not keep detailed patient records. At this inspection we saw the 'Patient Safety and Care Policy' had been re-written and approved on 6 June 2019. This included guidance around maintaining patient care records.

The company had an 'Information Governance Policy' which was reviewed on 11 July 2019. All staff were required to complete mandatory training in information governance. This was part of their induction and they attended yearly updates.

All patient journeys were recorded in patient care records (PCRs). These were available at each site. Completed PCR's were couriered by team leaders in sealed envelopes weekly to the headquarters. The paper records, (booking forms and paper risk assessments), were stored in a manager's office in cardboard boxes. This was for three months unless they were related to an incident/complaint. There was no filing system. This meant they would be unable to locate records quickly and easily if needed.

At the inspection in April 2019 we saw the service did not have assurance that patients did not sustain harm during the patient journey. This was because the body maps in the records were not always completed. Staff were expected to complete body maps to confirm if patients had any visible marks. This was before the journey started, and on completion of the journey. Non-visible injuries were to be completed by the nurse or doctor at handover times.

At this inspection we also reviewed a random selection of five patient care records. We saw body maps were completed pre and post journey, as required. This was an improvement in this area of documentation from the last inspection.

Patient care records had been introduced. The record included images of different types of restraint. These included 'escorting/guiding', 'holding' and 'immobilising'. Alongside the images were boxes for the crew to tick to confirm the type of hold and category. For example, if they had used 'escorting/guiding' they were required to tick the relevant box to confirm what type of escorting or guiding was used. There was a box to tick if hand cuffs were applied and an additional box to confirm if they were soft or hinged. There was also a text box at the bottom of all the images titled 'non-standard holds or immobilisations. The following text was included: "we appreciate that the calibre

of patients can be challenging and sometimes situations occur when non-standard techniques are used. This section is to help us learn and develop our training and support. Please be honest".

The images and information were clear, and the tick boxes made it simple and quick for staff to complete. We reviewed a random selection of 80 patient care records and did not see any completed sections related to restraint. However, we reviewed the providers' incident log. We saw that staff were reporting the use of restraint as incidents.

Medicines

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

The provider's 'Medicine Management Policy' was reviewed on 10 June 2019. It gave clear guidance to staff on their role and responsibility. The policy was appropriate for the service provided.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with staff who were involved. They had plans to share lessons learned with the wider service. However, they did not always assure themselves that the loop was closed with incidents.

We read the provider's 'Patient Safety and Care Policy' which was last reviewed on 6 June 2019. This included a definition of an incident, serious incident and never event. The policy included information on the types of incident, the management of incidents and the reporting process. The registered manager was responsible for the reporting of statutory notifications to us.

The records now included a new risk assessment process which was implemented at the point of booking. All patient journeys were recorded in their patient care records, (PCRs). There was a list of incidents on the back of the PCR for staff to tick which type of incident had occurred and an information box to add detail. The completed forms were reviewed by the site team leader within 48 hours. The team leader entered the information onto the electronic risk log and was responsible for investigating incidents related to their team. Serious incidents (SIs) were reported directly to the registered manager and governance committee within 24 hours of the SI being identified.

Incidents were also reported to the control room. The crew rang the control room to confirm when they had completed a patient transfer. Control staff asked, "have you ticked any incidents on the back of the PCR?" at the end of every transfer. This information was cross referenced each week by the quality manager. They checked the team leaders had added the detail to the incident log and monitored investigations and learning.

The quality manager prepared a monthly summary of learning and recommendations for improvement which was presented to the governance committee and included in the board report. Control staff documented all incidents on each 12-hour shift report which was emailed to all the managers.

Shift over runs were not classified as an incident. They were reported to the control centre at shift handovers.

There was a shared incident drive for all the sites. This ensured the incident committee had access to all the information on a central database.

The provider had recently established a weekly incident call to review all incidents which occurred in the previous week. They monitored longer term investigations to keep them on track. The recently appointed quality manager chaired this. The training manager, regional managers and managers who were investigating specific incidents also attended the call.

We read the minutes of the incident review committee which took place during the day of our inspection. We saw there was an update on any recently completed investigations and any actions that had been completed. Thirteen new incidents were recorded during this meeting. The incident number, location and any agreed actions were recorded as part of the meeting. For example, we saw an incident had been reported because a patient had been searched during transfer. The learning to be disseminated from this was that if a patient search was required, it should only be completed before the patient leaves the point of collection.

However, we did not see any evidence that the committee discussed the duty of candour. The duty of candour is a legal duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. We raised it with a manager who told us they were looking into this.

Requires improvement

Patient transport services

The minutes of the meetings were disseminated to team leaders who were responsible for ensuring actions were completed and feeding back to their crew. They planned to disseminate wider learning across their intranet. The quality manager had plans to introduce a regular newsletter. This would include key messages to support lessons learned across the organisation and not just to staff involved in the incidents.

We reviewed the incident spreadsheet for the eight weeks prior to this inspection. All incidents had the date recorded, the site it related to, a booking reference, location, type of incident and brief description. It also included brief details of the team leader's assessment and recommendations before the incident review committee. For example, following one investigation, the team leader had recommended the crew attend refresher training in restraint. However, it did not include the date the team leader reviewed the incident, the date the incident review committee had reviewed the recommendations, or the date the training had been organized for. There was no closure date for the incidents.

Are patient transport services well-led?

Good

Our rating of well-led improved We rated it as **good.**

Leadership

Leaders had the integrity, 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 was initially set up in 2013. A board of directors invested in the company in July 2018 and since then they established a new management team. This included the managing director, the registered manager, the operations manager for the north, the regional manager for the south and control room (vacancy), the quality manager, the human resources (HR) manager for strategy and communication, the HR manager for operations and the finance and IT manager.

Day to day operations at all sites were managed by team leaders who reported to the operations manager in the north, and the regional manager for the south and the control room.

There was an emphasis on managers engaging with staff. Managers also completed the staff induction programme and buddied the crew on some 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 reported seeing their managers most days and that they were visible and approachable. We were given several examples of issues staff had raised with the managing director. Staff had felt listened to, advised they were impartial until investigations were completed, and their concerns had been dealt with.

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. Leaders understood and knew how to apply them and monitor progress.

We saw a copy of their draft strategy for the next five years. This was being finalised for their December board meeting. It confirmed the company's values of 'patient first, respectful, openness, unity, determination,' (PROUD). It outlined their vision ''to improve the lives of vulnerable patients by providing safe and responsive mental health care.''

Underpinning this vision was a strong business strategy focusing on the next five years. It showed the providers awareness of the challenges in achieving this strategy. They had five strands to it which included inspiring people, therapeutically led care, to be the best in the business, continued growth and insightful intelligence. Their five-year mission was outlined ''to help 100 patients a day. To be able to provide care to 90% of Great Britain within 2 hours, 24 hours a day, 7 days a week.'' The strategy included their recruitment projection and ''smart planning'' to ensure financial efficiency and competent staff.

Senior managers had completed staff roadshows across the sites in April and May 2019. They had used this time to share their vision, values and 12-month plan.

Patient transport services

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff told us the culture had become more open and honest. Staff told us that the managing director led by example. They were described as ''amazing,'' ''caring'', ''understands the job'' and ''really listens to us.'' They told us, ''we know what's happening now'' and ''we feel involved''.

Staff were encouraged to attend the open board meetings which occurred every second month. Managers felt this supported their open and honest philosophy. They told us some crews had attended. We read the minutes which showed the meetings were inclusive.

Staff told us they felt able to raise concerns. They gave us examples of how their concerns had been investigated and dealt with. We were given an example of how the whistleblowing policy had been applied and we were confident it had been managed effectively. Staff told us they felt listened to, and confident to raise concerns, or blow the whistle on a colleague.

The provider had an arrangement with an external company to provide counselling support to staff. This was an anonymous service to offer support regarding personal or work-related issues. A member of staff had accessed the service following a difficult episode of patient care. They decided the job wasn't right for them and left the company, but they continued to use the counselling service after leaving.

We saw details of how to access their health and well-being portal in their employee handbook. This portal included information about accessing counselling, legal advice, a range of self-help tools and information and bereavement support. This information was available 24 hours a day and could also be accessed via a free mobile application.

All staff received a copy of the employee handbook as part of their induction. Staff were familiar with the service. One member of staff told us they were experiencing a personal issue. They felt well supported by management, had been sign posted to additional support services and had been supported to take additional time off.

Staff told us they could have time off for personal appointments such as dental and hospital. They told us there was an emphasis on wellbeing and work/life balance. One of the managers told us they had an arrangement to work from home on a Monday to support their work/life balance. This was at the discretion of their manager.

We read their 'Family Policy' which was reviewed on 26 July 2019. This included time off and support for maternity/paternity leave, adoption and carers leave. Staff gave us examples of how the policy had applied to them and they told us they had felt well supported.

Staff told us mental health transport assistants were always offered a debrief session following an incident. They received a wellbeing call or face/face contact on the same day of the incident and additional support was available. This included counselling via an external company, time off, and lighter duties. We were given several examples of when this had been applied. However, this was an informal process and not embedded into any policy or procedure. This meant it may not always happen and there was no monitoring of the process.

Staff were encouraged to share their ideas of how to improve the service as well as raise their concerns. We were given examples of ideas that had been implemented. For example, the kit bags which had been recently introduced were an idea of some of the staff.

Staff gave us examples of positive feedback they had received from the managing director and their line manager. They received this in person. It was also uploaded onto their internal communication channel to share with colleagues. We saw the managing director had written to all staff on 14 October 2019 to disseminate positive feedback and confirm some new staff appointments. They also confirmed they were investigating three incidents related to bullying behaviour. It was made clear the organisation had zero tolerance on bullying and they were an inclusive organisation. They said they would take appropriate actions following completion of the investigations. This included the possibility of dismissal.

However, we saw inappropriate language was used in two incidents that were discussed during an incident review

committee. One read, ''patient dragged back into van''. The other read ''grabbed patient's arm.'' There was no reference of this in the team leader assessment or the review by the incident review committee.

Governance

Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The provider had a governance committee which had terms of reference. These included the aim of the committee and roles and responsibility for each member. They had a strategic plan which outlined their key responsibilities for the year ahead. This was to drive improvement and align it with their overall vision.

We saw the first aim of their strategy was to improve information flow between frontline staff and the board in both directions. Since April 2019, they had implemented a new governance structure which included a recently appointed quality manager.

We saw the escalation process for raising and managing concerns had been strengthened. Staff knew who to escalate issues to. We were given several examples of when they had raised concerns, been listened to, and concerns were investigated and resolved.

We saw evidence of how duty of candour was applied following the investigation of complaints. However, we did not see how the duty of candour was embedded into the weekly incident review meetings to determine when it needed to be applied.

Their second strategic aim was to improve staff awareness of policies and align policies with operational realities. The quality manager coordinated the programme for updating policies.

We saw evidence of processes to disseminate information to ensure all staff were aware of policies and procedures. All polices were available online on their communication platform and hard copies were available at all sites. Staff were expected to read all policies as part of their induction. Their team leader was required to sign the new staff checklist to confirm this had happened. Staff were alerted by their communication platform when policies were reviewed and updated. However, we saw some practice did not reflect their policies. For example, they did not have an effective filing system. This did not comply with their 'Information Governance Policy' (July 2019), and they did not comply with their 'Recruitment and Selection Policy,' (September 2019).

The third strategic aim at the April 2019 inspection was to improve the management of incidents and audit the process. Their governance and audit timetable were now operating within the organisation. There was a monthly programme of policy reviews and audits being reported through their governance meetings.

The quality manager recently established a weekly conference call. This was to review all incidents which had occurred within the previous week and to ensure longer term investigations progressed as expected. They now reported on the conclusions and recommendations from the weekly meetings. This was a standing agenda item at their monthly governance meetings.

Staff told us relationships and communication had improved with the NHS trusts they had contracts with. We saw the results of an audit summary that one of their NHS trusts had shared with the provider. The trust completed a survey of patient experience relating to s136 suites. This included the collection of feedback regarding the patient transfer to and from these suites.

The trust wrote to 124 service users and 105 people completed the survey. Overall the response showed service users were treated very well by the staff who had supported the patient transfers. This included some very positive feedback. The trust concluded, ''it appears from the feedback that Secure Care are really showing compassion and kindness towards our service users, and I have received some really good feedback which I will share directly with them.'' This showed that improved communication and multidisciplinary working was supporting the service(s) to monitor and evaluate their care.

Management of risks, issues and performance

Leaders and teams did not always use systems to manage performance.

We checked five staff files. All staff had a full driving licence, but four out of the five staff had not had reference checks

before starting employment. We raised this with the HR department. We were told there was a back log and they were diarising fortnightly dates to chase references. We also saw that two out of the five staff did not have a record of a competency-based interview which was part of the recruitment process. Therefore, it was unclear how their suitability for the job and been assessed.

The HR department had completed an audit of all staff files (154), in September 2019. The audit showed some data was missing, however, it had not identified the missing references.

The provider had recently completed a full upgrade of their remote asset management services tracking system. This provided them with complete visibility of the drivers. We were told the control room would be alerted by GPS if a driver had driven over the speed limit. This was reported by the end of shift report, so all managers were aware, and the link team leader would manage this immediately. Team leaders and line managers reviewed this data on a regular basis. They could undertake formal investigations and consider disciplinary procedures if colleagues were found to have broken speed limits or other violations.

The organisation could also deploy closed circuit television cameras in vehicles for staff and patient safety. Team leaders and line managers could review the footage on a regular basis for patient safety. Management could undertake formal investigations and consider disciplinary procedures if colleagues were observed acting outside of their code of conduct or employee handbook.

The risk register was comprehensive with an outline of each risk, rating and mitigating actions. The provider had added one new risk since the previous inspection in April 2019.

The risks on the register were aligned to the concerns we identified during the inspection. However, the mitigations were not always effective. For example, they identified that practice did not always reflect their policies, and this was added to the risk register on 15 April 2019. The policies had all been reviewed since April 2019, but some practice was still not in line with their policies.

Incomplete DBS checks were added to the risk register on 28 November 2017. This was because pre-employment checks were not always carried out in line with policy. The risk was closed, although the closure date was not included. However, we saw an audit of staff files was completed in August 2019. This included their DBS clearance. The audit identified that 16 out of 154 staff had not had DBS clearance. Management advised us that staff did not have any patient contact if they were waiting for DBS clearance. However,this was to be actioned by 31 October 2019, but there was no documentation to confirm it had been completed. Also, although they identified this risk during the audit, they had not re-added it to their risk register.

We saw the provider identified that the employee appraisal process and effective management of staff were a risk. This was because regular one to ones and appraisals did not happen. It was added to the register on 18 May 2018. However, all staff told us that meetings, one to ones and appraisals were unplanned and happened during quiet periods. This meant this risk had not been effectively managed and monitored.

We saw their plan for their monthly board meetings for 2020. The risk register and management of risks, issues and performance were to be reviewed every six months. Every meeting was to focus on a specific part of their strategy and link this to a governance 'deep dive.' For example, part of their strategy was to 'inspire people' and this was linked into a deep dive into diversity and inclusion.

Their audit programme included information about the standard to be audited. Results and recommendations were colour coded to highlight the priority of action. However, we did not always see a date applied to actions. For example, the audit of vehicle checks was scheduled to be completed every six months. We saw the results from September 2019. The action was required to be completed by 31 October 2019, but there was no documentation to confirm this.

We saw the biannual audit of patient care records and incident reporting was scheduled for February 2020. An incident review committee had been established on the 18 November 2019. The meetings were minuted and included the type of incident, location, a brief description, the assessment, actions completed by the team leader and any recommendations following review by the committee. Some of the actions included ''referred back to the trust for investigation'', ''further information requested'' and ''ensure crew have a set of handcuffs''. We noted a recommendation to discuss an issue about use of restraints at one of the trusts. This was also raised in their quarterly report.

Requires improvement

Patient transport services

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.

Their policies gave clear guidance on data or notifications that were required to be submitted to external organisations.

The provider monitored, managed and reported on its quality and performance to key stakeholders. It captured real time information. All information surrounding performance such as response times were completed based on their central data sources.

Forty six percent of staff had completed information governance training at our inspection in April 2019. As of 25 November 2019, 92.9% had completed it.

Public and staff engagement

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

The management team were determined to be visible and approachable to all staff. Staff told us this was reassuring and helped them to feel valued and able to contribute ideas as well as concerns. They gave us several examples of ideas they had contributed that had been implemented.

The managing director who was appointed in March 2019 spent a day per week at each site. This helped to ensure they had oversight across the service. It also gave them an opportunity to meet and get to know all staff. The recently appointed registered manager was to be based at the headquarters. This was to support the operational management of the service.

The provider had maintained its contract with three NHS trusts. One member of staff told us communication and partnership working had improved between hospital staff and advanced mental health practitioners There was representation from the provider at multi-agency meetings, a single point of contact for incident reporting and sharing of information.

We saw evidence that staff engagement had improved since our last inspection. At the April 2019 inspection it was highlighted that there was a disconnect between management and frontline staff. They completed a staff survey in April 2019. This helped them to understand staff concerns and ideas. The feedback was used to make improvements. The major theme was related to concerns over their working hours and shift patterns. We saw evidence of several changes made because of staff feedback.

The introduction of a governance structure, visible managers who were easily available and a more open and honest culture had improved communication. All staff that we spoke with told us there had been significant improvement.

The provider had an internal online site that was used as a communication channel. There was also an electronic communication group to enable team discussions. These channels were used to discuss operational matters such as shift availability. They were also used to ask questions, share ideas and best practice. Managers told us they monitored both. This was to identify and monitor any themes such as staff concerns which they raised at management meetings.

Managers had a higher level of administration controls, so they could monitor information uploaded onto the platforms. This helped them to ensure staff complied with their guidance around the use of social media as outlined in their 'Working Standards Policy' (25 July 2019).

Managers told us they were starting a process for staff awards. This was due to commence in January 2020. The plan was for there to be a nomination every quarter. Colleagues would be able to nominate staff for 'Employee of the Quarter.' Nominations would be reviewed by an internal panel of managers and each quarter there would be an announcement to celebrate the winner of 'Employee of the Quarter.'

Innovation, improvement and sustainability

Although we did not see evidence of any innovation, we saw evidence of improvement since our last inspection in April 2019. The service was now well led, and the managing director was aware of the challenges and changes that needed to be made to improve the service further.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take prompt action to ensure recruitment procedures are completed in line with regulation 19: Fit and proper persons employed.

Action the provider SHOULD take to improve

- The provider should consider offering all staff appraisals, as part of their performance management.
- The provider should consider if debriefing should be included in policy so that it was mandatory when the use of restraint is used.
- The provider should review staff compliance with mandatory training.
- The provider should consider writing guidance for staff that outlines when they should take and use defibrillator.
- The provider should audit practice for assurance that practice reflects policies.
- The provider should consider whether incidents meet the threshold for duty of candour and monitor this.
- The provider should consider how they store patient records to make sure information is secure and easily accessible.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed They did not always use reference checks to determine if new employees were suitable to employ. We reviewed five staff files. The provider requested a Disclosure and Barring Service (DBS) check. We saw two staff had started to work for the service before the DBS check had been completed. There were also no references on file for these two employees. However, management told us staff were not allowed to work with patients until after their DBS has been received. They told us a small number of staff started employment before the DBS had been fully completed. These staff could complete training whilst they waited for the DBS to be returned and reviewed. .