Starcross Trading Limited

Starcross Trading Ltd T/A Bears

Quality Report

C/O Cannons Park Motors
229 Whitchurch Lane
Edgware
HA8 6QU
Tel:0208 202 5160
Website: www.bears-pts.co.uk

Date of inspection visit: 24 and 25 October 2017
Date of publication: 24/01/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

British Emergency Ambulance Response Service (BEARS) was founded in 2009 and is an independent ambulance service providing a range of patient transport services across London. This includes the transfer of high dependency and critical care patients, bariatric patient and paediatric patients. It also includes secure transfers of mental health patients.The service has contracted work with two NHS trusts in London and also provides ad-hoc work for other NHS and independent hospitals. In addition, the service are providing a step in arrangement for a trust in North West London. Journeys are made to various locations within London and longer journeys occurred on a regular basis. The service has vehicles operated by paramedics, ambulance and emergency care assistants and emergency medical technicians.

We carried out this inspection in response to some concerns we received in September 2017. We responded to these concerns by carrying out an unannounced inspection on the 24 and 25 October 2017. The inspection we carried out was a comprehensive inspection covering all five domains.

We had not previously inspected this service under the current methodology. However, the service had previously been inspected in December 2012.

At the time of the inspection the registered manager was Claire Olohan-Bramley.

Summary of the information triggering the responsive inspection:

In September 2017, we identified some concerns about aspects of care one of the patient transport services was providing. BEARS subcontracted work out to the service. We also received some enquiries regarding BEARS. These concerns were about:

- Staff recruitment including reference and disclosure barring services (DBS) checks.
- Staff blue light training.
- Subcontracts in place and audits of subcontracted work.
- Subcontracted services registration.
- Allocation of jobs to other patient transport service.

Inspection findings

We identified areas of poor practice where the service needs to make improvements:

- The safeguarding lead was not trained to the recommended level of safeguarding training.
- Patient group directions (PGDs) were not being appropriately used.
- Information governance training was not part of mandatory training as per national guidance.
- The secure services division was occasionally using mechanical restraint without appropriate consideration of the mental health act code of practice.
- Subcontracts with other patient transport services were not signed off at the time of the inspection. However, audits of the services had begun.
- A number of policies were currently under review.
- Staff had not had appraisals at the time of the inspection.

However, there were also areas of good practice including:

Summary of findings

- The service had an incident log and learning from incidents was shared with staff.
- Staff adhered to good Infection prevention and control practice.
- Vehicles were maintained to a high level of cleanliness.
- There were good systems in place for checking controlled drugs and drugs on ambulances.
- We saw staff treating and caring for patients with compassion and respect.
- The service had good performance against Key performance Indicators (KPIs) and regular communication with providers.
- Staff felt valued and enjoyed working for the service.
- The new management team was taking steps to improve the service and changes were apparent during the inspection. This included ensuring all staff had DBS checks.
- The service had developed a mobile phone application which promoted good information sharing with staff.

Importantly the provider must:

- Ensure they consider the Mental Health Act (1983) Code of Practice in their policies and procedures around secure patient transfers.
- Not use mechanical restraints on patients in a way that deprives their liberty.
- Ensure use of mechanical restraints must be appropriately risk assessed and the least restrictive option.
- Ensure patient record forms include all key information around the secure services patient transfer. This should include detailed information of the decision to restrain patients including any risk assessments.
- Ensure patients who are sedated are accompanied by a qualified mental health profession.
- Not use patient group directions for care assistants and technicians.
- Ensure all staff must receive information governance training.
- Ensure all staff must receive training on duty of candour and understand their role with regards to the regulation. The duty of candour policy should be up to date and incorporated into the serious incident policy.

In addition, the provider should:

- Train the safeguarding lead to the appropriate level of safeguarding training.
- Make sure staff are competent and appropriately qualified.
- Improve completion of mental capacity and mental health training to support staff when they are making mental health transfers.
- Have service level agreement in place with all services BEARS subcontracts work too. The service should audit these services to ensure they are safe and providing good care and treatment.
- Continue to update all out of date policies and procedures.

The above list is not exhaustive and the service should examine the report in detail to identify all opportunities for improvement and determining its improvement plan.

Amanda Stanford
Deputy Chief Inspector of Hospitals, on behalf of Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		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. There was a good incident reporting culture within the service and safeguarding concerns were appropriately escalated. We found staff were compassionate, dedicated, caring and respected patient's dignity. The vehicles we inspected were clean and we observed good practice with regards to hand hygiene and infection control. Staff felt proud to work for the service and the service. However, we had concerns regarding the governance of the secure transport services. Secure services did not keep appropriate records with regards to the use of mechanical restraint of patients. It was not clear if the service took into account the Mental Health Act code of practice when transporting patients detained under the Mental Health Act (1983). Patient group directions were being inappropriately used.

Starcross Trading Ltd T/A Bears

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Starcross Trading Ltd T/A Bears

British Emergency Ambulance Response Service (BEARS) is operated by Starcross Trading Ltd T/A (trading as) BEARS. The service opened in 2009 and is an independent ambulance service based North West London. The service provides a range of different patient transport services. This includes the transfer of high dependency patients, extracorporeal membrane oxygenation (ECMO) patients, non-emergency transfers, secure/mental health patient transfers and a paramedic service. The service provides transport for both adults and children and young people.

The service performs contracted work with a number of NHS hospitals and provides ad-hoc work for various other hospitals in London. Journeys are made to various locations within London and longer journeys outside of London. The service has vehicles operated by ambulance care assistants, emergency medical technicians and paramedics.

The service has a new registered manager who joined the service in June 2017 and became the registered manager in October 2017. We inspected the service using the urgent and emergency care ambulance service core framework.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspector assistant and two specialist advisors with expertise in ambulance management. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

How we carried out this inspection

We visited the ambulance service for a two day unannounced inspection 24 and 25 October 2017. We gathered further information from data provided by the service.During the inspection, we visited the provider's base in Edgware. We spoke with 21 staff including; senior leaders, patient transport drivers, controlled drugs lead, fleet manager and the ambulance cleaner. We spoke with two patients and two relatives. We also inspected eight ambulances during the course of the inspection.

Detailed findings

Facts and data about Starcross Trading Ltd T/A Bears

British Emergency Ambulance Response Service (BEARS) was founded in 2009 and is an independent ambulance service providing a range of patient transport services across London. This includes the transfer of high dependency and critical care patients, bariatric patient and paediatric patients. It also includes secure transfers of mental health patients. Bariatric is a branch of medicine that deals with the causes, prevention and treatment of obesity.

The service has contracted work with two NHS trusts in London and also provides ad-hoc work for other NHS and independent hospitals. In addition, the service are providing a step in arrangement for a trust in North West London. Journeys are made to various locations within London and longer journeys occurred on a regular basis. The service has vehicles operated by paramedics, ambulance and emergency care assistants and emergency medical technicians.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the provider's base in Edgware. We spoke with 21 staff including; senior leaders, patient transport drivers, controlled drugs lead, fleet manager and the ambulance cleaner. We spoke with two patients and two relatives. We also inspected eight ambulances during the course of the inspection.

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 under the new methodology. However, the service had previously been inspected in December 2012.

Activity (October 2016 to September 2017)

- In the reporting period there were 34408 emergency and urgent care patient journeys undertaken. 115 bariatric, 174 Extracorporeal Membrane Oxygenation(ECMO), 7727 High Dependency, 22400 medical, 1297 paramedic High Dependency and 2695 secure patient journeys. ECMO is a form of life support that provides prolonged cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life.
- We requested a breakdown of how many journeys involved children and young people but this was not provided by the service. The service did not hold information on patients date of birth so this information could not be obtained.

In the past 12 months the services track record on safety

- No Never events
- One Serious Incident

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

British Emergency Ambulance Response Service (BEARS) was founded in 2009 and is an independent ambulance service providing a range of patient transport services across London. This includes the transfer of high dependency and critical care patients, bariatric patient and paediatric patients. It also includes secure transfers of mental health patients. Bariatric is a branch of medicine that deals with the causes, prevention and treatment of obesity.

The service has contracted work with two NHS trusts in London and also provides ad-hoc work for other NHS and independent hospitals. In addition, the service are providing a step in arrangement for a trust in North West London. Journeys are made to various locations within London and longer journeys occurred on a regular basis. The service has vehicles operated by paramedics, ambulance and emergency care assistants and emergency medical technicians.

Summary of findings

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.

Our key findings are:

- The safeguarding lead was not trained to the recommended level of safeguarding training. However, following the inspection this training had been booked.
- Patient group directions (PGDs) were not being appropriately used.
- Information governance training was not part of mandatory training as per national guidance.
- The secure services division was occasionally using mechanical restraint without appropriate consideration of the mental health act code of practice.
- Subcontracts with other patient transport services were not signed off at the time of the inspection. However, audits of the services had begun.
- A number of policies were currently under review and were not due to be updated until February 2018.
- Staff had not had appraisals at the time of the inspection.

However,

- The service had an incident log and learning from incidents was shared with staff.

Emergency and urgent care services

- Staff adhered to good Infection prevention and control practice.
- Ambulances were clean and we observed good practice with regards to infection control on vehicles.
- There were good systems in place for checking controlled drugs and drugs on ambulances. Controlled drugs were stored securely.
- We saw staff treating and caring for patients with compassion and respect.
- The service had good performance against Key performance Indicators (KPIs) and regular communication with providers.
- Staff felt valued and enjoyed working for the service. They were positive about the services management.
- The new management team was taking steps to improve the service and changes were apparent during the inspection. This included ensuring all staff had DBS checks.
- The service had developed a mobile phone application which promoted good information sharing with staff.

Are emergency and urgent care services safe?

Incidents

- The incident reporting policy gave guidance to staff on how to report incidents. The policy stated that incidents needed to be reported to BEARS control immediately and an incident report form completed as soon as possible. Whilst the policy gave guidance on how to report an incident it did not give any information on what happened following an incident, such as the investigation, any learning for improvement, and how staff received feedback. However, staff did tell us they received feedback following incidents.
- If an incident occurred, staff told us they were required to inform their manager and complete paper incident reporting forms, which were available at the base. The incident storage policy required all incident forms to be scanned onto the services computer system. The hard copies were stored in a fire proof cabinet and then archived. After six years the hard copies were destroyed.
- During the inspection staff were able to show us how to access the incident reporting forms.
- Where there was joint responsibility for the incident, the service and the hospital involved, investigated the incident jointly. The service would investigate the incident locally and feed this into the hospital's investigation process.
- The service kept a log of incidents which recorded details of when the incident occurred, what happened and who reported it. The service had appointed a new compliance manager in June 2017 who had incorporated the incident severity rating into the incident reporting log.
- Between June 2017 and October 2017 the service had reported 29 incidents. Of these, 25 were reported as no harm, two low harm and one moderate harm.
- The incident involving moderate harm was being investigated as a serious incident as it involved patient harm. BEARS were investigating the incident themselves and this was feeding into the NHS hospitals investigation process.

Emergency and urgent care services

- Managers told us they regularly encouraged staff to report incidents and if incidents occurred without being reported then staff were challenged with regards to this.
- Crews were made aware of incidents and feedback by face to face contact, the services newsletter and also via an application on their portable electronic advice.
- From April 2015, all registered providers of health and social care services are required to comply with the Duty of Candour (DoC) Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulation 20, 2014. Duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had an out of date policy for the DoC and we did not see a clear reference to the DoC in the incident reporting policy. However, the DoC policy was currently part of a list of policies that were under review. This was due to be published before the end of November 2017.
- The compliance manager and managing director showed a good level of understanding of DoC. Both managers were able to give examples of when DoC would apply, They stated the service would be open, transparent and honest with the patient as well as offering an apology to the patient and owning up for whenthey were wrong. Knowledge amongst other staff was varied as some staff did not know what we meant when we asked about DOC.

Cleanliness, infection control and hygiene

- We found good levels of cleanliness, infection control and hygiene across all vehicle we inspected. Vehicles were visibly clean and free from dust.
- All staff had received training in infection control and staff had a good understanding of their roles with regards to infection control. We observed staff cleaning the ambulance seats and equipment after each journey.
- We saw staff following appropriate infection control procedures, including washing their hands and using hand gel after patient contact. There was access to personal protective equipment (PPE) such as gloves and aprons available in vehicles.
- Staff wore clean uniforms and were bare below the elbows at all times. Staff cleaned their uniforms at home and uniforms appeared clean on the inspection.
- The service had facilities to deep clean vehicles. Vehicles were on a six to eight week deep cleaning schedule. If a vehicle transported an infectious patient or there was an infection risk, extra deep cleans were conducted as and when required. The deep clean area was clean and equipment was stored appropriately on brackets to prevent touching the floor. We reviewed the deep clean process and saw it was comprehensive.
- There were good procedures for the storage of used sharps (small sharp instruments often used to penetrate the skin, for example a small needle to take blood). We saw sharps bins were regularly emptied and not filled above the line.
- There were no audits for hand hygiene and infection prevention and control. However, the service had recently started swabbing vehicles to check for levels of cleanliness. The service had identified some issues with steering wheels and had issued a notice to staff in the bulletin highlighting the concerns. The compliance manager told us the service was hoping to purchase an infra-red machine to conduct checks on the hands of staff. However, this was not in place at the time of the inspection.

Environment and equipment

- There were five different makes of vehicle used for the ambulance service. The oldest vehicle in the fleet was registered in 2012 and the newest purchased in 2017. We were told vehicles would be replaced for a number of reasons including too many mechanical issues.
- Vehicle MOTs and servicing was monitored via an electronic database. This gave details on when the MOT had taken place and when the next MOT was due.
- All vehicles in the fleet except one were B vehicles, i.e. vehicles up to 3500kg. The additional vehicle was the specialist ECMO ambulance which was a C vehicle, which is between 3500kg and 7500kg. ECMO stands for extracorporeal membrane oxygenation and is a form of life support that provides both cardiac and respiratory support to persons whose hearts and lungs are unable to provide an adequate amount of gas exchange to sustain life.

- All driving licences were checked to ensure staff were licensed to drive the appropriate class of vehicle. Driving licences were checked via the Driver and Vehicle Licensing Agency (DVLA) at quarterly intervals. This allowed the provider to check for any recent driving convictions.
- Ambulance staff were required to sign out the vehicle they would be driving at the beginning of each shift. Supervisors were they provided with keys to individual lockers which contained the vehicle keys, portable electronic device, satellite navigation, observation kits and cables. On return at the end of the shift all items and the keys had to be signed back in.
- Staff were required every day to conduct vehicle checks on the vehicles which included cleanliness and oxygen levels. It also included tyre pressure, tread wear, fluid level and bulb checks. The fleet manager conducted additional checks each week. We checked a number of records and saw they were fully completed.
- Staff were trained to secure hospital provided incubators and pods. There was training around safe systems of work for connecting and clamping correctly. The hospital provided a suitably trained and qualified nurse for incubator transfers.
- For ECMO vehicle transports the hospital were required to provide a fully trained team. The service was contracted to drive the ECMO Team. The patient was under the specialist consultant and ECMO teams care at all times. The trust provided all necessary equipment and BEARS were not contracted to have any responsibility over the use of equipment supplied by the hospital.
- The control centre – called Control, was able to track each of the vehicles via an online map which was displayed in the office. Control staff were able to see where a vehicle was and which job the vehicle was on. Once jobs were completed control was made aware of this via the system.
- We saw ambulances were fully equipped with equipment in sufficient quantities. We saw that specialist equipment including PPE needed for everyday jobs within the service were appropriate and available in sufficient amounts.
- The vehicle windows were one-way windows which meant that passers-by could not see who was in the vehicle when the vehicle was stationary. This protected patient's confidentiality.
- All vehicles in the fleet had CCTV both internally and around the perimeter of the vehicle which provided an extra level of security for patients and for staff. Secure vehicles were also fitted with panic alarms which could be activated by staff in the event of an emergency. If activated, these alarms would send an email to the control centre in real time. The control centre would then call the drivers for further information. The secure vehicle system allowed a live feed to be streamed back to the office for viewing and management of incidents. Control could also see information on where the vehicle was when the alarm was activated via the vehicle tracker.
- When drivers found any issues with the vehicles this was reported to the station manager and logged in a maintenance book.
- We checked various pieces of equipment and saw they had all been serviced and there were stickers identifying when the next service was due. We saw there was an asset register that enabled the service to monitor when equipment was due for servicing. This was in line with best practice.
- We observed oxygen canisters were stored appropriately both at the vehicle base and within vehicles. Oxygen cylinders were stored upright and securely to prevent them being tampered with.
- We found one defibrillator which was not tied down securely in a vehicle. This could pose a risk for patients when the vehicle was moving. We saw the crew of the ambulance had marked this on the vehicle checklist. However, we observed defibrillators in other vehicles were stored securely.
- Sharps bins were regularly emptied and not overfull.

Medicines

- Medicines management was the responsibility of the paramedic manager with input from the clinical governance team. To order prescription medication the

manager prepared the order which was signed off by the medical director or a member clinical governance team. The medical director was a medically trained doctor who worked in healthcare services.

- Each day the manager did a controlled drugs audit and conducted checks on the paramedic bags to ensure they were still tagged and restocked. We noted that whilst there were tags on bags to prevent tampering there was not a relevant register recording the tag numbers to provide an extra level of security. When we returned the following day, a register had been created to ensure records were kept of the numbers of each bag to prevent tampering.
- Paramedic bags had a range of drugs available. However, there was no visible table of contents stating which drugs were available and the expiry dates of the drugs. When we returned on the second day of the inspection the service had introduced table of contents for each of the paramedic bags.
- Managers told us that all relevant staff held a patient group directions (PGD) on order to administer medication. PGDs are documents permitting the supply of prescription only medicines to groups of patients without individual prescriptions. We reviewed copies of PGDs and found there were PGDs in place for assistants and technicians. Guidance states that PGDs can only be extended to healthcare professionals. The PGDs for assistants and technicians were therefore being inappropriately used by the service.
- Following the inspection the service provided us with an update on PGDs for assistants and technicians. The service removed PGDs and replaced them with Standard Operating Procedures (SOPs). The medicines management policy was also being updated to reflect this.
- We were told salbutamol was given by paramedics, assistants and technicians. Salbutamol is a drug that is not listed as available for administration in the event of an emergency. It is not a medicine on general sale which means accordingly it should not be administered by assistants or technicians unless a paramedic is present.
- We reviewed the PGD for Oxygen administration, which is a summary document setting out conditions where the use of oxygen should be considered either in high dose or low dosage. Whilst the PGDs were accurate it was insufficiently detailed to meet the requirements of the British Thoracic Society on its own. We saw evidence that training covered the requirement of the JRCALC guidelines but these were not readily available for staff to access. There was also no other supporting documentation available for staff regarding guidance on oxygen administration.
- We observed crews appropriately reporting some damaged morphine by raising this as an incident. The three damaged vials had been booked out as 'damaged' to maintain the appropriate stock levels.
- Controlled drugs (CD) were stored safe and securely and locked away at all times. The service showed outstanding practice with regards to the storage of CDs. There were alarms, CCTV and access could only be gained via a fingerprint and door code. The medicines manager also received a text every time the door was opened.
- Medicines management was part of mandatory training. Ambulance care assistants had a completion rate of 73%, emergency medical technicians was 50% and paramedics was 100%. The service told us medicines management will be included at the next training day.

Records

- Patient information including pick up and drop off locations and any key information was communicated via portable electronic devices.
- We looked at training records for the information governance training and saw that this was not included in staffs mandatory training. This is not line with the commercial third parties information governance toolkit published by the department of health which states all staff should have training on information governance requirements.
- Staff completed Patient Record Forms (PRF) for patient journeys which were then scanned into the computer system. Hard copies were kept in locked cabinets and disposed of after a period of six years. The service told us their insurance company had previously advised them to hold all documents in original form for at least 6 years. We were told this was being reviewed because the service was now scanning documents. The services plan was to hold all documents electronically for an indefinite period.

- We saw some records were stored in an annex (loft storage space) which was not securely locked. We raised this with the managers who told us they were aware this was an issue. This was not on the services risk register at the time of the inspection. However, the annex could only be accessed via a pole to open the hatch area. The pole was kept in a locked cupboard within the services office. Only staff could access this office as it was behind a locked key coded door and the desks were manned 24 hours a day seven days a week.
- The clinical governance team conducted spot checks on staffs PRFs forms to audit whether they were appropriately completed. Staff received feedback on this via the services application.
- The secure transport PRF included a section where the service could record the use of physical restraint and mechanic restraint. We reviewed some cases where restraint had been used and had concerns that the information provided did not give enough detail regarding the decision to restrain patients.
- We reviewed various PRFs for the secure services transports. Whilst the majority of them were completed to a good quality we did find some in which the writing had limited legibility.

Safeguarding

- Staff received handovers of patients from hospital staff prior to transporting them. This enabled the staff to ascertain important information about the patient including any safeguarding issues.
- The safeguarding adults and safeguarding children policy had recently been updated to include relevant national guidance. A notification regarding the updated policy has been included in the staff communication bulletin and was posted on the services mobile phone application. This meant all staff had access. The company had also produced a quick guide to accompany the policy for staff to access which described key points from the policy such as types of abuse and how to report abuse.
- Safeguarding children and adults was part of mandatory training. National guidance for the Intercollegiate Document for Healthcare Staff (2014) recommends that all ambulance staff including communications staff should be trained to level two safeguarding. This applies to all clinical and non-clinical staff that have contact with children/young people and parents/carers. Senior leaders told us all staff were trained to level two, however the certificates did not state what level was completed. We reviewed the services mandatory training records and saw 79.7% of staff had completed level one and level two safeguarding children and 85.5% had completed level one and level two safeguarding adults. We were told new starters had safeguarding training via their previous companies but had not been trained by BEARS themselves.
- The safeguarding lead at the service was the new registered manager. They were trained to level two safeguarding and were in the process of organising level three and four training. This meant that at the time of the inspection the services safeguarding lead was not trained to the appropriate level of safeguarding training as per national guidance. National guidance states that safeguarding leads should be trained to level four. Staff knew who the safeguarding lead was and how to access them if they had concerns. Following the inspection we were told the safeguarding lead had completed level three training and was booked to attend level four training in February 2018.
- Awareness of safeguarding processes and procedures was good amongst staff. The majority of staff were able to identify what would constitute a safeguarding concern and the escalation procedure for reporting. One staff member was not certain what safeguarding was and the managers arranged for this person to be retrained.
- The services incident log showed that between September 2016 and October 2017 there were 14 incidents relating to safeguarding reported.Any concerns were escalated and the hospital was informed. We saw staff had taken appropriate action to protect patients including one case where the local safeguarding team were notified.
- We spoke with staff who drove the secure transport vehicles which included patients detained under the mental health act. Staff told us patients could be escorted in the Cat B secure cage area of the vehicle and on occasion patients could be restrained . The service had carried out 3295 secure journeys since April 2016. Of this, there were 37 occasions where restraint devices

were applied. There were 494 journeys where the Cat B secure vehicle was used. We reviewed the PRFs for some of these patients and information provided on the forms did not always give enough details to explain why restraint was used. In one instance the reason given was that the patient had tried to abscond. National guidance states that restraints should not be used unless it has been appropriately risk assessed with the involvement of a multidisciplinary team. We found no evidence that appropriate risk assessments were being completed for these patients. Patients should not be restrained just because they are at risk of absconding, this is a deprivation of a patients liberty. We were not assured the service had considered the Mental Health Act (1983) Code of Practice with regards to the secure transfer of patients. Since the inspection the service has stopped using restraints until they have appropriately reviewed their policies regarding consent and risk assessments with the clinical governance team. The use of restraints had never been reported as a safeguarding incident.

Mandatory training

- We spoke with the training manager during the inspection who told us permanent and bank staff completed the same mandatory training. He told us all staff had to complete the First Responder Emergency Care 3 qualification (FREC 3).
- Emergency care assistants were required to undertake FREC3 first and then FREC4.
- The service required emergency medical technicians (EMTs) to have completed the Institute of Health Care (IHCD) EMT course. All EMTs had completed this course except one crew member who was currently completing their hours.
- We were told all subjects covered in the training package are included in the initial induction. We reviewed mandatory training records and saw completion levels for some mandatory trainings were low. As of January 2017, basic life support completion was 72% and Duty of Care was 72%. We were not provided with more recent data for these two trainings. As of October 2017 completion rates were as follows: dementia (74%), fire safety (77%), health and safety (76%), infection prevention and control (64%), managing conflict (63%), mental capacity (61%), moving and handling (60%), safeguarding children level one and two (66%) and safeguarding adults level one and two (64%). Following the inspection we were provided with an updated mandatory training record. As ofthe end of October 2017 mandatory training completion rates was still low for managing conflict (75%), mental capacity (73%), moving and handling (68%). Safeguarding children level one and two had increased to 80% and safeguarding adults level one and two had increased to 86%.
- Following the inspection the service told us mandatory training rates only included staff whose training was due whilst in the services employment. New starters received mandatory training on induction or had training at their previous company. We were told a total of 88% of staff had completed mandatory training as of January 2017.
- At the time of the inspection there was no evidence that staff underwent refreshers on a yearly basis. Following the inspection the service provided a record to show staff undertook a refresher in January 2017.
- The senior leaders told us they were now considering how to improve their annual re-fresher training and on-line training activity.

Assessing and responding to patient risk

- When jobs were booked the control centre completed a booking form which asked for details around any risks for the patient. This included risk of aggression and whether the patient had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in place.
- Early Warning Scores (EWS) enable early identification of a deteriorating patient. Staff did not use the National Early Warning Scores (NEWS) or Paediatric Early Warning Scores (PEWS) during journeys. However, on high dependency or critical care transfers the hospital provided staff who were able to identify if patients were at risk of deteriorating.
- Staff were aware of the procedure to follow if they had any concerns that a patient was deteriorating. This included calling 999 and going to the nearest emergency department. Each vehicle had a flow chart which provided staff with guidance on the steps to follow in the event of a patient becoming unwell.
- BEARS had a number of secure transfer vehicles. Staff members operating these vehicles had received training

called 'BTEC Disengagement and Restraint Training'. This was a three day course which taught staff methods to deal with aggressive patients. They also received a one day training course on the use of restraint.

- National guidance states that the use of handcuffs as a method of restraining patients' needs to be appropriately risk assessed and discussed by a multidisciplinary team. We found no evidence that crews were doing risk assessments before deciding to apply handcuffs to patients. We reviewed some PRF forms where handcuffs had been used. Some cases handcuffs were applied because there was a risk of physical violence and aggression, however it was not always stated whether it was just a risk or this behaviour had occurred. We saw one case where a patient had handcuffs applied because they were at a risk of absconding. This is not an appropriate reason to apply handcuffs on a patient.
- A number of patients were detained under section two and section three of the Mental Health Act (1983). We saw these patients were sometimes transported by assistants and technicians without the presence of a qualified mental health professional. The Mental Health Act Code of Practice states that patients who have been sedated should be accompanied by a qualified professional. We found some occasions where this was not the case. The service had not considered the code of practice in their policies and procedures around transporting this type of patient.

Staffing

- BEARS had a total of 126 staff members which included ambulance crew, management, control room crew and administration staff.
- Of the 126 staff members 100 (79%) were full time staff, five (4%) were on flexible hour contracts and 21 (17%) were self-employed. The service also used one company if they required agency staff.
- There were two patient transport drivers, 47 ambulance care assistants, 12 emergency care assistants, 27 secure transport staff, 10 technicians and six paramedics.
- In addition, there were five team leaders, seven control staff, three administrators and five senior management members. There was also two Vehicle Make Ready Officers (VMRO) staff.
- There were some vacancies for control room staff which were being advertised at the time of the inspection.
- Staff worked 12 hour shifts with a 30 minute break. Some staff raised concerns that shifts were only allocated the day before.
- Staff were allocated to certain ambulances depending on their skill. All staff worked in two person crews.
- Prior to the inspection we had received some concerns about DBS and reference checks. During the inspection the manager gave us an update with regards to DBS checks for all staff. We reviewed the staffing list database and saw all staff either had a DBS checked completed which was in date or were not employed whilst waiting for a DBS check to come through.
- At the end of September BEARS had agreed to step in to support patient transports at an NHS hospital. This was required because their main patient transport service had ceased operating. Bears held recruitment days for staff of this other ambulance service so they could be directly employed by BEARS. Staff were interviewed and recruited and reference and DBS checks were submitted. Staff who held valid DBS checks with the closed ambulance service were able to work following a DBS risk assessment conducted to ensure they were safe to drive.
- Staff who worked at other services outside of BEARS were required to sign a 'secondary employment' form. This made the service aware if any staffs working hours needed monitoring. Staff were given the opportunity to sign a working time directives opt-out form if required. This was for people who wanted to work longer than the recommended hours.

Response to major incidents

- The service had a business continuity plan in place. The plan provided a list of key contacts, however this was not updated as it included the old registered manager. The plan was in place to help BEARS ensure they were able to deal with any interruptions caused by external factors. For example, poor weather conditions, man-made events, major illness and major incidents.
- The service had an emergency management team in place and disaster recovery team. The business continuity plan provided information about each

person's role in the event of an incident. Senior leaders told us they had put this into practice during the recent London terror attacks. The service had provided additional support to emergency medicine crews.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Prior to our unannounced inspection the service had appointed a new compliance manager. The compliance manager had identified a number of concerns within the service and one of them was the number of policies that needed updating. The service had agreed a policy update schedule and the target was for all polices and guidance to be updated by February 2018.
- On occasion, secure services were transporting patients using mechanical restraints. Staff were not conducting and documenting appropriate risk assessments and decisions for the use of handcuffs in line with the Mental Health Act (1983) Code of Practice. The Code of Practice requires NHS bodies, who must have regard to the Code to agree joint local policies and procedures with ambulance services, and the police. These are set out in section 11.10 of the Code of Practice. In particular, this places a requirement on agreeing on the appropriate use of different methods of restraint in conveying patients and how decisions on their use will be made in any given case. We were not assured the service was following national guidance around this. Staff had also received no training on the Mental Health Act (1983).
- There was no clear evidence that national guidelines were being used. Joint Royal College Ambulance Liaison Committee (JRCLAC) guidance provide robust clinical advice to ambulance services and publishes updated clinical guidelines. Whilst staff were aware of these guidelines we did not see any copies of the guidelines available in vehicles or in the control room. One paramedic had a pocket guide but not all staff had easy access to this guidance.
- The service had guidance from the Resuscitation Council available in the control room for staff.
- We were told access to clinical support was through the services clinical team who accessed national guidelines.

Assessment and planning of care

- Any patient requirements were provided to the service at the time of booking. For example, if a stretcher or wheelchair was required. The service used this information to plan the patients' journey accordingly.
- Staff spoke with hospital staff to ask for any additional information they needed to know before completing the journey. For example, if the patient was infectious this would indicate to staff the need to wear personal protective equipment during the journey. Following the journey this would indicate to staff the need for a deep clean.
- Staff told us they were able to provide bottles of water to patients and relatives. However, the service did not provide food.
- Staff told us they would ask patients to rate their pain throughout the journey if required.
- There was formal training in the Mental Capacity Act (2005) and duty of care. This meant staff were competent in assessing patient's needs.
- The service provided secure transfers for mental health patients and staff had a good understanding of mental health and the mental capacity act. However, we were not assured the rights of people subject to the Mental Health Act (1983) were always protected. On occasion patients were mechanical restrained during transit. We reviewed patient record forms (PRFs) and were not assured staff had appropriate regard to the Mental Health Act Code of Practice.
- For example, the code states that mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. PRFs did not provide information on whether other methods of de-escalation had been tried prior to the use of handcuffs. On one occasion, a patient had been restrained because they were a risk of absconding.
- The code states the use of mechanical restraint should be approved following a multi-disciplinary consultation. There was no evidence this was occurring.

- The code states the individual should be reviewed by a nurse every 15 minutes for the duration of the mechanical restraint. The PRFs did not provide this information and it was not always clear whether patients were transported with a qualified nurse.
- The code states that the patient's clinical records should provide details of the rationale for the decision to mechanically restrain. We reviewed some PRF documents and found information was brief and limited. There was no evidence de-escalation techniques had been used prior to the restraint and no evidence a risk assessment was conducted before the decision to restrain.
- Senior leaders told us secure services staff had been trained to conduct risk assessments. We reviewed training slides and saw this was part of their training. However, this was not documented in the patient records.
- Staff told us they had access to an emergency button if a patient had a mental health crisis during transportation. The button immediately notified control there was a concern who contacted the driver for further information.
- We were not assured mental health patients were always accompanied by a mental health professional.

Response times and patient outcomes

- The service had Key Performance Indicators (KPIs) for the NHS contracted work. One of the contracts had only recently started and therefore no KPI data had been reported. For one the NHS contacts the service measured four KPIs. This included 95% of patients arriving at the trust not earlier than 45 minutes and later than 15 minutes prior to the appointment (KPI 1a), 100% of patients arriving at the trust not earlier than 60 minutes and not later than zero minutes prior to appointment (KPI 1b), Ninety five percent of patients to depart the trust within 30 minutes of booking ready to travel (KPI 2a) and 100% of patients to depart the trust within 60 minutes of booking ready to leave (KPI 2b). We reviewed KPI data for one of the NHS trusts contracts between October 2016 and September 2017 and saw the service met the KPI targets the majority of the time. There were only three months where the KPI 1a target was missed and one month where the KPI 1b target was missed.
- The service put together a general KPI datasheet which covered all BEARS activity for each month. Between January 2017 and September 2017 the service met the KPI targets the majority of the time. There were only three occasions where a KPI target was missed. The KPI 1a target of 95% was missed in May 2017 (89%) and June 2017 (82%). The KPI 2a target of 95% was missed in August 2017 (85%).
- We reviewed KPI data for the services community contract. There were five KPIs in place for work with this service. This included no patient should be brought to the centre before 8:30am (KPI 1), no patient should be collected from the centre after 5pm (KPI 2), 95% of patients should be brought to the centre no more than 30 minutes before their appointment time (KPI 3), 95% of patients should be brought to the centre no later than 15 minutes after their appointment time (KPI 4) and 100% of patients should be collected within 30 minutes of their appointment time (KPI 5). Each month the service rated themselves 'green' if they achieved this target and 'amber if the target was not achieved. Between October 2016 and September 2017 the service met the KPI 1 and KPI 2 targets were met every month. The KPI 3 target was missed on six months out of 12 months. The KPI 4 target of 95%was missed on two occasions in October 2016 (94%) and September 2017 (90%). The KPI 5 target of 100% was not met in most months and was only met in April 2017.
- The service held contract monitoring meetings with contracted providers to discuss KPIs on a monthly basis.
- The service did not benchmark their service against other ambulance providers.

Competent staff

- All staff had received emergency transport "blue light" training and BEARS had a programme in place to develop and ensure that all staff who require blue light training will have level two and level three next year to meet the requirements of Futurequal. Section 19 of the Road Traffic Act is currently prospective legislation, which at some time in the future will require blue light users to have a qualification such as the Futurequal blue light award.
- There was no training programme in place for paramedics. The managers said this is something they

would like to develop. The paramedic's team leader was not a clinician, however the service said they had access to the clinical governance team for support. The clinical governance team included paramedics.

- Staff did not receive annual appraisals. We were told team leaders were booked on a training in November 2017 which would skill them up to provide appraisals to staff in the service.
- The team leaders training programme planned for November 2017 included training on appraisals and HR processes. Following the training each team leader would be responsible for a number of staff members.
- Staff who worked with secure transport patients had been trained in disengagement and restraint training. We reviewed the training slides and saw staff were provided with education around the Mental Health Act (1983) and the Human Rights Act (1998).
- We were told all staff all staff received training on the use of equipment including stretchers, spinal boards and suction units. During the inspection one staff member was unable to show us how they would test a suction machine in the vehicle.
- Secure services staff had received training on disengagement. However, there was no formal training on mental health or the Mental Health Act.

Coordination with other providers

- The service was in regular communication with the main contracts. There was a monthly meeting in place to discuss KPIs and any other required areas.
- The service subcontracted some work out to other patient transport services. At the time of the inspection there were no service level agreements in place with these services. Therefore, the service was not regularly monitoring the services. Prior to our inspection some concerns had been raised regarding the monitoring of subcontracted work. The compliance manager told us the service was in the process of putting service level agreements in place which would include regular auditing of the services. Following the inspection we were provided with a copy of one of the checks the service had done with one of the subcontractors. This included an audit of the vehicle used. Some concerns had been highlighted and required actions were noted in the document.
- Staff said they had good relationships with staff at the different hospitals they visited.
- We observed good interactions between the services staff and the hospitals staff when moving patients. Staff ensured they received clear and detailed handovers.
- In the event of an incident, complaint or safeguarding concern the service would liaise with the hospital regarding the investigation. We saw an example of a recent incident whereby the service were conducting their own investigation which would feed into the hospitals incident investigation process.

Multi-disciplinary working

- Staff told us there were no team meetings currently. However, the service was in the process of setting up a staff forum.
- The service employed ambulance care assistants, emergency medical technicians and paramedics. Staff reported good multidisciplinary working between each of the professions whilst conducting patient journeys.

Access to information

- Staff we spoke with told us they downloaded the services mobile phone application which allowed them to access a range of information. This included service announcements, procedures and policies and the services communications bulletin.
- Managers were able to monitor who read announcements via the application.
- Patient information was communicated to staff directly via their electronic portable device. This information included addresses of where the patient needed picking up and other key information the crew needed to know. For example, mental health needs, equipment required and whether the patient was DNACPR.
- Staff spoke with hospital staff to ask for any additional information they needed to know before completing the journey. For example, if the patient was infectious or required an wheelchair.
- There was a BEARS patient information leaflet available in reception which contained all key details about the services. However, we did not see these available in the ambulances.

- Each vehicle had an information folder that was available for staff. This included key information such as the drivers handbook and escalation procedures if a patient deteriorated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were two types of consent to investigation or treatment forms, which covered adults and children. We did not see any of these used in practice.
- Mental Capacity Act (2005) training was part of mandatory training and staff knew what we meant by consent the capacity. Staff said if a patient were unconscious they would act in the persons best interests when assessing care.
- If patients appeared confused, staff said they tried to explain to the patient what was happening on a regular basis.
- Staff told us they received a full handover when transporting mental health patients. However, we were told staff were not always accompanied by a registered mental health professional on journeys.
- We reviewed the PRF forms for patients being transported in secure vehicles. These patients were often detailed under the Mental Health Act (1983). On occasion patients were subject to physical restraint or placed in a Cat B secure cell within the vehicle. We were not assured the service was considering the Mental Capacity Act (2005) when making decisions as to whether to restrain patients. Section 6 of the MCA (2005) lays out the limits of this protection from liability: the situation must not amount to a deprivation of liberty, which needs special authorisation, and, if the person is being restrained, two extra conditions apply: the restraint must be necessary to prevent harm to the person, and proportionate to the risk and seriousness of that harm. The PRFs did not contain enough information for us to determine whether the restraint was proportionate.
- We raised these concerns with the service during the inspection. Following the inspection the service provided us with an update. The service had stopped the use of physical restraint until the policy and procedures were updated. The PRF had been updated to include a section for consent, capacity and risk assessment. The form also included a section for the staff to record whether a mental health nurses was accompanying the patient. The service had also developed a risk assessment tool for staff.

Are emergency and urgent care services caring?

Compassionate care

- We shadowed two crews during the course of our inspection. We observed both crews demonstrating empathy and compassion towards their patients. Patients and relatives were greeted on arrival in a warm welcoming way. We did not shadow any mental health journeys during the inspection.
- Staff spoke to patients with respect and kindness during the journeys.
- Staff maintained patient's dignity at all times, and ensured they were covered with a blanket if necessary.
- We spoke with two patients and two relatives who said they were happy with the service they had received whilst being transported.
- We reviewed some of the services comment cards from service users. Feedback was extremely positive with comments such as; 'The staff were very kind and polite and arrived on time', 'Brilliant service', 'Friendly staff who made me feel respected and valued', 'Excellent service, good driving and cheerful', 'Polite and good service all round'. 'Friendly staff, clean and comfortable'.

Understanding and involvement of patients and those close to them

- Staff always kept patients informed of what they were going to do, for example when the driver wanted to wheel the patient up ramp.
- We observed staff communicating with patients throughout the journey.Staff asked patients a number of things, such as if they were comfortable and if they were in any pain.

Emotional support

- We observed staff reassuring and communicating with patients during their journey.

Emergency and urgent care services

Are emergency and urgent care services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service tracked the locations of its ambulances which helped identify who had finished jobs and was nearest for the next transfers' pickup.
- The control centre had a permanent member of staff which meant bookings could be responded to quickly.
- The services workload were based upon the work that came in via the three main contractors. Pre-planned work was allocated by control each day.For any same day bookings, hospitals were required to complete a booking form, which was sent to control and the job allocated out.
- The transfer of high dependency patients and secure transfers patients were planned. Bookings were made via the booking form and sent to control. This allowed the service to ensure appropriate staff were allocated to each job to meet patient individual needs. For example, if a patient required wheelchair use.
- The service provided transport for an NHS trusts ECMO service and had vehicles specifically designed for ECMO patients.
- Staff told us they collected patients from a range of different places and therefore it was difficult to plan services to meet local needs.
- Staff were made aware via their portable electronic device of the patients conditions and current medical needs. This allowed staff to plan ahead using the information.

Meeting people's individual needs

- There were access to bottles of water for both patients and staff if required during a long journey.
- There was no access to pictorial charts or Makaton (a language programme designed to provide a means of communicating with individuals who cannot communicate effectively by speaking). Some staff highlighted that the service transports a lot of children with learning disabilities so pictorial aids would be a useful tool to have. Children and young people were accompanied by parents and/or carers.
- Staff were made aware if a patient had communication difficulties or did not speak English via the control centre; their electronic portable device and the hospital. Staff told us they did not have direct access to interpreters but would rely on the hospital to provide this service if it were needed. Sometimes patient's relatives and staff were used to provide translation. The services senior managers said they were hoping to recruit more staff who spoke additional languages in the future.
- The provider was able to meet the needs of bariatric patients by having the necessary vehicles available for this type of patient. There were equipment available to accommodate the needs to bariatric patients, such as stretchers
- All bookings were made via a booking form where control would note any specific requirements of the patients, such as if they needed a wheelchair.
- Each vehicle had access to satellite navigation systems to enable them to travel efficiently between their destinations.
- Staff were provided with dementia training as part of their mandatory training. However, there was no training on mental health and learning disabilities.
- Two staff members told us the service had been very supportive during challenging times, including allowing them to have time off.

Access and flow

- The service had specific KPIs to monitor the access and flow of the service. The drivers used their electronic portal device to capture transport data daily.
- Staff accepted jobs and completed jobs via their electronic device, this information was used by the service to calculate whether they were meeting the required KPIs.
- We observed the control room provided services with updates regarding any delays to transport services. This included apologising to the hospital and providing them with an explanation.

Emergency and urgent care services

Learning from complaints and concerns

- Between September 2016 and October 2017 there had been 11 complaints made to the service. The most common complaint was late running of the service which had happened on three occasions.
- The service stated they would respond to complaints within 28 days if receiving the complaint.
- Complaints were recorded on a complaints log which provided information about the complaint resolution and the date the complaint was closed. Most of the complaints were dealt with on the same day. The service send letters of apology where required.
- Feedback from complaints was shared with staff via the communications bulletin and the services application. For example, one complaint involved a relative who complained that they had supported the lift of a patient which was not appropriate. Staff had received communication to prevent this from reoccurring.
- At the time of the inspection there was no information on how to make a complaint available on vehicles. The managers said this was due to infection, prevention and control risks. The plan was to laminate the complaints procedure and put them back into the vehicles.

Are emergency and urgent care services well-led?

Leadership / culture

- The service was managed by a managing director who was the overall manager of the service with the support of the general manager and compliance manager. They were also supported by the fleet manager, control room manager, secure division manager, training manager and clinical/procurement manager.
- A new registered manager was confirmed in post the week before our inspection. However, the manager had been working at the service since June 2017 in order to help improve the service.
- There were five team leaders and we were told by senior management that these team leaders were booked to attend training
- Staff told us they saw the management team on a regular basis. Some staff highlighted that they had noticed improvements to the service since the new compliance manager had come into post.
- Staff spoke very positively about the management team and felt they were able to approach them if they had any questions or concerns. Comments included:: “We are like a family here, we have lunches together”, “I feel very supported by the managers”, “I think they are friendly and approachable”.
- Staff told us they felt proud to work for the service.
- We reviewed the managers meeting action log and saw the service was taking proactive steps to ensure equality for all staff. The service had identified that staff had concerns they were treated differently depending on length of service. The service discussed the importance of equality and diversity management in order to provide a well-led service. The service was currently looking into introducing equality and diversity as part of staff training.

Vision and strategy for this this core service

- There were three values set out by the service; namely safety, comfort and care. Staff we spoke with were aware of the values and how they underpinned their work. We saw the values were displayed on the services signs and on the front page of the services information booklet.
- The managing director told us there was no formal documented strategy in place for the service. However, the culture of the business is ‘not to be the biggest but to be the best’.
- The service had identified that some staff were travelling for long periods to get to the bases current location. The service were looking for a new and larger location that would help reduce travel time for staff.

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

- The service had a clinical governance team who were employed on a contracted basis to provide clinical support 24 hours a day, seven days a week. The clinical governance team were a team of clinicians who were involved in the service in a variety of ways. Including

unannounced inspections, PRF audits, medicines management and provide mandatory training updates for staff.They were also part of the clinical governance meetings held on a quarterly basis.

- The service did not minute clinical governance meetings. Therefore, at the time of the inspection we were unable to see exactly what was discussed in clinical governance meetings. Following the inspection we were provided with some minutes from a meeting held in January 2017.
- Following the last clinical governance meeting in August 2017, the service had started a clinical databased called the 'BEARS clinical governance team notes and action log'. Within this document the managers logged any actions identified at the governance meeting. These actions were recorded as outstanding actions until they were completed and moved to the closed actions tab. We reviewed the most recent action log and saw there were four outstanding actions that were in progress. These were reviewing the terms of reference for the group, mandatory training, incidents and notifications and occupational health reviews. The action log had a section for staff to update any progress on the action.
- Whilst the log provided details on any actions from the meetings we were unable to see whether items such as incidents and complaints were discussed during the meeting. There was no standardised agenda in place for the meeting.
- We also reviewed the management meeting action log. Similar to the clinical governance meeting the service did not document minutes for the meetings. The service kept an working action log of what action points were decided during the meeting. This action log contained numerous actions for the managers. Including recruitment drives, drugs licence, training, security. They discussed the management teams human resources training which had been booked and would ensure staff were receiving suitable appraisals.
- We also reviewed the board meeting minutes from September 2017. The minutes from this meeting were brief and included seven bullet points. There was no detailed information on what was discussed. There was no standardised agenda in place for this meeting and no action log.
- The services compliance manager had developed a Quality Improvement Programme (QIP) database. This database incorporated all the CQCs Key Lines of Enquiry (KLOE) and information on whether the service was meeting them. There was a section for suggested actions the service needed to take in order to meet the KLOE. For example, 'do people who use the service know how to make a complaint or raise a concern? Are they encouraged to do so?' was identified as an area for improvement. The suggested actions were that the complaints policy and procedure needed to be reviewed, staff updated and how to make complaints information more accessible for patients.
- There was a risk register in place at the service. The risk register provided details of the risk, a risk rating details of the actions the service were taking to reduce the risk. For example, Disclosure and Barring Services (DBS) checks were identified as a high risk to the service. Upon joining the service in June 2017 the compliance manager had identified concerns regarding DBS checks. Some DBS checks were out of date and some staff members had DBS checks from other organisations. The service was in the process of undertaking new DBS checks for all required staff. Drivers were unable to drive patients without a DBS or DBS risk assessment in place.
- We were told the risk register was discussed at the managers meeting. However, minutes from the managers meeting were not recorded so we were unable to ascertain if this was discussed.
- We found some risks in the service which were not on the services risk register. For example, the records stored in the annex which was not a secure area was not recorded as a risk.
- Prior to our inspection we had contacted the service with regards to some concerns around the subcontracting of work to other ambulance services. Some of the concerns identified were that BEARS were not auditing the services they were subcontracting work out to. This included the monitoring of infection, prevention and control practices, inappropriate patient transfers, no formal contract between the service and BEARS and staffing skill mix. Following our concerns, the service ceased working with the subcontracted ambulance service.

- During the inspection the service gave us an update on what they were doing to mitigate the risks with subcontracted services. The service told us they were now conducting spot checks on each of the remaining ambulance services they subcontracted work too. This included checking the vehicles and equipment, clinical waste storage and medicines management. We were told the service was also currently working on the service level agreements (SLAs) with these services in order to improve how they were monitored and audited. However, this was not in place at the time of the inspection.
- We had concerns the secure services part of the service was not appropriately governed. The policy for the use of restraints did not reflect the services practice. There were no risk assessments in place for the use of handcuffs on vehicles. We were not assured the Mental Health Act (1983) Code of Practice was appropriate considered in the services policies and procedures. The service level agreement with the NHS Trust did not give details regarding the transport of sedated patients or violent and aggressive patients. Based on the information in the PRF documents we could not ascertain whether the use of handcuffs was proportionate. The service conducted no internal or external audits on the use of handcuffs and physical restraint.

Public and staff engagement

- At the time of the inspection there were no staff groups or forums operating. The service was in the process of starting a staff forum group. They had advertised for representatives from the different staffing grades to take part in the forum. The plan was for the forum to discuss a range of items such as clinical and service development and policies. It would also give staff the opportunity to raise any concerns.
- The service had a communication bulletin that was published around every six weeks. This allowed managers the opportunity to communicate a range of different things with staff, including any key concerns, feedback from any learning from incidents and policy updates.
- There was no routine questionnaires given to patients from this base. However, the service did offer out comment cards to patients following journeys in order to get some feedback.
- Staff told us the service had previously organised a paintballing trip to allow staff to get to know each other. A Christmas party will also be organised.
- Senior leaders told us they had done some work with the local community. For example, we saw a thankyou letter from the local cadet's services. BEARS had provided ambulance and first aid cover for Barnet's Remembrance Day Parades and Armed Forces Day Parades. The service had done this free of charge to help the local community.
- The service had also visited a nursery in Watford to allow children to see inside an ambulance and experiment with some of the equipment.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The service had created a mobile application which staff could access of the services portable devices and their personal mobile phones. The application gave staff access to a range of things including policies and guidelines, the communication bulletin, service announcements and PRF audits. Staff accessing the application on the services portable devices could access information about the jobs for the day and input their time sheet information. The service is hoping to further develop this application so that all BEARS activity runs via the application.
- The controlled drugs security demonstrated outstanding practices. Appropriate staff could only access the controlled drugs via the use of both a door code and finger print scan. An alert was sent to the controlled drugs lead every time someone accessed the door and there was CCTV in operation in the room.

Outstanding practice and areas for improvement

Outstanding practice

- The controlled drugs security demonstrated outstanding practices. Appropriate staff could only access the controlled drugs via the use of both a door code and finger print scan. An alert was sent to the controlled drugs lead every time someone accessed the door and there was CCTV in operation in the room.

Areas for improvement

Action the hospital MUST take to improve

- Consider the Mental Health Act (1983) Code of Practice in their policies and procedures around secure patient transfers.
- Not use mechanical restraints on patients in a way that deprives their liberty.
- Ensure the use of mechanical restraints is appropriately risk assessed and the least restrictive option.
- Ensure patient record forms must include all key information around the secure services patient transfer. This must include detailed information of the decision to restrain patients including any risk assessments.
- Ensure patients who are sedated are accompanied by a qualified mental health profession.
- Not use patient group directions for care assistants and technicians.
- Ensure all staff must receive information governance training.
- Ensure all staff must receive training on duty of candour and understand their role with regards to the regulation. The duty of candour policy should be up to date and incorporated into the serious incident policy.

Action the hospital SHOULD take to improve

- Train the safeguarding lead to the appropriate level of safeguarding training.
- Make sure staff are competent and appropriately qualified. Improve staff refreshers and appraisals.
- Improve completion of mental capacity and mental health training to support staff when they are making mental health transfers.
- Have service level agreements in place with all services BEARS subcontracts work too. The service should audit these services to ensure they are safe and providing good care and treatment.
- Continue to update all out of date policies and procedures.
- Have an evidence trial of thinking and decision meeting and should consider introducing meetings minutes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Patient's safe care and treatment was at risk due to inappropriate medicines management. • Patient group directions (PGDs) were in place for ambulance care assistants and technicians. PGDs can only be extended to health care professionals. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • Service users must be protected from abuse and improper treatment and must not provide care or treatment in a way that includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, risk of harm posed to the service user or another individual if the service user was not subject to control or restraint • The service provided secure transports for patients detained under the Mental Health Act (1983). On occasion, the staff were using mechanical restraints on service users. There was no evidence of risk assessment and patient records were not detailed enough to provide information as to why the use of handcuffs was a proportionate response. This meant patient's liberty could have been restricted. Regulation 13(1)(2)(b)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Services must assess, monitor and mitigate risks relating to the health, safety and welfare of service users and maintain securely accurate, complete and up to date record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. • Staff were transporting patients detailed under the Mental Health Act (1983) without appropriate regards to the Mental Health Act Code of Practice. • The policy around restraint was not up to date with how the service practiced. • The policy stated a risk assessment needed to be completed. However, there was no documented evidence that risk assessments were being conducted before the decision to use mechanical restraints. • The lack of risk assessment meant the service could not ascertain if the use of restraint was proportionate to the risk. On one occasion, the patient record said the patient was mechanically restrained due to being a risk of absconding. This is not proportionate and a potential deprivation of liberty. • Patient record forms did not provide evidence the service was considering the Mental Capacity Act (2005) when using mechanical restraints on patients. We found no evidence patients gave consent regarding the use of handcuffs. Due to poor records, the service could not monitor if the use of handcuffs was restricting a patients liberty. • Patients were being transported sedated without a qualified mental health professional. There were no information in the services policy or service level agreements to state when a nurse would be required. • The safeguarding lead was not trained to the required level of safeguarding training.