Definitive PSA Ltd

# Secure 24

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Secure 24 is an independent ambulance service operated by Definitive PSA Ltd. The service provides a patient transport service specialising in the transfer of mental health patients, including those detained under the Mental Health Act 1983.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 10 October 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this service was patient transport services.

**Services we do not rate**

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

We found the following areas of good practice:

- Vehicles we reviewed were clean, serviceable and well maintained.
- Staff worked effectively with other providers in order to provide the transport service.
- Vehicles used by the service were bespoke and were designed with the patient and staff comfort and safety in mind.
- Patient experience forms circulated by the provider demonstrated consistently positive feedback.
- The service was provided 24 hours a day, 365 days a year.

In addition, the provider also reacted promptly in response to the following issues raised:

- The incident reporting policy for the service lacked definition of what constituted an incident and we were not assured that all incidents and near misses were being reported. Following our inspection, the provider made amendments to their policy, including definitions and examples of what constituted an incident or near miss.
- Not all of the service's policies such as the safeguarding or use of force policies, reflected current guidance or best practice. Following our inspection, we saw that the provider had significantly improved their policies on safeguarding and use of force, to include current guidance and best practice.
- The provider did not have a risk register for the service. Following our inspection, we saw that the provider had initiated this.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

**Amanda Stanford**

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

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| Patient transport services (PTS) | | Patient transport services was the only service provided by Secure 24 and this was provided 24 hours a day, every day of the year. The service completed 808 patient journeys between September 2016 and September 2017, which equated to an average of 67 journeys per month. The services transported both adults and children, and there were eleven members of full time staff. |

# Secure 24

## Detailed findings

**Services we looked at**
Patient transport services (PTS)

# Detailed findings

## Contents



## Background to Secure 24

Secure 24 is operated by Definitive PSA Ltd and registered with the CQC in 2013. The service had recently moved to a new base in Felbridge, and was going through the registration process for this. The service is available 24 hours per day, every day of the year.

Although registered as a patient transport service; patients transferred by the service were physically able and this meant that vehicles used by the service were not equipped in the same way that conventional ambulances would be.

The service is an independent ambulance specialising in the secure transfer of mental health patients and those sectioned under the Mental Health Act 1983. The service transported both adults and children across the United Kingdom and the types of transfers included from secure mental health units, to prison or courts, transfers from mental health inpatient units and extraction and transportation to and from patients' homes.

The service has had a registered manager in post since December 2013 and this individual was the Managing Director of the service.

We inspected this service on 10 October 2017 and this was the first compliance inspection of the service following its registration.

## Our inspection team

The team that inspected the service comprised two CQC hospitals inspectors, one CQC mental health inspector, and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Elizabeth Kershaw, Inspection Manager.

## Facts and data about Secure 24

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the provider's headquarters, which is where the service was provided from. There were no other registered locations.

We spoke with eight members of staff including; a director, business development manager, two supervisors, secure transport officers and a clerical assistant. We did not speak with any patients or relatives during the inspection. We also received 15 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed eight sets of care records.

# Detailed findings

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (September 2016 to September 2017)

- In the reporting period September 2016 to September 2017, there were 808 patient transport journeys undertaken, which equates to an average of 67 patient journeys per month.

A managing director, business development manager, two supervisors, seven secure transport officers and one clerical assistant worked at the service. There were also ten self-employed staff that the service could access to cover additional shifts or cover sickness and annual leave.

The service had four ambulances and two cars. At least three secure transport officers (STOs) would be used per patient transfer for patients transported in the secure ambulances, and two STOs would be used for transfer in the people carriers. Following the inspection, the job titles of STOs was amended to Secure Technicians. For the purposes of this report, they are referred to as STOs.

Track record on safety

- No patients had absconded from the service's care since it started trading in 2013.
- The service reported no never events during the reporting period (September 2016 to September 2017).
- Seven incidents had been reported during the reporting period (September 2016 to September 2017). Level of harm was not recorded for these incidents.
- No serious injuries were sustained by patients during the reporting period (September 2016 to September 2017).
- No complaints were received by the provider during the reporting period (September 2016 to September 2017).

# Patient transport services (PTS)

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |
| Overall | |

## Information about the service

## Summary of findings

# Patient transport services (PTS)

## Are patient transport services safe?

### Incidents

- The provider reported no never events for this core service between September 2016 and September 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- Between September 2016 and September 2017, the service reported seven incidents. We reviewed these incident reports and saw that these ranged from an attempted absconsion of a patient, to issues with documentation on arrival at a destination. Level of harm was not routinely recorded on these incident reports, which meant that the service may not be able to have an overview of the trends and level of harm sustained from incidents.
- There was a company incident reporting policy. However, whilst this emphasised the importance of raising concerns regarding service users that were at risk, it did not define what an incident or near miss was, or what the process was following the reporting of an incident to the team leader, supervisor or manager. It also did not advise staff how to grade the harm or impact of an incident, such as "no harm", "low harm", "moderate" or "severe". Following our inspection, we saw that the incident reporting policy had been amended and further improved.
- We spoke to staff who advised us that minor injuries such as scratches or strains from retrieving or moving patients would not generally be reported as these were considered "part and parcel" of the job. This meant that the service could be under-reporting incidents and did not have an overview of the amount of incidents occurring on a daily basis. However, staff did use the patient task form to record when/if restraint was used, and there was an observation sheet on which staff could record if the patient became agitated or displayed aggressive behaviour. However, this was kept on the paper record and was not recorded anywhere else, meaning that staff could not have an overview.
- No patients had absconded from the service's care since the service began in 2013.
- No vehicle accidents had been reported in the last 12 months while using blue lights.
- Duty of candour was discussed at the morning briefing that we observed where staff were asked about their knowledge of duty of candour. There were no patient injuries sustained during the reporting period according to the incident reports that we reviewed.

### Cleanliness, infection control and hygiene

- We reviewed two out of the six vehicles at the base. These appeared visibly clean and tidy and we saw vehicle cleaning checklists which provided assurances that these were completed regularly.
- Vehicles were cleaned when they were returned to base following their completed transfer. If staff were going from one transfer straight onto another, the inside of the vehicle would be cleaned as soon as the patient had been handed over, and we saw cleaning equipment on board to enable staff to do this.
- Deep cleans could be completed at the base where there was equipment to enable this.
- Spill kits were available on the vehicles in the event of a spillage whilst travelling on the vehicle.
- We saw personal protective equipment (PPE) such as gloves were available for staff to use.
- Staff took care of their own uniform on a daily basis. The only exception to this was where a uniform had been badly soiled or stained with bodily fluids. An example was given where a staff member completed a house extraction and badly contaminated their uniform . They were able to return to the base, put the uniform in a contamination bag and went to the local gym (free for all Secure 24 staff) to shower before returning to work.
- There was a cupboard containing cleaning chemicals in the base. This cupboard was locked and we saw that staff had to obtain PPE before they could get the key to open this.

# Patient transport services (PTS)

**Environment and equipment**

- The service's base was in a warehouse within an industrial estate in Felbridge. The building had swipe card access and a high rising motorised door to allow vehicles to be cleaned within the building.
- Safe walkways were marked with tape on the ground floor of the building indicating where it was safe for staff and visitors to walk. The ground floor housed an office where the managing director, business development manager and clerical assistant worked from. There was a unisex bathroom and small kitchen area available, and replacement stock for the vehicles such as uniform, gloves and bottled water was stored on the ground floor. The first floor was accessible by steps, and there was a spacious area where the twice daily handovers were held. There was also an office space on this floor but this was not used by the Secure 24 staff.
- The provider had six vehicles which all had valid MoT and tax. Four of these were described as frontline ambulances and two as informal ambulances. The frontline vehicles were recommended for patients with acute mental health conditions or challenging behaviour and were large vehicles that contained a seclusion cell. A minimum of three members of staff would be used in these types of vehicles, with two in the back, and one driving the vehicle. The informal vehicles were people carriers that had screens to separate the driver from the passenger, and were designed for low risk patients. Two members of staff would be used in these vehicles, one to drive, and one to sit with the service user in the back. Staff told us they found both types of vehicles safe and comfortable.
- All of the secure vehicles had two CCTV feeds in – one in the back of the vehicle and one in the driver's cab. As well as a visual feed, these also recorded audio, which meant they could be used if there were any concerns or feedback raised about a particular journey. These were kept for 35 days in line with the service policy for retaining records. There was also an intercom between the back and the front of the vehicle so that the driver could communicate with the staff in the back of the vehicle at all times.
- Before taking an ambulance out on the road, staff would carry out a roadworthiness check which included checks on both the interior and exterior of the vehicles. There were also checks to ensure there was sufficient water on board for patients and staff and that there were spare keys and handcuffs available. The checklists also had an additional sheet were staff could report faults if noted.
- The ambulances had space for an automatic external defibrillator (AED), however these were not currently carried by the service. We spoke to staff who told us that there had not been any incidents where a defibrillator would have been needed.However, the service was considering whether these could be stocked in the future.
- An emergency first aid kit was available on the vehicles. There were check sheets that would be updated and when anything was used, the sheets would be handed in to the supervisors who would re-stock the kit. We found two consumable bandages that were past their expiry date out of nine items we checked. This was passed onto the supervisor who immediately replaced these.
- All staff were provided with a uniform and two sets of handcuffs. Other equipment such as stab vests and high visibility jackets were available for staff to take out on individual journeys depending on need.
- The service had a contract with a local garage who provided servicing for the vehicles and could also carry out repairs to vehicles if required. There was also a contract with a breakdown agency if a vehicle were to break down on route. The breakdown company was aware of the company carrying high risk patients. No breakdowns had occurred in the last 12 months

**Medicines**

- Due to the nature of the service, no medicines were kept on site. Patients' own medicines would be transported in a tamper proof folder that was kept in the driver's cab for the duration of the journey.
- If patients had medication they needed to take whilst on the journey, the service would accommodate them but only on the proviso that a registered nurse would travel with the patient.

**Records**

# Patient transport services (PTS)

- Two types of form made up the patient record within the service; a booking form and a task form. Completed copies of these were kept in locked filing cabinets within the site base.
- Booking forms were completed by supervisors on receipt of an email from the call centre, based in Manchester. This was split into four sections: authorisation, task information, service user (SU) information, and resource requirement. The authorisation details contained space for staff to document the name of the person booking the transfer, their invoice number and contact details. Task information was information related to the journey, including the reason for the transfer, and start and end addresses. The SU information section of the form was for documenting the SU's details including an initial risk assessment, for example; "does the SU have a history of violence?"; "Is the SU considered a risk to the public?": and their recent behaviour. There was also a risk matrix where staff could tick whether high risk incidents such as absconding or self-harm- was a low, medium or high risk. The risk matrix then led on the resource requirement – where depending on the risk matrix outcome, they would decide whether the most appropriate vehicle would be one with a cell or an informal vehicle, and therefore how many staff were required.
- Once this had been completed, the information was transferred into a task form document which was to be used whilst on the journey. This included information such as time of pick up, whether a cell was used, whether any restraint was used and what type, and an observation chart to be used while travelling.
- We reviewed eight completed task and booking forms. Some of the booking forms contained scant information and not all of the fields such as telephone number and authorising organisation were consistently filled out. The "reason for task" section often was completed with the word "transfer" and often did not convey any further information. The "type of facility being transferred from or to" was often not completed, even though there was space to include this.However, the risk assessment and matrix sections were consistently completed.
- On the task forms, the main bulk of the information was transferred from the booking form, so this information was only as useful as the information obtained at the time of booking. Recent behaviour was sometimes recorded as "kicking off", whereas more informative information such as "unsettled and agitated" were rarely used.
- The observation section was a full side of A4 and had space to record the times of the observation. This was the main documented interface between the staff and the patient. However notes, and observations were very brief and did not always describe the patient's state, for example, "SU saving half a cigarette for later as only have one on them".
- All forms had authorised and signed delegated authority to convey from originating hospital and signed confirmation of handover at receiving hospital.
- We spoke to the staff about the lack of information seen on the task forms and they showed us an audit tool (verification sheet) that had been recently started. This is where forms were audited and checked by supervisors to ensure all fields were completed fully and correctly. Where incomplete fields were found, supervisors would discuss the case with the relevant STO and update the details.

**Safeguarding**

- According to staff we spoke with, the youngest patients that the service had transported were 13 years of age. Due to the service transporting children and young people as well as adults, a certain level of safeguarding must be attained to ensure the safety of these groups. All staff must have at least a level two safeguarding competence, and one member of staff who acts as the lead on safeguarding issues, must be level three trained.
- All staff had safeguarding training delivered as part of their induction training, and this covered safeguarding adults and safeguarding children's level one and two. One member of staff had attained level three safeguarding training with a previous organisation.
- When transporting children and young people, staff always aimed to use the more informal vehicle for them if possible. This was assessed by a risk matrix and the secure vehicles were only used if the risk assessment deemed them a medium or high risk. All vehicles contained an audio and visual CCTV feed, which could be used to corroborate any concerns or information required from a journey.

# Patient transport services (PTS)

- There was a safeguarding policy which was in date and was version controlled. However, there was one policy that covered both adults and children, and best practice suggests these should be separate, and clearly define the different legislation applicable to adults and children. The policy referenced guidance from 2000, which did not reflect the most recent guidance available, and there was no clear examples of how to report safeguarding and who the lead for the organisation was. Following the inspection, we saw that this policy had been significantly improved.
- We spoke to staff that were aware of how to report safeguarding referrals to relevant authorities or their supervisor.
- We saw records on a computer screen demonstrating that two out of 13 members of staff needed refresher training in safeguarding. This meant that 85% of staff were up to date with their safeguarding training.
- No safeguarding referrals were made by the service during the last 12 months and the CQC received no safeguarding concerns over the last 12 months.
- Disclosure and Barring Service (DBS) certificates and checks were completed on line and the originals were kept on personnel files. We reviewed two personnel files and saw that both of these had in-date DBS certificates.

**Mandatory training**

- All staff had an extensive induction which included a two-day prevention and management of violence and aggression (PMVA) training course. Day one covered health and safety, safeguarding, physical restraints, and escorting and moving into holds. Mechanical restraints were day two of the workshop, along with compliant and non-compliant handling, limb restraint application, and introduction to spit guards. The training also covered handling of detention papers after some training on the Mental Health Act 1983.
- All staff had one day emergency first aid training.
- We reviewed six personnel folders and saw that these contained all relevant certificates and references to provide evidence of training and had a section for appraisals.

**Assessing and responding to patient risk**

- The service would only accept patients who were physically able to walk unaided and mobile.
- Staff did not carry out any clinical interventions on board the ambulances other than in emergency first aid which was a part of the induction process training.
- If patients required to use bathroom facilities during the journey, staff would risk assess this to decide on the most appropriate place to stop such as a police station or secure unit. If there was an emergency, there was a bottle that could be utilised and adjusted to suit both male and female patients. When a patient requested a stop for the toilet, this was recorded in the patient observation notes and reasons if there was a delay or they were unable to stop. For example, one patient requested to use the toilet but would only agree to use a service station, not a police or secure unit. Staff assessed this was too high risk and refused.
- Patients sat furthest from the door in the formal vehicles to prevent them from opening the door whilst the vehicle was moving. A minimum of three staff travelled with the patient, with two allocated to the back of the vehicle with the patient.
- Personal possessions as well as medicines were stored in a secure folder that travelled with the driver. Paperwork was checked on handover and pockets of patients checked for any undeclared items they may be carrying such as lighters or other small items. An example of why this was an important step in the handover process was where a hospital staff member wanted to put a jumper on a patient before they left. Staff refused as this had a cord in the hood and staff declared this as a hanging risk in a known self-harmer and there were blankets on board the vehicle if the patient became cold.
- Staff could demonstrate appropriate use of restraints (handcuffs and limb restraints). All permanent staff carried their own handcuffs as provided and logged by the service, however there were ten self-employed staff who used restraints from the spares carried on vehicles if required.
- Staff were taught to use the prone (lying face down) restraint if required, but to move the patient off their front as soon as possible.

# Patient transport services (PTS)

- Three members of staff were blue light trained. This meant that they were competent to drive ambulances in emergency situations. There was a blue light policy which set out when it was appropriate to blue light a patient. The business development manager told us that unless a trained blue light driver was able to drive, if a patient was to deteriorate whilst on route, the ambulance would pull over and dial for emergency assistance.
- Staff gave us an example of a patient known for phantom seizures, who appeared to have a seizure on board. The crew pulled over and provided emergency first aid until an emergency vehicle could attend. This was considered to be a fake episode by the NHS emergency ambulance staff, however, it demonstrated that Secure 24 staff responded appropriately.
- Team briefings were completed at the start of each shift at 8am and 1pm. We observed both morning and afternoon briefings on the day of our inspection and saw that service user details were shared along with other relevant details, such as the level of section if applicable. There was a question and answer process which was informal and was led by supervisors. We saw both supervisors and STOs engaging in these meetings.

**Staffing**

- There were eleven full time members of staff. Seven secure transport officers reported to two supervisors. The supervisors reported to the managing director and the business development manager. There was a clerical assistant who was also fully trained as an STO.
- The managing director, business development manager and clerical assistant worked 9am – 5pm, Monday to Friday. STOs and supervisors covered seven days a week, 365 days a year on a rota.
- There were two shifts, an early and a late. The early shift ran from 8am to 8pm, and the late shift ran from 1pm to 1am. Any bookings that were requested for in between these times (1am to 8am) would be accommodated and resourced accordingly.
- The rota was managed by an online system that each staff member could access via a mobile phone application or "app". The standard rotation of staff was two days on a late shift, two days off, 3 days on a late shift, 2 days off, 2 days on an early shift, etc. The rota was static for permanent members of staff, but available extra hours were published on the app that self-employed staff could put themselves forward for. We spoke to a self-employed member of staff whotold us this app worked well.
- If staff worked late over their planned shift finish time, they were not expected to come in for their next shift until at least 11 hours had passed in order to keep them fresh and protect their wellbeing.
- Supervisors could cover STOs if there was sickness and annual leave, but there was also a bank of self-employed staff who received the same training and recruitment procedures as permanent staff.

**Response to major incidents**

- The service was part of two nearby mental health units' disaster contingency plans. These stated that Secure 24 would be used to help move/repatriate service users should they be unable to stay at the site.
- The service had a business continuity plan that was version controlled and dated. However, annexes D to I of the plan, were blank, and it was not clear what the procedure would be in the event of an emergency.

## Are patient transport services effective?

**Evidence-based care and treatment**

- Staff told us any form of restraint they used was the minimum amount necessary for the shortest possible time, as a last resort. This complied with the Department of Health guidance entitled Positive and Safe (2013) and National Institute of Clinical Excellence (NICE) guideline 25.
- We saw that the service had policies that staff followed in the course of their work. These were all dated and included version control, owner of the policy and the date on which it was due for review. However, not all of the policies we reviewed referenced the most up to date guidance or best practice, such as the use of force policy and the safeguarding vulnerable adults and children policy. Following the inspection, the provider reacted promptly to our feedback, and made significant amendments to their safeguarding policy, along with their use of force policy.

- There was a blue light policy which told staff when it was appropriate to use blue lights. An example given was if a patient transferring to a hospital emergency department was becoming difficult to control, they would use blue lights to arrive quickly. Another example was when a patient they were transporting had swallowed blocks and a spoon. The patient began to experience pain and the use of blue lights was authorised by the service. The service only used blue lights where there was a justified and a reasonable cause to do so. Staff endeavoured to inform the police that they may be on the road using blue lights.

**Nutrition and Hydration**

- All vehicles were stocked with bottled water for patients and staff. If a journey was due to go over meal times, staff ensured that the referrer had provided appropriate food.

**Assessment and planning of care**

- When a transfer was booked, call centre staff established the nature of a patient's mental health, including whether or not the patient was sectioned under the Mental Health Act (1983) in order to plan the staff and vehicles used accordingly. We saw this on the booking forms that we reviewed.

**Response times and patient outcomes**

- The service kept an electronic spreadsheet detailing all of the journeys that had taken place. They were able to easily access this and tell us an accurate and up to date number of journeys which had taken place within any given time period.
- The electronic spreadsheet kept details of the time a crew was expected for a journey, and the time that the crew arrived on site. However, there was no way of having an overview of this at the time of our inspection. For example, we could look at a snapshot of arrival times but could not accurately see how many had been on time over the past 12 months. This meant the provider might not have had assurances the service responded quickly enough to meet patients' needs.
- Use of restraint was documented within the patient record including the time of restraint and how the patient was restrained – for example via handcuffs or limb restraints. Staff told us that it was very rare that patients were restrained on their journeys, however without the data we were not able to accurately reflect this. Staff told us they hardly ever used restraint, but without looking in every patient record, there was no way of corroborating this information. Following the inspection, the provider analysed records completed between October 2016 to September 2017. Out of a total of 808 journeys, 726 (90%) required no intervention,49 (6%) required handcuffs, 19 (2%) required an escort hold, 12 (1%) required limb restraints and 2 (less than 1%) required a spit guard.

**Competent staff**

- On starting work with the company, all staff had a comprehensive induction package. This meant the provider had assurances new staff received appropriate training to give them the basic skills and knowledge they needed to do their jobs.
- Some staff felt they would benefit more learning on specific illnesses/diagnosis and presentation and working with patients with learning difficulties and felt this would further enhance their ability to fulfil their role. However there were not any immediate plans for additional training.
- The service was moving to standardise appraisals to every January. Appraisals were currently completed by the business development manager, but plans were afoot to train the supervisors to be able to do this in November. The service did not keep an overview sheet of appraisals and due dates, and we could see from the folders that some staff were overdue for their appraisal date. The provider told us this would be rectified with the move to standardised appraisals.
- We reviewed two personnel files and saw that both had completed the prevention and management of violence and aggression PMVA training as part of their induction to the company.

**Coordination with other providers and multi-disciplinary working**

- The business development manager met with a local NHS director quarterly to discuss feedback involving the service however we were unable to corroborate this as these meetings did not have agendas and were not minuted. We were shown an email trail demonstrating that feedback was given from the service to the referring organisation and that this was shared with relevant

teams at the referring organisation. Following our inspection, we were told that more formal documentation of these meetings would be undertaken.

- Staff gave examples of where they had worked with local crisis teams, interpreters, police and fire service.
- We received two comment cards from other providers who commented on the professionalism of the Secure 24 staff, and the effective communication when handing patients over. One provider also stated that they had received positive feedback from patients who had used the service.

**Access to information**

- We saw that staff were able to access information about a patient easily on the booking and task form. If when the call centre took the booking, not enough information was present, supervisors would obtain further information and feed this back to the call centre for future reference. This enabled supervisors to allocate appropriate resources.
- Policies were available in hard copies in the office, or on a shared drive on the services computer systems.
- Supervisors at the base were able to accurately track where staff were on their transfer via a real time satellite navigation system. This meant that for any given journey, staff at the base could identify where the vehicle was, who was driving it and at what speed they were travelling.
- Each staff member's ID badge also had a driver number on it. This was inserted into the vehicle prior to driving so that staff at the base could see who was driving at any given time.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We spoke to one member of staff who had a basic understanding of the Mental Capacity Act (2005). Staff had some role play training on interaction with people with mental illness. Staff had no set training on different illnesses or for people with learning difficulties.
- Whilst it was possible that the provider could be transporting a service user that was under a DOLS, the notes we reviewed were for patients detained under Part II (civil) and Part III (criminal) of the Mental Health Act. This meant patients were transported in line with the relevant legislation.
- There was no specific dementia training given to staff, but the provider noted an increase in the number of patients living with dementia and was looking at arranging this in the future.

## Are patient transport services caring?

**Compassionate care**

- We did not observe any direct patient interactions as we were unable to attend the journeys booked for the day of our inspection. We did however speak to staff and review 15 comment cards that patients and relatives had fed back.
- The 15 comment cards we reviewed all described positive interactions with the Secure 24 team. Words such as "caring", "engaging in conversation", "friendly" and "cheerful" were used to describe patients' experiences whilst travelling.
- Staff could provide patients with blankets or covers if required to keep them warm and protect their dignity.
- When arriving at a public place such as an emergency department, staff told us that on several occasions hospital staff had attempted to complete a handover in a busy reception environment which did not promote the dignity of the patient. Staff told us they always insisted that they received the handover in a more private environment.
- Where possible, if patients chose to have same sex crew, the service tried to accommodate this. If they were unable to, they informed the patient and we saw on the booking forms that there was a section for crew gender preference to be completed.
- In some circumstances, crew would take a change of casual clothing if it was felt this would be less intimidating for the patient, for example for house extractions. The stab vests that staff used had recently had the service logos added to them to make them look less like police vests.

# Patient transport services (PTS)

- Comfort objects such as fluffy toys could travel with the patient. An example of this was where a young person with communication difficulties was able to travel with their favourite comfort item and staff would speak to the comfort item to help them communicate.

**Emotional support**

- Staff gave us an example of a time where crew laid on the floor for three hours trying to encourage a patient that was distressed to transfer. Staff had anticipated this would be a difficult extraction and wore plain clothes to make the patient feel more at ease.

**Understanding and involvement of patients and those close to them**

- Staff recognised that sometimes relatives or carers would want to travel with the patient. Wherever possible, this was accommodated.

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

**Service planning and delivery to meet the needs of local people**

- The service offered a UK-wide service to accommodate the needs of those patients who required secure transportation.
- The service had one contract where they were the preferred provider for the group, which primarily served two private secure hospitals in the South East. The service approximated that 60% of their work came from the public sector, such as NHS trusts, and 40% of work originated from the private sector.
- Staff told us that approximately 90% of the patients they transferred were patients detained under the Mental Health Act 1983.
- Although shifts were planned and two, 12-hour shifts ran every 24 hours, all staff (including the supervisors and clerical assistant) were trained as Secure transport officers (STOs). Therefore, the service could pull a second team together at short notice. The service also had a bank of 10 self-employed staff.
- The business development manager showed us how the amount of journeys per year had grown over the last three years, and that this growth had prompted the new location and recruitment of more employees.

**Meeting people's individual needs**

- When booking patients, staff checked whether they had a gender preference, and where possible, they would allocate staff based on this.
- Patients were able to take a small amount of personal belongings with them when they travelled. These would be transferred securely with the driver.
- Staff were able to give several examples of how they met people's individual needs. For example, they asked the referrer what a young person with autism's favourite things were. They were then able to ensure that their favourite type of music and a boxset of their favourite TV programme to watch on board were available for the duration of their journey.
- Vehicles were discreetly marked and had tinted windows. Vehicles were coloured black and staff told us that this was to ensure they were discreet and did not resemble a standard ambulance or police vehicle. The company had recently added company logos to the vehicles, primarily so that when they used blue lights, police could recognise the service that was running them.
- Staff told us about how they worked with patients whose first language was not English. Some members of staff were able to speak other languages and therefore they would use these staff for journeys. There were no examples given of when these language needs could not be met, and there was no procedure in place for sourcing translation services.
- The service did not currently have facilities to transfer bariatric patients or wheelchair users. However, if they received these bookings through, for some patients, they were able to subcontract to a local firm who could transfer bariatric patients or wheelchair users. The Secure 24 ambulances did however have seatbelt extenders, to cater for patients up to a bariatric level.

**Access and flow**

# Patient transport services (PTS)

- We saw a task sheet that demonstrated the service had carried out 808 journeys between September 2016 to September 2017.
- The service was available 24 hours a day, seven days a week across the year. Bookings could be made on the day of transfer or in advance.
- Bookings were taken at a call centre based in Manchester. These were subcontracted by the service. When the call centre took a booking, they would generate an email that would come to the staff at the service base, who would then process the booking further, risk assess the details and allocate appropriate resources. There was also a form on the website to book an ambulance, however, staff told us the main route of booking was through the telephone line.
- All vehicles were tracked by a navigation system that allowed staff at base to see where a vehicle and crew were, who was driving and what speed they were travelling at.
- While the time of requested booking and time of crew arrival was documented, there was not an overview of on-scene or turnaround times, so it as not possible to assess whether the journeys made were always at the time agreed at booking.

**Learning from complaints and concerns**

- There was a complaints procedure that was within its review date. This referred to serving a diverse population and being committed to providing a complaints service to all regardless of their racial or cultural background, gender or sexual orientation, religion or disability.
- The procedure stated that if verbal complaints were not resolved with an apology and explanation, then the service should invite the complainant to send a letter to the managing director. The service aimed to provide an acknowledgment to the complaint within seven days of receipt. The complaints procedure stated a full investigation will be launched and the conclusion fed back to the complainant within 28 days. Following the complaint investigation being concluded, the policy stated that the investigator would decide whether there were grounds for the complaint and what, if any, recommendations would be required.
- The provider received no complaints between September 2016 and September 2017. Therefore, we were unable to assess how the service responded to complaints and concerns.
- An additional light had been fitted to the secure ambulances between the cell and the rear of the vehicle, following feedback that when transferring patients in the dark, this light could improve safety and make patients feel safer when exiting the vehicle.
- If lucid enough to answer questions, patients were given a feedback card to complete. When staff received a personal plaudit from a service user, we saw that this was shared with the team via the closed social media page that staff had access to.

## Are patient transport services well-led?

**Leadership / culture of service related to this core service**

- The organisation structure of the service was that the secure transport officers (STOs) reported to supervisors, who reported to the business development manager. Supervisors' roles had recently changed so that they were always at the base. This meant there was a member of staff that STOs on the road could get in contact with should they need to escalate problems or update them with timings or delays. Although STO staff were the primary operational staff, all staff at the service (including the clerical assistant) were fully trained by the service and could transport patients in the event of an emergency or a staffing crisis.
- We spoke to staff who told us this was a good place to work. Staff told us that the senior team were friendly and approachable.
- If a staff member's shift ran over 14 hours, a subsistence was paid by the provider to cover refreshments.

**Vision and strategy for this core service**

- The service website stated that their ethos was to treat staff, customers and service users with integrity and that their staff possess empathy, compassion and dedication. While we did not observe any patient interaction, we observed daily briefings where staff demonstrated values such as compassion when asking about the patient likes and thinking about what films or

music to take on the journey to make it a more pleasant journey for them. We also saw feedback and an incident form from an occurrence where staff stopped to help someone who had been involved in a car crash. While they were unable to provide any clinical support, theyhelped support the people involved in the incident and stayed until further help arrived.

- There was currently no formal strategy. We spoke with the business development manager, who showed us the growth of the company over the last three years. The service had recently moved to bigger premises to accommodate growth in the team and the need for more staff. They told us that they wanted to continue to grow in a phased approach without diluting the quality of the service. A long-term goal was to add a second location elsewhere in the country as the need for the service continued to grow.

**Governance, risk management and quality measurement (and service overall if this is the main service provided)**

- The service did not hold a risk register at the time of our inspection. We spoke with the business development manager, who told us the main risk to the service was working with unpredictable service users. This meant that other known risks, such as use of blue lights, risk of staff injury, and risk of absconsion were not documented and meant the provider as a whole may not have full recognition of all the risks to their service. Following the inspection, the provider had initiated a risk register.
- Some of the policies we reviewed did not contain up to date references or best practice. This meant that the service could not be assured they were providing the most up to date service to their patients.
- For example, the use of force policy was an overarching policy that had its basis in both criminal and common law and reflected contemporary practice under those laws. However, it did not embody or reference the Mental Health Act Code of Practice (2015) or the Mental Capacity Act (2005), both of which were applicable in the conveyancing of patients under the Mental Health Act (1983). There was also no specific reference relating to restraint of children within this policy, although the provider told us that all of their policies were designed for all people, encompassing mental and physical age. Following our inspection, we saw that the provider had updated this policy, with references to the above legislation and a section on the restraint of children and young people. The updated policy had been renamed the 'Restrictive Measures' policy.
- The service monitored feedback from both patients and other providers that they worked with. We saw that out of 18 people who took the survey for working with Secure 24, 82% answered that they were "extremely professional", and 18% answered "very professional". 100% of those surveryed answered that Secure 24 staff showed respect to their patients and other staff.

**Public and staff engagement**

- The service was a sponsor at various charity events in the local area, and members of the team attended the events in their uniform to raise awareness in the local community.
- Staff could all access a closed social media page. We reviewed this page and saw that it was used primarily to pass on praise and there was no personal identifiable data of service users posted.
- Managers at Secure 24 valued there staff and considered their welfare important. They encouraged and enabled them to access areas to maintain fitness.
- The service's website had a 360-degree tour available. This meant anyone who accessed the website could look at the ambulance vehicles and see what to expect on the inside and outside of the vehicle.

# Outstanding practice and areas for improvement

## Outstanding practice

The service had bespoke vehicles designed with the comfort and security of the patient in mind. Vehicle chassis were purchased, which were then fitted as per the service's chosen specifications. Modifications in the ambulances included seat belt extenders, different coloured lights in the cell which the patient could choose (calmer and less daunting), a choice of music to be playing in the cell and a TV screen with a range of TV shows and films that could be played. An additional light was also fitted between the cell and the rear of the vehicle, following feedback that when transferring patients in the dark, this light could improve safety and make patients feel safer when exiting the vehicle.

## Areas for improvement

**Action the hospital SHOULD take to improve**

The provider should ensure that staff are aware of the definition of a near miss incident and that all occurrences matching these definitions are reported.

The provider should ensure data is available to provide an overview of the service performance.