St. John Ambulance

St John Ambulance South East Region

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

St John Ambulance South East Region is part of St John Ambulance, a national first aid charity. St John Ambulance provides a number of services including first aid at events, emergency and non-emergency patient transport services and first aid training. The objective of the organisation nationally is the relief of sickness and the protection and preservation of public health. Both volunteers and employed staff are involved with the services provided by St John Ambulance.

St John Ambulance South East Region provides an ambulance service across a number of counties in the south east region through a contract with two local ambulance trusts and a local NHS hospital. There is also an events service that provides first aid support, at public events. St John Ambulance South East Region has contracts with a number of organisations, which hold events in the local area and provides first aid at these events including the provision of an ambulance.

We inspected St John Ambulance South East Regions on 6 and 12 October 2016. This was an announced comprehensive inspection. We visited five different locations during the visits but were unable to visit any events where St John Ambulance South East Region were providing cover during this inspection.

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

We found the following areas of good practice:

- We saw staff provided compassionate care for patients. They ensured patients' privacy and dignity was maintained. Patients and their families were involved in decisions about their care. Staff understood the importance of respecting and responding to patients' specific and individual needs.
- Staff followed infection prevention and control procedures to reduce the spread of infection to patients. They kept vehicles clean, tidy and well stocked. The system for servicing vehicles was effective, with accurate records kept.
- We saw good multi-disciplinary team working with other emergency services and during handovers at hospital. Staff working for the service were competent in their role and followed national guidance when providing care and treatment to patients. They knew when to escalate concerns so patients' needs were responded to promptly.
- The service only provided cover for contract or event work if it had sufficient staff to do so safely. Managers worked with contract providers and commissioners for events to enable services to be delivered which meet the needs of local people. Debriefs were held to identify changes which could be made.
- All staff, both employed and volunteers, had an induction and could access further training for their role.
- The service had systems in place for reporting and investigating incidents and complaints. Staff could describe changes to practice after managers had investigated these.
- There was a national vision and strategy in place, which the service had implemented locally. Additional key performance indicators were being used regionally and nationally to support the quality monitoring of the service. Some of these had not been fully adopted at the time of our inspection.
- Staff felt able to make suggestions on how the service could be improved and developed. They felt the leadership of the service were supportive and accessible.

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

Summary of findings

- The provider's safeguarding children training for staff did not show how it met and was in line with key national documents and recommendations on safeguarding children. Therefore, we were not able to confirm staff had completed the correct level safeguarding children training for their role.
- We found one of the two ambulances used for the neonatal transfer and retrieval service did not lock. Staff had reported the vehicle defect but the service had taken no action until after our inspection. The processes to keep patients safe had not been followed.
- The majority of volunteers had outstanding mandatory training to complete. Also, there was no performance review for staff who worked for the service on a casual basis to ensure they remained competent in their role.
- On ambulances responding to emergency calls, there were no suitable restraints to secure children during transfer to hospital. The service recognised this as a risk and a review was taking place. There were also no paediatric defibrillator pads so staff could use the defibrillator safely on children.
- There was limited provision on vehicles to support people who were unable to communicate verbally or who did not speak English.

Information on the actions we have asked the provider to take are listed at the end of the report.

Professor Sir Mike Richards
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 do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve. We saw staff provided compassionate care to patients that respected their privacy and dignity and was patient centred. Staff involved patients, where possible, in decisions about their care. Staff supported patients and their families, recognising how stressful and emotional the situation was for everyone. The service was able to support patients whose circumstances made them vulnerable, with staff respecting peoples' individual needs when providing care and treatment Staff followed relevant national guidance to provide effective care for patients. Staff worked well with all healthcare professionals, involved in a patient's care, to ensure care was planned and co-ordinated to meet the patients' needs. The service did not cover a shift unless it had sufficient staff to do so safely. The service had a strong focus on training and there was a comprehensive induction process for new employed staff and volunteers. Staff told us they had time to complete their training and they were provided with additional training at team meetings. All staff had to complete an annual competency assessment. The environment and equipment were visibly clean and tidy and we saw staff kept vehicles well stocked with the kit they needed. Managers told us there was an effective process for keeping the servicing and maintenance of vehicles up to date and records we saw confirmed this. During observations of care we saw staff following good infection control practices to keep minimise the spread of infection, such as hand washing and cleaning equipment in between use on patients. Staff felt able to report incidents, with learning and action from these and complaints shared with staff. They told us all leaders were visible and there was good leadership of the service locally and regionally.

Summary of findings

There was a national vision and strategy for the service, which reflected the values of the organisation. Staff knew and understood the vision and values of the organisation.

Nationally, the organisation had recognised the need to improve the data it collected, to enable it to better monitor the quality of the service, particularly using audits and service performance dashboards. These changes were in progress at the time of the inspection, with some initial results available.

However:

The safeguarding training for staff did not align with the nationally recognised safeguarding children training levels. We did not have confidence the organisation had trained staff to the correct level for their role. However, staff could describe how to make a safeguarding referral and could describe the signs of abuse.

There were policies and procedures in place for staff to use to protect patients and their own safety. However, the service had taken no immediate action when staff reported the saloon door on one of the two ambulances for the neonatal transfer and retrieval service did not lock. There was a potential risk to patient safety if the equipment or vehicle were tampered with.

There was no formal performance review for casual staff and most volunteers had not completed all of their mandatory training.

There were no child specific defibrillator pads or safety restraints on the ambulances we checked which were used to respond to emergency calls.

Language guides were not available on all vehicles and there was no communication aid to support patients who were unable to verbally explain their concerns.

St John Ambulance South East Region

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Detailed findings

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Background to St John Ambulance South East Region

St John Ambulance South East Region is part of St John Ambulance, a national first aid charity. St John Ambulance became a separate legal entity and subsidiary of The Priory of England and the Islands of the Order of St John in 1999. St John Ambulance nationally provides a number of services including first aid at events, emergency and non-emergency patient transport services and first aid training. The objective of the organisation is the relief of sickness and the protection and preservation of public health. Both volunteers and employed staff are involved with the services provided by St John Ambulance.

St John Ambulance South East Region provides emergency and urgent care services operate from five main locations, Ashford, Bicester, Brighton, Guildford and Southampton, which provide vehicles for the commercial and event first aid aspects. There are specific vehicles for the event first aid service based at an additional 46 locations across the area. In the south east region, St John Ambulance South East Region provides emergency and urgent care services through a contract with two local ambulance trusts and a local NHS hospital. Through this contract, St John Ambulance South East Region is involved with the emergency transfer of patients to the accident and emergency department or the appropriate hospital department or ward. In addition, the service transfers patients between hospitals if the patient needs to be admitted to a different ward for continuing care. There is also an events service that provides first aid support, at public events. St John Ambulance South East Region also has contracts with a number of event organisations in the local area to provide first aid at these events.

The South East Region was formed in 2012 following a planned review of the organisational structure. This review included the introduction of a new regional management structure. There were further changes in 2015, resulting in the re-organisation of the management team for ambulance operations (patient transport). At the time of our inspection, this same approach was being applied to event first aid services.

We visited three of the five main stations from which the provider operates its service, Bicester, Brighton and Guildford and completed interviews at the regional headquarters in Aylesbury. We also accompanied staff on ambulances to observe the complete care pathway for patients from collection to handover at hospital or return to their home. We did not visit any events or complete checks on vehicles stored at event only first aid stations.

We conducted an announced inspection of St John Ambulance South East Region on 6 and an unannounced visit 12 October 2016. This was a routine comprehensive inspection to check whether the service at this location was meeting the legal requirement and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service.

Detailed findings

Our inspection team

Our inspection team was led by

Inspection manager: Lisa Cook, Inspection Manager Care Quality Commissions (CQC).

The team of eight included three CQC inspectors and four specialist advisers; paramedics, all with management experience.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Before visiting St John Ambulance South East Region, we reviewed a range of information we held about the location, including data provided by the service and asked other organisations to share what they knew. We carried out an announced visit on 6 October 2016 and unannounced visit on 12 October 2016. We visited the main headquarters for the region in Aylesbury and three stations at Bicester, Brighton and Guildford. During the unannounced inspection, we visited the neonatal and paediatric transfer and retrieval service, based at the John Radcliffe Hospital in Oxford, due to St John Ambulance providing the vehicles and drivers for this specialised service.

During the inspection, we observed how people were being cared for and reviewed patient records. We spoke with 19 staff, including emergency transport attendants, emergency medical technicians, patient transport assistants, team leaders and station managers. We also spoke with the regional senior management team, including the leads for safeguarding, complaints, quality and fleet management and three volunteers. We observed four interactions of care, by accompanying staff on an ambulance when they responded to a call. This included the interactions between the ambulance crew and hospital staff or other emergency crews. We reviewed two patient records. We also looked at local and national policies which staff worked to and checked servicing records for a sample of ambulance vehicles and equipment on these vehicles. We carried out spot checks on a total of 11 vehicles, six at Bicester, two at Brighton, four at Guildford and one at Aylesbury, looking at cleanliness, infection control practices and stock levels for equipment and supplies. During the two weeks after the inspection, we conducted telephone interviews with three volunteers.

We would like to thank all staff and patients for sharing their views and experiences of the quality of care and treatment provided by St John Ambulance South East Region.

Detailed findings

Facts and data about St John Ambulance South East Region

Incidents

For July 2015 to June 2016, staff reported 247 incidents:

121 classified as insignificant or minor,

116 classified as moderate,

7 classified as major,

1 classified as catastrophic,

2 unclassified.

Staff Turnover

Between 21/09/2015 and 21/09/2016:

Permanent staff starters = 44

Permanent staff leavers = 54

Staff Sickness

Between 21/09/2015 and 21/09/2016:

Permanent staff sickness = 491.5 days lost

Appraisal rates

Permanent staff 100.0% (Actual number = 33)

Event First Aid services (Volunteers) 13% (Actual number = 189)

Complaints

From July 2015 to June 2016, the service received 42 complaints

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

St John Ambulance South East Region provides an emergency and urgent care service to patients across the south east of England. This is through a contract with two local NHS ambulance trusts and with a local NHS hospital. The service also provides event first aid, for local and national events in the area.

Emergency and urgent care services operate from five main locations, Ashford, Bicester, Brighton, Guildford and Southampton, which provide vehicles for the commercial and event first aid aspects. There are specific vehicles for the event first aid service based at an additional 46 locations across the area. The service has 112 vehicles used for emergency and urgent care and four adapted vehicles to meet the specific requirements for the neonatal transfer and retrieval service. The headquarters for the region are at Aylesbury. The service has a mix of employed staff (63 employed and 34 casual workers) for contract work and 191 volunteers involved in event first aid, covered by the service's CQC registration.

The service provides cover seven days a week, for its contract work. Shifts length very between eight and 12 hours, depending on the contract, with core hours generally between 9am and midnight. The service completed 5809 journeys from January 2016 to July 2016. Cover for the neonatal transfer and retrieval service is provided 24 hours, through two 12-hour shifts. Event work is predominantly at weekends. The service attended a total of 4520 events from October 2015 to September 2016.

During the inspection, we visited three stations (Bicester, Brighton and Guildford), the neonatal transfer and retrieval service based at the John Radcliffe Hospital in Oxford and the regional headquarters. We spoke with 19 staff including emergency transport attendants, emergency medical technicians, patient transport assistants, team leaders and station managers. We also spoke with the regional senior management team, including the leads for safeguarding, complaints, quality and fleet management and three volunteers. We observed four interactions of care, by accompanying ambulance crews, when they responded to a call and reviewed two patient records. We also spoke with five staff at a local NHS hospital who had a contract with the service. We carried out spot checks on a total of 11 vehicles, six at Bicester, two at Brighton, four at Guildford and one at Aylesbury. We analysed data provided by the service both before and after the inspection.

Emergency and urgent care services

Summary of findings

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

- We saw staff provided compassionate care to patients that respected their privacy and dignity and was patient centred. Staff involved patients, where possible, in decisions about their care. Staff supported patients and their families, recognising how stressful and emotional the situation was for everyone. The service was able to support patients whose circumstances made them vulnerable, with staff respecting peoples' individual needs when providing care and treatment
- Staff followed relevant national guidance to provide effective care for patients. Staff worked well with all healthcare professionals, involved in a patient's care, to ensure care was planned and co-ordinated to meet the patients' needs. The service did not cover a shift unless it had sufficient staff to do so safely.
- The service had a strong focus on training and there was a comprehensive induction process for new employed staff and volunteers. Staff told us they had time to complete their training and they were provided with additional training at team meetings. All staff had to complete an annual competency assessment.
- The environment and equipment were visibly clean and tidy and we saw staff kept vehicles well stocked with the kit they needed. Managers told us there was an effective process for keeping the servicing and maintenance of vehicles up to date and records we saw confirmed this.
- During observations of care we saw staff following good infection control practices to keep minimise the spread of infection, such as hand washing and cleaning equipment in between use on patients.
- Staff felt able to report incidents, with learning and action from these and complaints shared with staff. They told us all leaders were visible and there was good leadership of the service locally and regionally.
- There was a national vision and strategy for the service, which reflected the values of the organisation. Staff knew and understood the vision and values of the organisation.
- Nationally, the organisation had recognised the need to improve the data it collected, to enable it to better monitor the quality of the service, particularly using audits and service performance dashboards. These changes were in progress at the time of the inspection, with some initial results available.

However:

- The safeguarding training for staff did not align with the nationally recognised safeguarding children training levels. We did not have confidence the organisation had trained staff to the correct level for their role. However, staff could describe how to make a safeguarding referral and could describe the signs of abuse.
- There were policies and procedures in place for staff to use to protect patients and their own safety. However, the service had taken no immediate action when staff reported the saloon door on one of the two ambulances for the neonatal transfer and retrieval service did not lock. There was a potential risk to patient safety if the equipment or vehicle were tampered with.
- There was no formal performance review for casual staff and most volunteers had not completed all of their mandatory training.
- There were no child specific defibrillator pads or safety restraints on the ambulances we checked which were used to respond to emergency calls.
- Language guides were not available on all vehicles and there was no communication aid to support patients who were unable to verbally explain their concerns.

Emergency and urgent care services

Are emergency and urgent care services safe?

By safe, we mean people are protected from abuse and avoidable harm.

- Frontline staff knew how to make a safeguarding referral and could describe the signs of abuse. However, we had concerns that the safeguarding training did not meet the recommendations and requirements of key national documents for safeguarding children. Staff did not know what level safeguarding children training they needed to complete for their role. Training did not align with the different levels of safeguarding children training and was not in sufficient detail, given the potential situations that staff may encounter.
- We found an ambulance for the neonatal transfer and retrieval service did not lock. Staff had reported the fault two weeks prior to our inspection but management had taken no action. There was a potential risk of harm to patients and staff. Processes and polices to keep people safe had not been followed.
- The ambulances we checked, which responded to emergency calls, did not contain any paediatric defibrillator pads so staff could use the defibrillator safely on children. These vehicles did not have suitable restraints to secure children during transfer to hospital.
- There was a mandatory training compliance target of 100% however, information provided showed most volunteers had not completed all their mandatory training.
- Staff had a limited understanding of the duty of candour and the service had not fully implemented the requirements of this into their incident investigation process.
- Staff did not monitor the temperature of rooms were medicines were stored, to ensure they were stored within the correct range for the medicine to be effective.
- The regional emergency plan was 18 months out of date for review, with a potential risk the processes and contact details may have changed.

However :

- Staff felt able to report incidents and could describe learning that had taken place as a result of incidents. Different methods were used to ensure learning and actions were shared with all staff, employed and volunteers.
- Staff followed infection prevention and control procedures to reduce the risk of the spread of infection. Vehicles and stations were clean and tidy and staff kept ambulance well stocked. Servicing, MOT and insurance information was current for all ambulances.
- There were effective systems in place to provide sufficient suitably qualified staff to cover contract and event work. Staff worked within their scope of practice and knew when to request support if a patient's condition deteriorated.
- Medicines, including controlled drugs were stored securely at all locations and on vehicles. Staff followed the correct procedures for the ordering, receipt and monitoring of medicine stock levels.
- There were systems in place to monitor the quality of patient records. We saw staff stored records securely on vehicles.
- Business continuity plans were in place and the service worked well other organisations to plan a joint response should a major incident occur.

Incidents

- Staff told us they knew how to and felt confident to report incidents and in general received feedback and learning from incidents took place.
- The service had a paper-based system for staff to report incidents for both contract and event work. There were separate forms for vehicle and non-vehicle incidents. If an incident occurred whilst staff were completing NHS work, they were required to dual report the incident to both the provider and St John Ambulance.
- The service collected incident data regionally. The quality and assurance group were responsible for reporting at a national level. The assurance manager completed quarterly reports on the number of incidents and any trends around the type of incident. Recent learning (July 2016) from trend data highlighted the need to reinforce appropriate practice for manual handling, to minimise the risk of harm to staff when moving patients. The service planned to do this through the annual refresher training and re-assessment.
- Managers were responsible for investigating incidents. Staff completed root cause analysis training to support

them with this process. Some incidents were investigated by the contract provider, if it related to the care of their patient. Staff told us they did not always receive feedback when this happened.

- For July 2015 to June 2016, staff reported 247 incidents. One hundred and twenty one incidents were classified as insignificant or minor, 116 as moderate, seven as major, one as catastrophic and two were unclassified. The majority of incidents related to incidents involving vehicles. The log kept by the service included what action had been taken for each incident and any lessons learnt.
- There were no never events over the same period. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Learning from incidents was shared with staff through email updates, bulletins on the intranet, face to face training and for volunteers by a newsletter and at district meetings. The team leader or ambulance station manager met the crew at the start of most of their shifts. This enabled staff to discuss any incidents or concerns, and the management team to feedback any changes. We saw this when we inspected on 6 October 2016.
- We saw that safety alerts were emailed to team leads from the contract provider, they then shared these with staff verbally and also put the information on staff noticeboards. We saw a recent alert had been sent on recognising the signs of Kawasaki disease. Ambulance staff were required to sign to say they had read any safety alerts, to show they were aware of changes they needed to make to their practice.
- The duty of candour 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'andprovide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with people when something had gone wrong. Nationally, St John Ambulance were focusing on the requirements of the duty of candour, ensuring this was included in training for all new staff.
- At the time of the inspection, the incident database did not include if the duty of candour process had been started because a notifiable safety incident had occurred. The 'Incident management framework policy' (August 2015) did not reference duty of candour despite this being introduced for all providers in April 2015.

Mandatory training

- Staff told us they completed mandatory training which was a mix of e-learning and practical assessed courses. Both employed and volunteer event staff had to complete mandatory training.
- The service required staff to complete a number of core courses, which included medicines management, information governance, conflict management, resuscitation training, equality and diversity, foundation driving and moving and handling. Staff then completed additional courses relevant to their role or as required by the contract ambulance provider. One provider would not allow St John Ambulance staff to book on for a shift until their system showed they were up-to-date with all their training, to ensure staff and patient safety.
- We were told staff were given time at work to complete their training. Staff sometimes chose to access and complete the online training from home.
- New staff required to drive under blue lights completed a four-week course which included competency assessments. Staff had to pass the assessment as part of the conditions of employment to work for St John Ambulance.
- Managers told us it was difficult for them to monitor staff compliance with their mandatory training, as they had to refer to two different systems. There were plans to merge these in January 2017.
- We requested data to show current compliance with mandatory training. The service provided spreadsheets but these only indicated which staff had completed which training, rather than a current compliance rate for each mandatory training course. We were toldthe expected compliance rate was100%. The spreadsheets did show the majority of volunteers needed to complete their information governance and conflict management training. This was not identified as a risk on the regional risk register.

Safeguarding

- We had concerns that the safeguarding children training provided for staff did not align with the Safeguarding children and young people: roles and competences for health care staff Intercollegiate document : March 2014.

- Staff completed an introduction to safeguarding training course (face to face) and then up to five modules (online) depending on their role as part of the safeguarding awareness programme. There were further additional courses on working safely with children and adults at risk of harm, child sexual exploitation and insight into safeguarding but these were not mandatory. The Safeguarding policy (2016) listed which courses staff needed to complete. The policy did not include how these courses aligned with the requirements in the Intercollegiate document and the level of safeguarding children training that staff needed to complete. The policy did not reference this document.
- We reviewed training documents provided by the service but were unable to correlate and have assurance that staff had completed safeguarding children training to the correct level for their role as stated in the Intercollegiate document. There was a potential risk that staff did not have the correct level of knowledge for their role, potentially placing vulnerable children at risk.
- The organisation had plans to introduce PREVENT (Protecting people at risk of radicalisation) and female genital mutilation awareness training but no date was provided for this. The PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who are at greater risk of radicalisation.
- Staff updated their safeguarding training on an annual basis. Again, there were no current compliance figures available for the training, which meant the service could not easily monitor that staff safeguarding knowledge was current. A review of the volunteer spreadsheet showed the majority of volunteers had not completed the introduction to safeguarding, which was mandatory but had completed the relevant safeguarding awareness modules for their role. No reason was provided for this.
- Station managers and team leaders did not complete additional safeguarding training to enable them to support staff or respond to a safeguarding allegation made about a member of staff. Senior staff told us they would speak with the regional or national safeguarding lead for advice.
- Frontline staff we spoke with could describe the signs of abuse, knew when to report a safeguarding incident, and knew how to do this. Staff gave examples of when they had made a safeguarding referral; they told us they did not receive feedback unless they contacted the local safeguarding team. For contracted work, staff faxed completed forms to the relevant trust and also completed an internal form so St John Ambulance were aware and could report on safeguarding referrals made.
- When responding to a call, ambulance staff would only know if a protection plan was in place if this information was held by trust emergency operations contact centre. They would then share this with staff.

Cleanliness, infection control and hygiene

- A national St John Ambulance infection control policy was in use, supported by procedures for staff to follow and annual training.
- All staff completed infection control training on induction and had an assessment of their infection prevention and control knowledge and skills as part of their annual revalidation.
- We visited four locations belonging to the service; all areas at these locations were visibly clean and tidy. We also checked 11 ambulances; all were clean including areas not obvious to the patient, such as around and behind equipment on the ambulance.
- All vehicles we checked had a record of the last deep clean, which was in date. A deep clean involved steam cleaning a vehicle to reduce the presence of certain bacteria. An external company completed this on a 12 weekly basis for vehicles used under contract and six monthly for mobile treatment centres and support vehicles. Set locations on the vehicle, were swabbed pre and post each deep clean, to confirm the clean had been effective and the results reported to the service. We saw records confirming the deep cleans had been effective. The regional fleet services team also kept a record and monitored compliance with the deep clean programme. In the event of a significant contamination, the company provided a deep clean at short notice. Staff told us they responded promptly. The vehicle was taken off the road whilst the deep clean took place.
- For all observations of care, staff followed best practice to minimise the risk of the spread of infection between staff and patients, such as cleaning their hands prior to and after providing care. However, on two vehicles we checked at Bicester, there was no hand sanitiser gel in the dispenser as the wrong size pack had been ordered. To reduce the risk, all staff carried a pocket sized hand sanitising gel with them. Personal protective equipment, such as gloves and aprons were provided for staff, both on vehicles and at premises, to protect staff from

contact with infectious materials. The straps on the five point harness on the stretcher were not made from a fabric which could be wiped clean, to ensure effective cleaning between patients. The service did not have plans to replace these.

- We saw staff cleaning relevant areas and pieces of equipment on vehicles between patient contact. All linen was disposable and staff ensured there was spare linen available when they completed their daily vehicle check. The service provided spills kits on all vehicles, to minimise the hygiene risk until the vehicle could be cleaned more thoroughly.
- Staff used different colour mop heads to clean inside and outside the vehicles, and the garage area, to reduce the spread of infection. For the event service, some volunteers were vehicle champions and completed additional checks to ensure the cleanliness of vehicles. At Brighton, there were a few boxes of clean disposable linen stored on the garage floor which meant this area could not be easily cleaned.
- Staff were provided with sufficient uniform, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniform, unless it had been heavily contaminated, when it was disposed of as clinical waste. There were no showers at any of the locations we visited. The station manager at Bicester had submitted plans to alter the layout and provide new facilities for staff, including showers.
- On one vehicle at Bicester, we found an open packet of chest pads used with the defibrillator. There was no assurance that these items were still sterile.
- There was an updated national audit programme introduced in 2016, which included infection control audits, such as hand hygiene. Regional assurance managers reported quarterly and there was monthly national call with the infection control leads to discuss any concerns. At the time of our inspection, there was no local infection control lead. This was vacant volunteer position.For the volunteer side of the service each district should then have a infection prevention and control officer, there two out of the five.
- Managers were required to complete a quarterly infection control audit of their buildings and complete an action plan at the end of the audit and escalate any concerns. The most recent audit at Bicester identified the risk of the toilet being off the kitchen. The toilet was not in use as there were alternative facilities for staff to use.

Environment and equipment

- We checked two vehicles for the neonatal transfer and retrieval service at Oxford. One vehicle was in good condition and well maintained; we had concerns because the other would not lock. The vehicle was stored at the hospital and was not visible to the crew whilst they waited for a call. The 'Managing the regional fleet' local operating procedure (2015) required all unattended vehicles to be locked to ensure the safety of the crew and care of the patient. As the vehicle would not lock, there was a significant risk due to the type of patients being transferred and the potential impact if the vehicle or equipment was tampered with or items removed. There was potential access to specialist equipment, medical gases and general sale item medicines; none of which were locked away.
- Staff had reported the vehicle did not lock on 27 September 2016 and completed a vehicle defect form as per policy. The vehicle was not taken off the road or repair organised and could not be locked during our unannounced inspection on 12 October 2016. There was no assurance the processes to keep people safe were being followed and implemented correctly. We made senior management aware of our concerns and action was taken the following day, with the lock being repaired.
- Managers told us and we saw in minutes the vehicle was due to be taken off the road for additional non-urgent repairs once the neonatal service had confirmed all the equipment fitted safely and securely in the new vehicle. Staff at the neonatal service told us there had been difficulties in getting the correct length tracking fitted in vehicles to secure the specialist equipment.
- We checked 11 ambulances all were well stocked with single use items. We checked approximately 20 items and all were all within their expiry date and safe to use. The layout of equipment and consumable items on vehicles was the same at each location, so staff could use any vehicle and locate things promptly. All staff were responsible for maintaining stock on vehicles, by restocking when back at base, or during a shift if needed. Team leaders told us and we saw that staff did a detailed stock check every month for each vehicle in addition to the daily checks.

- Staff completed a daily vehicle check. Staff at Bicester had 30 minutes to do this and at Guildford 60 minutes. The service was looking to change this to 30 minutes in all areas and had made staff aware.
- The regional fleet management team maintained an asset register for medical equipment. This included the item number, next service date and the frequency of service. We checked two items and the servicing information matched the sticker on the piece of equipment. The team leaders managed the logistics of arranging servicing of both equipment and vehicles and ensuring enough vehicles for a safe service well. They told us external companies worked flexibly with the service to meet their needs.
- All vehicles had an up-to-date MOT, annual service and were insured. Contract vehicles had a safety inspection every three months or 10,000 miles and event vehicles every six months or 10,000 miles. We found one ambulance at Bicester that did not have a current MOT certificate in the document folder. We spoke with senior management and were emailed a copy of the current certificate and advised a copy would be placed in the vehicle the next day. Keys were stored securely with only relevant staff having access. Access codes were changed every six months. If a staff member left codes would be changed sooner, to restrict unauthorised access.
- Team leaders and station managers had overall responsibility for ensuring vehicles were safe to be on the road. They kept noticeboards updated on which vehicles were off the road and why; signs were also placed in vehicles. We saw at Brighton, two new vehicles were received from the fleet management teamin August 2016. Staff told us these vehicles were off the road due to missing equipment and safety mechanisms. Staff told us the missing equipment included a side step, to enable the removal of equipment from a vehicle to be undertaken safely and a mobile data terminal to be enable them to communicate with the contract provider.
- Two volunteers told us there were no issues with restocking of kit or equipment on event vehicles or for personal kit they carried with them.
- One vehicle at Brighton had two vacuum splints that did not work. The ambulance crew were only required to visually inspect this equipment and not check it was functional during daily vehicle checks. We saw the ambulance crew were able to look after a patient effectively through using other equipment. Also, the ambulance crew were carrying a bag containing an oxygen cylinder loose in the vehicle, as there was not enough storage. Staff also had three other unsecured items on the vehicle. This was a potential risk, if for example, the vehicle was involved in a road traffic accident.
- There was a process in place to ensure any vehicle taken out of service was disposed of correctly, to prevent it being purchased and used for terrorism activities. This included removing anything that identified it as an ambulance and may allow someone to take the vehicle into a restricted access area.
- Staff were aware of an update taking place with the defibrillator they used. Staff told us there was a plan in place to replace this equipment to a newer version. This was because in December 2016, the company producing the machines was going to stop making parts for the current model.
- We did not see any paediatric defibrillator pads on the vehicles we checked so the machine could not be safely used on children. They were not listed on the daily vehicle check sheet.
- Team leaders told us if staff reported a piece of equipment as faulty they tried to swap the crew to another vehicle so the equipment remained correctly logged to each vehicle and took the other vehicle off the road. If this was not possible, equipment was borrowed from any vehicle that may be off the road or from another ambulance station.
- None of the vehicles we checked had a child harness so staff could safely restrain children in the ambulance. Senior staff told us the service did not routinely transport children but acknowledged they needed to review current equipment. The review had started but there was no completion date for this. However, frontline staff told us they did transport children and asked the parent to hold their child and used the straps on the stretcher to secure them both. Alternatively, children were transported in a child seat secured to the ambulance chair.
- Containers for the disposal of clinical waste and sharps were in place on each vehicle. On one vehicle at Brighton, the container for sharps was open and not securely held in the vehicle. We spoke with staff who closed the sharps box, so sharps could not accidentally fall out and cause injury and possible infection to staff or patients. The ambulance crew could not secure the sharps box within the vehicle due to lack of space. There

were suitable facilities at all premises for the disposal of clinical waste, at the end of a shift. The station manager at Guildford told us there were plans for new sluice area for the disposal of clinical waste.

- The service had introduced, in August 2016, an updated building audit form to identify any risks such as building security and suitable storage for equipment. Staff sent the information to the regional assurance manager, who had overall responsibility for ensuring any actions were taken. Due to the recent change, the service had not yet implemented any changes but we saw the audits had been completed. At Bicester, Control of substances hazardous to health (COSHH) documentation was available for all staff to access, to ensure they minimised the risk of harm when working with certain chemicals and medical gases.

Medicines

- There was a 'Medicines management policy' (June 2015) and local operating procedures in place for staff to follow for the order, receipt, storage, administration and disposal of medicines, including controlled drugs. Staff knew which medicines they could administer dependent on their role and scope of practice.
- Staff completed daily checks as part of the vehicle inspection to ensure they had the correct medicines on their vehicle. We checked four drugs bags and all medicines were in date. Crews could top up supplies of general sale medicines (these are medicines that can be bought without a prescription or pharmacy advice) themselves and updated records to show current stock levels. For prescription only medicines, two senior staff at each location had access to the safe where these were stored and recorded in the logbook when and how much they had issued. Kit bags only contained the medicines that staff could administer to reduce the risk of staff giving medicines that they were not trained to administer. Managers were only able to order the medicines they used at their location to further reduce the risk.
- All medicines were stored securely at each location we visited, including in make ready cupboards and additional storage areas. There was no room temperature monitoring to ensure medicines were stored within the correct temperature range, so they remained safe to use. This was a requirement of the St John Ambulance 'Procedure for storing and recording medicines' (June 2015). For crews using prescription only medicines, these were stored in a safe, with staff signing the tagged medicines bag out and then back in once they had completed their shift. Crews recorded any medicines they had issued and the patient report form (PRF) number so stock levels could be monitored and the reason for issue checked. We saw crews storing medicines securely on vehicles.
- At Bicester, the additional stock was stored in plastic baskets. Some of these were very full so it was not easy to see which medicine was in the basket or expiry date on the medicines. One basket contained both glucose tablets antihistamine tablets, rather than them being separated to make it easy for staff to collect the correct medicine.
- We saw medical gas cylinders were stored safely and securely at each location, with hazard warning stickers used to show where they were stored. A coloured tagging system was used to show cylinders that were empty or faulty so staff did not use them. They were stored separate to the full cylinders. No staff raised any concerns around replenishing stock and records were up-to-date to reflect current stock levels.
- The service stored controlled drugs at two locations. We saw the controlled drug licenses for possession and supply were current for each location. We checked the contents and stock levels of one controlled drugs cupboard and this matched the controlled drugs record books. There was a process in place for the issuing and return of controlled drugs to relevant event volunteers, such as paramedics and doctors.
- There were limited medicines management audits completed by the service. The regional assurance manager recognised this as an area for improvement and had included this on the annual medication declaration for the region (July 2016).
- Staff recorded medicines administered to patients on the PRFs. We saw from two clinical practice audits complete at events, staff had correctly explained why a medicine was needed and offered written information to the patient or their parent to support the discussions that took place.
- We saw at all locations managers kept of medicines that were disposed of, to ensure traceability and safe disposal, including for controlled drugs. At Aylesbury, we found some out of date controlled drugs, which were

waiting for collection by the responsible person. They were securely stored in a separate area to current controlled drugs so there was no risk of them being given to patients.

Records

- The ambulance crews completed patient report forms (PRFs), based on the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines. There were separate forms in use depending on whether staff were completing contract or event work.
- Staff stored completed PRFs securely on vehicles in the cab area, which they kept locked when the vehicle was unattended, for both contract and event work. Secure records storage was available at each station for staff to leave records on completion of their shift. However, at Bicester the PRF box, was locked but not wall mounted to prevent the box being removed. There was though CCTV in this area and the building was normally secure. Team leaders were responsible for collecting and reviewing the records on the subsequent day. There was a secure storage for archived records.
- There were standard operating procedures for records management, which covered creation, storage, security and destruction of records, these were contained within the Management of the legal aspects of care, treatment and support policy (2010). Staff understood their responsibilities relevant to their role.
- Some of the PRFs staff completed were carbonated. They passed the original form to staff at the receiving hospital, to ensure all staff delivering care for the patient could access the information. The second copy was kept by the contract provider to ensure they had a record of care.
- The ambulance contract providers undertook a monthly and quarterly external review of record quality for patients seen by the service and provided written feedback to the station manager who discussed any concerns with the member of staff concerned. The station managers also had to send the trust an action plan in response to the key recommendations from the audit. Local audits were also carried out on completed PRFs. Recent actions included arranging a training session for staff on the accurate completion of the PRF and ensuring staff recorded two sets of observations for each patient. One contract provider had requested copies of completed PRFs were sent to them sooner and put a new process in place to support this. There had been delays of up to two weeks, which made it difficult for them to respond to any incident or complaint forms they received.
- Senior managers told us there were delays in auditing PRFs for the event service due to lack of clinical volunteers to do this. They had recently recruited three volunteers, who were completing training prior to completing audits during January 2017 to March 2017.
- Trust emergency operations staff made ambulance crews aware if their system flagged, a patient had a do not attempt resuscitation document or advanced decision to refuse treatment in place. This ensured staff respected the patient's wishes around their care and treatment. Staff also knew to check for this information in the patient's home, via the 'message in a bottle scheme'. A bottle in the fridge contained information on where the do not attempt resuscitation form was located. At events, staff tried to establish the patient's wishes but in the event of cardiac arrest, staff always started resuscitation in accordance with current protocols.

Assessing and responding to patient risk

- Staff completed clinical observations on patients, as part of their care and treatment to assess for early signs of deterioration. If a patient did deteriorate, staff requested additional emergency clinical support. Staff had access to suitable equipment on the ambulance to enable them to monitor and assess patients.
- At Brighton, we observed a patient assessment being undertaken using the Joint Royal Colleges Ambulance Liaison Clinical Practice Guidelines (JRCALC). The ambulance crew monitored the patient visually due to their challenging behaviour.
- Staff were taught during induction the knowledge and skills needed for their role and knew the limitations of their role and the scope of practice they could work within. This ensured crews and volunteers knew when to seek help, to ensure patients were safely treated**.** If they needed specialist clinical advice, they contacted the trust they were working for and for events followed the St John Ambulance escalation process.
- During our observations of direct care we saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was maintained and injuries avoided.

- We were told and saw detailed risk assessments completed for event work, to ensure if a member of the public became unwell their health needs could be met safely. The manager for the event would place the risk assessment on the staff intranet so staff could read it prior to the event. A senior member of the ambulance crew also held a briefing prior to the event, to ensure all staff were clear about the risks and knew how they would be managed. A debrief was held after the event to see if any changes were needed prior to cover being provided at the same or similar event in the future.
- Staff completed training as part of their induction to enable them to provide emotional support to patients with challenging behaviour and those experiencing a mental health crisis. A police officer accompanied any patients detained under the Mental Health Act (1983), as part of the agreement with the contract providers. The NHS ambulance contract provider had a flagging system for addresses for patients where there were known risks of violence and aggression towards ambulance staff. This information was passed onto St John ambulance crews by the emergency operations staff.

Staffing

- Team leaders and senior staff, regularly reviewed staffing levels and appropriate skill mix of staff to cover shifts through the contract with the local ambulance trusts and for planned event work.
- For event work, the service used an electronic planning system. The event organiser completed an online form, the information they submitted was used to produce a score indicating how many volunteers were needed at the event and the skill mix. This was dependent on the type of event, location and expected numbers. Event staff reviewed the suggested staffing numbers and discussed this with the customer before they asked volunteers to sign up for an event.
- The local event lead was responsible for ensuring the planned staffing numbers were met and that volunteers had the correct skills needed for the event, so people would receive safe care and treatment. Recruitment of volunteers to events was a national challenge for the organisation and included on the regional and national risk register. Staff completed an incident form when the staffing levels were not as planned. The service would not cover a shift for event or contract work if it could not do so safely.
- For contract work with the local NHS ambulance trusts, the service provided an agreed number of ambulances on each day of the week, all with two appropriately qualified staff. Team leaders used an electronic rostering system to plan shifts. Shortfalls in cover were shown on this system and staff could request to work additional shifts. Station managers and team leaders sometimes completed shifts when they remained unfilled. Team leaders and station managers told us they had to cancel some shifts if cover could not be found. From October 2015 to September 2016, the service had covered 89% of shifts for one contract and 95% for the other contract. The contracts with the NHS ambulance trusts did not stipulate a set number of sessions per month, which made it difficult for senior staff to anticipate staffing requirements. At the time of our inspection in October, the team leader in Bicester was waiting for shifts to be confirmed for November so they could confirm their rotas.
- For the neonatal transfer and retrieval service, agency staff were requested for any unfilled shifts, as the service was unsafe if no crews were available to drive the ambulances. This was because the equipment would not fit in a standard ambulance. From October 2015 to September 2016, 99.5% of shifts were covered. St John Ambulance used a core group of agency staff so they were familiar with the specific needs of the service. Performance concerns had resulted in some agency staff not being recruited for further shifts. At the time of the inspection, there were two ambulance crew vacancies for the service. Minutes from the July 2016 meeting held with the neonatal service, showed they had requested a standard operating procedure around safe staffing of the service by St John Ambulance.
- We reviewed the rotas at Bicester for the week prior to our inspection. Actual staffing levels were as planned. For all contract work, staff worked an agreed shift pattern of four shifts on and then four shifts off, shifts were 10 to 12 hours in length. Staff felt this system worked well and the regular shift pattern provided them with a better work life balance.
- Staff did not raise any concerns about access to time for rest and meal breaks. We saw crews taking their breaks. Staff rosters allowed staff to have adequate time off between shifts.

Anticipated resource and capacity risks

Emergency and urgent care services

- The service worked with the ambulance contract providers to tell them in advance, where possible, of planned changes to staffing, which affected the number of vehicles that the service could operate.
- Meetings had been arranged for the service and trusts to make plans for resourcing bonfire night and the extra demands on services at winter. These were due to take place shortly after our inspection.
- Business continuity plans were in place for event first aid and contract work. This enabled the service to plan for, manage and operate in the event of significant disruption to services, such as fire or flood damage at a location or staff shortages due to illness. At each station, there was a 'resilience' vehicle, to use in the event that all other vehicles were off the road.
- All teams involved in the Southampton neonatal transfer and retrieval service had recently practiced moving the patient to another vehicle, in case they had to transfer unexpectedly if their vehicle broke down.
- Each station had a four-wheel drive events vehicle, for use when providing cover at events that were difficult to access.

Response to major incidents

- Ambulance crews were not routinely sent to major incidents as this was outside their scope of practice. However, there were occasions when crews would be dispatched to ensure enough resources were available for patients or they were the closest initial ambulance to the location of the incident. Staff completed training on responding to a major incident as part of their induction. There was a 'National policy for emergency preparedness, resilience and response' (August 2016) with associated procedures which staff followed in the event of a major incident.
- Station managers told us they could provide crews to respond to routine calls, to enable the local ambulance trusts they worked for to send vehicles to a major incident. Volunteers were asked to report for duty if a major incident occurred. If an ambulance trust was on 'black alert', St John Ambulance were contacted to see if they could provide assistance. Black alert is when a service is at the highest level of pressure and has to implement escalation plans to reduce the risk of harm to patients.
- Through the work with the local ambulance trusts, the service was part of the local resilience forum, which provided a co-ordinated response, involving all emergency services, when a significant incident occurred. The service had a regional emergency plan in place to support this. The document was out of date for review, which was due in March 2015. There was a potential risk the processes for staff to follow and contact details were not up-to-date.

Are emergency and urgent care services effective?

(for example, treatment is effective)

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff provided care to patients in line with national guidance. The service had processes in place for staff to get additional clinical advice, if needed.
- The service had a comprehensive induction and training programme in place for employed and volunteer staff. Staff completed relevant training for their role, with an annual assessment of their clinical competency. All employed staff had completed an appraisal in the last year.
- We saw good multidisciplinary team working between ambulance crews and other emergency teams. Information shared during patient handover was relevant and enabled continuing care of the patient.
- Staff asked patients for consent before starting observations or treatment.

However:

- There was no target compliance rate for appraisals. The majority of volunteers had not received an appraisal in the last year and there was no formal review process for casual workers employed by the service.
- There was only one audit to monitor staff adherence to national clinical guidelines.

Evidence-based care and treatment

- We saw staff providing care and treatment to patients in line with the Joint Royal Colleges Ambulances Liaison committee (JRCALC) clinical practice guidelines. However, there were only one audit relating to records to monitor adherence to these guidelines.
- The team lead at Brighton told us all staff received a copy of the guidelines. There was a pocket sized version of the guidelines which staff could keep with them at all time. Staff told us they found them useful to refer to before administering medication.
- Staff had access to a sepsis screening tool to ensure they took prompt action for patients with possible signs of sepsis
- The events manager explained to us the risk assessments for events were reviewed by staff using national guidance, including the 'Purple guide' to 'Health, safety and welfare at music and other events' supported by the Health and Safety Executive. Staff also used the 'The guide to safety at sports grounds (Green guide)' published by Department for culture, media and sport.
- The service was contracted by local commissioners to provide neonatal transfer provision. In meeting the contract, the service followed National Institute for Health and Care Excellence (NICE) guidance Quality Statement four: Neonatal transfer services which considered the arrangements to ensure the service was run 24 hours, seven days a week.

Assessment and planning of care

- Staff adhered to relevant national and local clinical guidance and protocols for their role, when assessing and providing care for patients of all ages, including children.
- If staff needed clinical advice, they contacted the clinical support desk, based in the emergency operations centre for the ambulance trust. Staff told us the advice provided enabled them to support the patient further. For event staff, an escalation process was in use, with staff contacting the commander on call.
- Ambulance crews took patients to the nearest appropriate hospital for their treatment, as advised by the healthcare professional who had requested the hospital admission or transfer. We observed staff requesting a change to the planned hospital, due to their observations. For event first aid, the patient was taken to the nearest accident and emergency department, should it not be possible to care for them at the event. If a patient was treated as a 'see and treat' and did not go to hospital, staff provided written information to the patient on who they should contact for further advice, if their condition changed
- We observed one crew ensuring a diabetic patient had eaten prior to their journey to hospital, as part of the crew's assessment of the patient's care needs.
- Staff followed guidance and protocols of the ambulance provider, if patients were detained by the police under section 136 of the Mental Health Act and they needed to transport the patient to hospital.

Response times and patient outcomes

- The ambulance provider monitored response times for work undertaken as part of the contract and reported these to the service at monthly meetings.
- We saw a summary document where performance times were displayed in colour rated charts. These showed St John Ambulance current performance met national targets, other than for Red 1 and Red 2 incidents for one of the two contracts. Category A (Red 1) incidents are patients presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. Data for June 2016, showed the service achieved this target for 66% of patients. Category A (Red 2) incidents are patients presenting conditions, which may be life threatening but less time-critical and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. Data for June 2016, showed the service achieved this target for 73% of patients.
- The service did not routinely collect or monitor information on patient outcomes, such as the number of patients seen by the event first aid team, who were treated at the scene versus taken to hospital. Patients seen as part of the contracted service were generally planned admissions to hospital, the collection of outcome data was therefore limited. There were also difficulties around access to data as the contract provider owned and held this.
- Staff did not raise any concerns about the relationship between the service and the different departments they took patients to.

Pain relief

- We observed staff asking patient's about their level of pain and administering pain relief to patients to good

effect. Staff recorded the pain score on the patient report form and rechecked this during the journey to hospital. Staff managed the patient's pain within their scope of practice, defined by the framework in which they worked.

- Employed staff in Brighton had completed training and competency assessment with the NHS contract provider to enable them to administer some additional pain medications, further to those normally used by St John Ambulance staff.
- Staff told us they would use the faces pain assessment tool for patients who were unable to communicate verbally their level of pain. Patients are asked to point to one of six faces, choosing the one that best describes their level of pain.

Competent staff

- The service had introduced a new interview format in 2016, to help with the selection of candidates. To support this a comprehensive induction process was also put in place for all staff, employed and volunteers. This included modules on first aid and providing an emergency response to patients.
- A role specification listed which modules staff needed to complete, dependent on their role, including volunteer roles. Nationally developed training programmes were delivered locally for both staff and volunteers. Not all trainers had completed a recognised training qualification, the service recognised this as a risk and had plans in place to address this. However, trained assessors monitored the standard of training by completing ad hoc observation sessions.
- New staff completed an induction programme. The service used competency based written and practical assessments throughout the programme. Staff driving frontline vehicles had to pass a driving assessment to continue working for the organisation at the end of their induction. Staff had an observational assessment of their driving standards every five years or after an incident whilst they were driving (such as a collision), to ensure they were still competent and safe to drive. Staff were offered additional training where necessary.
- All staff, whether employed or volunteers completed an annual revalidation, which was a mix of written and practical assessments, to demonstrate they were still safe to practice. The service recorded the due date for revalidation on the training spreadsheet. If a person failed, managers put in place an action plan support the person. If the person failed all parts of a course, they would be asked to repeat the course. The staff member would also be downgraded to a role they could safely fulfil, such as advanced first aider to first aider.
- In addition, station team leaders aimed to complete two clinical observations per year with employed staff when they responded to calls. For volunteers, audits at events also included observations of the care first aiders provided.
- Both volunteers we spoke with felt the quality of training for volunteers had improved. There was more training they could access and the change to on-line training for some courses made it easier to complete. Volunteers had to complete a minimum of 150 clinical hours a year to help them retain their competencies and maintain their St John Ambulance registration.
- Employed staff had four allocated continuing professional development days per year. We saw the programme for the next study day at Bicester, which included assessment of head injury. Team leaders and station managers also completed observational assessments of staff performance when providing care. The service had policies and procedures in place to manage poor performance, with managers describing how they had used these effectively. Staff were also encouraged to complete reflective written pieces to identify how they could respond to a situation differently in the future.
- All staff received an annual appraisal, with employed staff having a personal development review every six months. There was no compliance target so the service could see areas that were or were not compliant. Data provided by the service showed as of October 2016, 100% of frontline staff had completed an appraisal and 13% of volunteers. Line managers for volunteers were aiming to complete all reviews by the end of the year, with regular progress updates given to district managers. There was no formal review process in place for staff employed by the service on a casual basis to identify areas for improvement and progression.
- Staff feelings were mixed on opportunities for career progression based on the current job roles. However, the service had recently completed work on revising the ambulance crew skill levels for employed and volunteer staff. This was to support the introduction of the nationally recognised Associate Ambulance Practitioner (AAP) role, used by most NHS ambulance trusts. The organisation had identified what training staff would

need to complete to achieve this and other newly defined roles and would support staff if they chose to do so. They expected the organisation to implement the programme by January 2018. The change would enable volunteer first aiders to progress to AAPs with relevant additional training and ensure employed staff had the correct qualification required by the contract providers.

- Volunteers and employed staff who held professional registration followed guidance from their professional body to renew this. The regional assurance manager checked national registers to ensure staff remained registered to practice.

Coordination with other providers

- Ambulance staff told us that they had good working relationships with the other emergency services. This included the fire and rescue services, police and the local acute hospitals.
- Staff working with the neonatal transfer and retrieval service, understood their role and what they were accountable for. They worked within agreed frameworks set by the provider for this service.
- Ambulance staff worked to agreed care pathways with the local ambulance trusts, to ensure standardisation of care for patients across services and the best outcome for the patient. They took patients to the most appropriate hospital department for continuation of their care. We observed they did not always take patients to A&E, if another department was more suitable, such as the renal unit.
- The service had agreed processes in place for working with the police. This included the transportation of a deceased patient and patients detained under the mental health act.
- Through the work with the contract provider, the service was part of the local resilience forum, which provided a co-ordinated response in an emergency.
- The events manager explained if an event was planned where there may be a terrorism threat, St John Ambulance would liaise with security services, when reviewing the organisations risk assessment for an event.

Multidisciplinary working

- We saw good multi-disciplinary team working between ambulance crews and other emergency staff when responding jointly to a call. The teams worked together to stabilise and coordinate the care for the patient and agree onward transfer arrangements to hospital.
- We also observed four handovers between ambulance crew and hospital or hospice staff, for patients who were transferred for continuing care. Once staff where at the receiving hospital they gave clear information during the handover and brought any urgent concerns to the attention of staff.
- Staff at Guildford told us they worked well with paramedic staff from local NHS ambulance trusts, who provided guidance and advice when responding jointly to calls. No staff raised any concerns about getting additional clinical support when needed.
- All staff working for the neonatal transfer and retrieval service gave very positive feedback on the strength of the multi-disciplinary working with St John Ambulance crews, to deliver safe care and treatment to patients.

Access to information

- We observed and staff told us if multiple services were involved in the care of a patient, one set of paperwork was completed and this stayed with the patient, to ensure safe care and treatment at all stages of their care. Forms were carbonated so individual services could keep a copy for their own records and audit purposes.
- Staff did not have access to 'special notes' about a patient such as pre-existing conditions, safety risks or advanced care decisions, unless the patient told them or the information was provided by the emergency operations centre who dispatched the crew to the call. Staff told us they would check for a care plan in a patients' home or if they collected a patient from a nursing home. For inter-hospital transfers this information was provided by staff during the handover.
- Employed staff raised concerns GPs did not always leave a letter at the patient's home explaining why the crew was taking the patient to hospital. When they did, the letter did not always contain sufficient detail on the patients' past medical history. Staff attended a patient where they had only the name, date of birth. They requested further information and found the patient was end of life. This was a difficult situation for staff to manage, as the GP had not told the family.

- At events, staff offered patients a carbonated copy of their patient report form, so they could share the information with other healthcare services as part of their continuing care, if necessary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff, in non-emergency situations, explaining procedures, giving patients opportunities to ask questions and seeking consent from patients before providing care or treatment. Staff recorded verbal consent to treatment in the patients' records.
- Staff completed training on the Mental Capacity Act and Mental Health Act as part of their initial training and at continuing professional development sessions. No figures were available on the completion of this training.
- Staff had some understanding of the Mental Capacity Act (2005) and how it applied when obtaining consent, including the assessment of capacity and completing a best interest assessment. Staff could access further information via the services 'Management of legal aspects of care and treatment support policy' (2010). Staff knew when they could and should give treatment to patients without consent, such as in an emergency to preserve life. Staff used a form from the NHS ambulance contract providers in order to guide them in the assessment of a patient's mental capacity. The contract providers audited if staff recorded that consent was obtained part of the patient report form audit. For a recent audit (June 2016), compliance was 90%.
- Ambulance staff did not currently restrain patients as part of their legal powers under the Mental Capacity Act or Mental Health Act. There was no restraint equipment on vehicles and staff were not routinely sent to respond to this type of call. Police support was requested if a patient needed to be restrained.

Are emergency and urgent care services caring?

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

- We observed staff providing compassionate care to patients and their families. Staff anticipated and responded to patients' needs. Staff maintained patients' privacy and dignity at all times. Staff were kind and showed empathy to patients' they were caring for, particularly when upset or in pain.
- Staff clearly explained the care and treatment needed to each patient so they understood. They encouraged patients to be partners in their care and always asked for consent before they gave care.
- Staff supported patients who were distressed, anxious or had a mental health condition. Family members and carers were also provided with emotional support, with staff recognising the impact of the patient's health condition on the whole family not just the patient.

Compassionate care

- We saw staff were respectful, friendly, kind and compassionate when providing treatment or care to patients. They spoke with patients in a gentle manner and offered reassurance, particularly if the patient was distressed.
- Staff were professional in their approach and spoke politely to patients and carers travelling with the patient. They always introduced themselves prior to giving care.
- Staff maintained patients' privacy and dignity, ensuring they covered the patient using a blanket or sheet. Two observations of care took place in a public place and staff ensured patients' modesty was preserved at all times by use of blankets. Staff shut the ambulance doors after loading patients to ensure patient were kept warm or cool and their privacy and dignity maintained, whilst staff completed any assessments. A patient was offered clean clothing as theirs had become soiled.
- We observed a crew showing care and compassion to a patient who was aggressive and had challenging behaviours, maintaining a calm professional approach throughout.
- Staff at a local NHS hospital commented on the professional behaviour of the St John Ambulance staff they worked with and the considered and caring approach the staff used when talking with parents.
- Staff working as emergency medical technicians told us they completed training on supporting and transporting

patients who were deemed end of life, including support for family members. They described how they had used this training and quite often took patients to their local hospice, for respite or palliative care.
- Data from the online patient survey for August 2015 to August 2016, showed 15 out of 19 patients would recommend the service to friends and family.

Understanding and involvement of patients and those close to

- Staff gave clear verbal explanations to patients about the care and treatment they could provide.
- We observed patients being involved in decisions about their care and treatment. Staff checked with patients to ensure they understood the treatment offered, before they asked for consent.
- Where a patient did not require hospital treatment, we observed ambulance staff discussing this with the patient to ensure they were happy to remain at home or be referred to another care provider, for example their GP.
- Staff showed kindness towards relatives and carers of patients and were aware of their needs, ensuring they were kept updated. Staff explained things in a way they could understand to enable them to support their relative. We observed a crew providing support to a patient and their family so they were all actively involved, which was in keeping with the patient's wishes. We saw staff ask a relative if they wished to travel in the ambulance so they could continue to offer support.

Emotional support

- We observed staff showing empathy to patients, their partners and other family members. Discussions took place in a timely manner and at an appropriate stage prior to and during the journey to hospital.
- One crew member provided constant reassurance for an anxious patient. They kept them informed and explained why the patient needed to attend a different hospital than planned.
- Staff were aware of the need to support patients experiencing a mental health crisis and could describe situations where they had done so. Frontline staff and managers knew their responsibilities when transporting patients detained under the Mental Health Act.
- The service did not routinely transport deceased patients. However, staff received training on looking after the deceased with care and dignity should they transport a deceased patient.
- Staff who encountered difficult or upsetting situations at work could speak confidentially with an external counsellor. For NHS work one of the contract providers sent a welfare officer to see staff if they attended a challenging call whilst completing a shift for them.

Supporting people to manage their own health

- St John Ambulance staff provided written information to patients on alternate care pathways when they discharged a patient at the scene. This supported patients to manage their own health, care and wellbeing, ensuring they knew what to do if their condition changed and who they should contact.
- At events, the majority of patients were not taken to hospital. They were signposted to prearranged primary care, such as GP services or pharmacy facilities, depending on the nature of their injury.
- Frequent callers and users of ambulance services were identified from records held by the local NHS ambulance trust, St John Ambulance staff were working for. They informed the crew before they attended the call. St John Ambulance staff followed the frequent contact policy of the trust they were working for.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

By responsive, we mean that services are organised so that they meet people's needs.

- The service worked effectively with the contract ambulance provider and commissioners for event first aid work to ensure they planned services to meet the needs of local people. The contract provider monitored response times for ambulance crews and discussed performance at monthly meetings with the service.
- Staff took the individual needs of people accessing the service into account when providing care and treatment, making adjustments where they could. Staff had training to support patients in vulnerable circumstances.

- The service had a robust process in place to respond to feedback from patients and members of the public. Managers investigated complaints and provided a written response to the complainant. Learning from complaints was shared with senior and frontline staff, who could describe changes to practice as a result of complaints.

However:

- Multi-lingual phrase books were not kept on all vehicles to support communication with patients who were non-English speaking. Also there was no communication aid to support patients who had additional communication needs or who were unable to verbalise their concerns, other than for their level of pain.
- The service had not always sent a written response to formal complaints within the agreed timeframe.

Service planning and delivery to meet the needs of local people

- The service had contracts with two local ambulance trusts and an NHS hospital trust to help them meet patient demand for their services. Regular monthly or quarterly planning and performance meetings were held with the trusts and minutes showed discussions took place on any changes St John Ambulance needed to make, to better meet the needs of patients. This included ensuring sufficient staffing and suitable vehicles to meet the specific needs of the service, such as for the neonatal transfer and retrieval service.
- The events service had a number of contracts to provide event first aid, for local and national events within the area. Senior staff told us post event briefings were held with the organisers to review the service provision at these events. This included whether they had met people's needs and areas for improvement at future events, such as the location of the first aid unit at the event. A volunteer told us following learning from an event, senior managers asked the deep clean service to attend some events. This meant they did not need to take vehicles off site to be cleaned and St John Ambulance could provide a service to more people.
- St John Ambulance management staff provided staff to cover additional shifts during times of peak demand for contract providers, such as during the winter. However, there was fluctuation in demand from the contract providers that made service planning difficult for St John Ambulance teams.

Meeting people's individual needs

- We saw that staff were considered in their approach and where possible met peoples' specific individual needs.
- All staff received training on supporting people experiencing a mental health crisis or responding to challenging situations. Where patients were detained by the police under section 136 of the Mental Health Act, staff would follow the guidance and procedures of the ambulance contract provider.
- Staff told us they would transport a patient in their own wheelchair if possible, rather than transferring them to a trolley, so they were more comfortable.
- A staff member described how they had communicated with a patient who was hard of hearing by writing things down, to enable them to be fully involved in their care and treatment.
- Staff respected patients' spiritual or cultural needs, however, if these were in conflict with their health needs, staff spoke with the clinical advice team and for events they contacted the regional on call manager for advice. In an emergency, the patient was taken to hospital for care.
- A multi-lingual phrase book was provided to help staff speak with patients and their families who did not speak English. St John Ambulance policy required a book to be stored on each vehicle but we found a book on only one of the 11 vehicles we checked. The vehicle daily inspection sheet did not include checking the book was available. To reduce the risk staff told us they used a translation app on their mobile phone to help them communicate and had access to a telephone interpretation service. However, should they be in an area with no mobile signal, there was a potential risk to patient care if the phrase book was not on the vehicle.
- There was no communications book, containing pictures for common words and medicals problems, such part of the body affected, to support patients who were unable to speak due to their medical condition or who had complex needs. This was a potential risk if patients could not explain what was wrong or understand the treatment they needed.
- Staff completed training as part of their induction on how to support a patient with a learning disability.

Operations centre staff told the crew, where known, if a patient had a learning disability. Once at a call, staff assessed how best to meet the person's needs, such as a family member travelling with them.
- The service did not have an ambulance to support bariatric patients. If staff attended a call or where at an event, they would contact the emergency services and request a suitable vehicle.
- All staff completed communication training but this did not complete a specific course on supporting people living with dementia, unless they completed shifts for one contract provider. This provider then provided training for staff. However, staff described to us how they would approach and support a confused patient or people with dementia.

Access and flow

- Ambulance crews had travelling time built into their shift, to enable them to reach their base location prior to the start of their shift. This ensured they could provide an efficient response to patients, when the emergency operations centre received a call.
- St John Ambulance informed the contract provider of planned cover for shifts two weeks in advance, so the provider could allocate any unfilled shifts to other services.
- The contract provider monitored response, on scene and turnaround times for St John Ambulance crews via the data captured using the on-board GPS navigations system. They reported on these figures at monthly meetings between the service and the provider. Comparison was made to the contract ambulance provider response times and targets. However, direct comparison was difficult due to the difference in the number of calls responded to and the type of calls which the service were sent to by the provider.
- Crews also completed a written daily worksheet, which enabled St John ambulance mangers to monitor the time crews spent on calls, how long it took to handover at the hospital and the total length of the shift. Managers used this information if contract providers raised concerns around performance times.

Learning from complaints and concerns

- Patients, carers and members of the public could provide feedback verbally or via the St John Ambulance website, by email, letter or telephone. The website provided information on the complaints process and the expected response times to acknowledge a complaint and provide a written response.
- The regional assurance manager had overall responsibility for ensuring the service responded to formal complaints within the agreed timeframe or keeping the complainant updated if there was a delay. The service acknowledged complaints within three days and provided a written response to the concerns within 20 days or an extension to the time frame was agreed directly with the complainant. The service had a Feedback policy (April 2015) which had two supporting procedures depending on whether the feedback was from a patient or a customer/ member of the public.
- From July 2015 to June 2016, the service received 42 complaints. The majority of these related to driving standards or events. The service monitored whether response times were within the target of 20 days. Over the same period, the service closed 28 complaints, 40% of these within 20 days; 29% took up to 180 days to resolve and close but a response was sent to all complainants within 100 days.
- A senior member of staff was allocated to oversee the investigation of each complaint, with a formal written response provided to the complainant, identifying the outcome and any actions taken. The service also offered the complainant the chance to talk with the manager about their complaint. Senior staff completed root cause analysis training to provide consistency in how they investigated complaints. A member of the regional team approved and signed the response prior to it being sent to the complainant.
- Senior staff told us that learning from complaints was shared at a local, regional and national level. We saw information on staff notice boards included learning from complaints. Minutes from regional meetings supported this but local team minutes did not contain specific learning from complaints. However, staff across the service could describe changes to practice because of complaints. This included completing a chest examination when a patient was lying on their front rather than turning them over and ensuring staff requested paramedic support promptly.

- We saw written information on how people could provide feedback on some but not all the vehicles we checked. In one area, staff passed on the name of their manager and their work address to people who wished to provide feedback.
- If a complaint was made to the contract ambulance provider about St John Ambulance, the provider would sometimes lead the investigation and reporting of the complaint or a joint investigation was completed. Minutes from contract performance meetings, included discussions and actions in response to feedback, including staff completing reflective statements to help them manage a situation differently next time it occurred.

Are emergency and urgent care services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high- quality person-centred care, supports learning and innovation and promotes an open and fair culture.

- There was a national vision and strategy for the service, which reflected the values of the organisation. Staff knew and understood the vision and values of the organisation.
- Governance arrangements had been reviewed nationally to fit with the quality strategy of the organisation, although they had not been fully implemented at the time of our inspection. Senior managers recognised the importance of more detailed monitoring and review of the quality and performance of the service, against a number of key indicators.
- Senior staff kept risk registers current, reassessing the level of risk once actions had been put in place.
- Staff told us leaders were competent, approachable and visible. They felt well supported by their immediate manager and found St John Ambulance a caring place to work. The approach of staff was to provide person-centred care.
- The service encouraged feedback from patients through satisfaction surveys and from volunteers and staff, through debriefing sessions, surveys and staff forums. There were a number of different newsletters sent to staff to keep them updated on clinical and organisational changes.
- There was a focus on the long-term stability of the service, with ideas for service development assessed to understand the impact to staff and patient safety, before they were introduced.

However:

- There was a very high turnover of employed staff over the last 12 months.
- Systems to ensure patient safety had not always been followed and two policies were out of date for review.
- There was no key performance indicator dashboard in use for the events service, to enable the quality of the service to be monitored.
- Although audits were completed, actions plans were not always in sufficient detail so managers could monitor progress to complete the actions, within the agreed timeframe.

Leadership of service

- There had been a number of changes to the regional management structure over the last year. In 2015, ambulance operations became a separate function, led by a regional manager, with a station lead and team leader for each location. At the time of our inspection, a reorganisation of the event first aid service was going through a restructure, to help the service achieve its strategy and to support a greater focus on quality.
- Staff spoke positively about the leadership of the service. They told us that leaders, at all levels, were visible and approachable. They felt leaders had the appropriate skills and knowledge for their role and managed their aspect of the service well.
- No staff raised concerns about being unable to access or speak with their immediate line manager. The team leader at one location managed staff at two sites but visited both sites each week to maintain regular contact with frontline crews. Staff felt confident to raise concerns to a more senior manager when appropriate. Volunteers told us they felt well supported by their district manager.
- We saw and staff told us the station team leader or station manager met with them each morning to pass

on information, prior to them starting their shift, this included positive feedback received from the public. However, there were no regular planned team meetings at each location, other than Guildford. We requested the last set of minutes for each location, none were provided for Bicester.

- Station managers had monthly area manager meetings with the regional manager, for support and sharing of good practice ideas. We saw information displayed at stations advising staff how frequently different levels of management met.
- There was a formal on-call rota in place, with managers providing cover one out of every six weeks. Staff knew the process to contact management out of hours.
- Managers were aware of issues, which may affect the quality of the service and took appropriate steps to address these. For example, having regular IT access at stations to support staff to complete their training. Managers told us they were proud of their teams and how staff worked together. One manager told us 'staff always wanted to do their best for the patient, even if this meant they ran late'.
- However, managers for the neonatal transfer and retrieval service did raise concerns that communication with St John Ambulance was sometimes difficult and it took time for the service to make changes. They did not feel St John Ambulance managers always understood the risks of their service and the impact of these risks to patient safety.

Vision and strategy for this service

- There was a national vision in place for the service 'No one should suffer for lack of trained first aiders'. This was supported by the five organisational values of humanity, excellence, accountability, responsiveness and teamwork (HEART).
- There was a national five year strategy to support the vision and values with the aim of more people receiving first aid when they need it from those around them. Regionally the service hoped to achieve this through five key areas of advocate, equip, teach, treat and transport.
- Senior staff were keen to ensure they focused resources towards the most needy and ensure services were developed with patients' needs at the centre but they remained financially viable as an organisation. They realised the importance of recruiting and keeping the right staff, to enable them to develop their services and deliver against the key areas.
- Staff we spoke with were aware of the vision and values of the organisation and how they could apply them in their role.

Governance, risk management and quality measurement

- The corporate strategy for the organisation had identified the need to improve how the service collected and used data to monitor the quality and performance of the service. The organisation had moved to centralised reporting to help with the identification of trends, with access to regional results to help areas make specific improvements to benefit patient care. The service acknowledged there was further work to be completed before reporting systems were robust.
- A national yearly audit programme was in place, introduced in April 2016, therefore, staff had completed some but not all the audits. The regional assurance manager was responsible for reporting to the national regional assurance meeting and the regional quality, risk and assurance group.
- Some audits we looked at had suggested actions but no formal action plan to enable senior staff to monitor completion of any agreed actions. There was no assurance senior staff escalated any outstanding actions.
- There was a national quality dashboard for ambulance operations, which include information such as number of incidents, complaints and safeguarding referrals. This information was also provided at regional level for comparison and monthly trend analysis. There was no equivalent dashboard for the events service.
- There was a regional and national risk register, with controls in place to reduce each risk. Staff updated the level of risk as further actions had been taken. Whilst the risk registers were in depth, the regional risk register tended to focus on potential risks, rather than key current risks for the area and how they would be addressed, such as structural issues at specific locations or difficulties recruiting to a specific event or shift.
- The majority of policies were in date for review. Employed staff and volunteers worked to the same set of policies to ensure consistency across the service. However, if a policy was updated, employed staff signed to confirm they had read it. There was no such process in place for volunteers
- Although there were procedures and policies in place for staff to report concerns to reduce potential risks to

patients and staff, we found an unlocked ambulance used to transport high-risk patients. The service had taken no action until we raised this as a concern at the unannounced inspection although staff had reported the fault.

- We saw minutes from local team meetings did not follow a standardised agenda to ensure consistency of reporting and inclusion of items such as learning from incidents and complaints.
- The service held monthly meetings with the contract providers to discuss service performance and areas for improvement as part of the contract agreement. We saw from minutes St John Ambulance were overall performing as expected. Senior staff told us they had requested a further breakdown of the data, to help them further monitor the quality of their service.

Culture within the service

- Staff told us and we observed a positive culture within the service. Staff clearly cared for, supported each other, and were comfortable in raising concerns. The majority of staff told us they enjoyed coming to work as their job was rewarding and they liked the team they worked with.
- Team leaders and senior staff were competent to manage staff performance. They took action if staff did not perform or conduct themselves to the expected standard.
- A number of volunteers had completed more than 10 years service. Some employed staff also volunteered at events and clearly had a sense of pride in the organisation they worked for.
- There was a culture that promoted the safety and wellbeing of staff. For example, if a manager could not staff a vehicle with two suitable qualified staff the vehicle did not go out.
- There was no internal occupational health service but staff could be referred to a private doctor who the service had a contract with. In a recent staff newsletter, staff were given details of a meditation and mindfulness smartphone app the service had purchased access to, to support staff wellbeing.
- Staff knew and understood the reasons for the recent changes to the leadership structure.
- A couple of staff told us although they felt able to raise concerns, change was sometimes slow due to 'the St John way' of doing things.

Public engagement

- The service had a web site with information for the public about what the organisation could provide. This included events cover and education for the public, for example first aid.
- There was information on the website about how people could give feedback and the process the service would follow should this be a complaint. There was also an on-line patient experience survey. This included questions on the cleanliness of the vehicle and whether people were treated with dignity and respect. Friends and family test data was also collected as part of the survey. Data from the survey was reported on nationally but could be filtered to give regional responses, to show specific areas for improvement.
- Feedback forms were available on some vehicles but staff told us the nature of their work meant it was often not appropriate to give these out. The service recognised there was a low engagement level with patient surveys and the value of the results due to this. The regional risk register showed the service had developed a patient feedback framework to help address this.
- The events team were planning to use online surveys as a way to increase feedback from event customers and identify ways they could improve the service. The target response rate was set to 10%.
- A family had been involved in discussions around the layout for a new vehicle to ensure it met the specific needs of the patient group using the service.

Staff engagement

- The service had a number of different ways of communicating and engaging with staff, including newsletters, emails and staff forums. Most staff told us they felt the service kept them informed and they could be involved with decisions that affected their team.
- There was a national newsletter sent to volunteers and employed staff, with further regional or operations specific newsletters. These contained information specific to each staff group, such as any changes to contracts, requests for cover at events and updates on clinical practice or training requirements.

- Volunteers attended weekly meetings, with an attendance register kept and monitored by the district manager. Volunteers who did not attend for a while were contacted to ensure they had received any updates and to check on their wellbeing.
- A number of employed and volunteer staff from each region supported national staff forums. A programme of quarterly meetings was in place. The service used the forums to enable staff to raise concerns and make suggestions for improvement with the national service leads.
- St John Ambulance service had a 'People recognition procedure' (2015) in place to recognise the hard work and commitment that all staff showed. A member of staff told us how they had recently been recognised and given a long service award.
- The training lead for events actively sought feedback following training sessions. In response to feedback, the training lead now organised the training so theory and practical sessions were interspersed. This was because staff found it easier to consolidate their learning if a practical session, immediately followed a theory session.
- Debriefs were held after events so volunteers could provide feedback and suggest changes for future events.
- The service had completed a staff survey in 2016. The results were compared with national results for other not for profit organisations. Across 11 indicators, the service was rated as very good for five (goal quality, task satisfaction, teamwork, learning and development and engagement), some concern for two (management effectiveness and involvement) and issues to be addressed for four (support, recognition, communication and change). Actions included making sure one to one meetings were held regularly and providing a quick reference guide for all policies and procedures. There was no detailed action plan in place to show who had responsibility for each action and the target date for completion.
- Data on turnover and sickness for paid staff showed from January 2016 to September 2016 showed 44 staff joined the organisation and 54 left; 492 days were lost to staff sickness. The service did not provide data on the rate of staff sickness. The organisation was aware of the risk of such a high staff turnover and included this on the regional and national risk register. Actions included a clear and well-defined role and person specification to ensure applicants understood all aspects of the role before they applied.

Innovation, improvement and sustainability

- The service had reviewed the different ambulance crew roles and had plans to revise these to meet the change in requirements from NHS ambulance trusts. It also hoped the additional training would help with staff retention, giving financial stability through retention of contracts.
- Regionally the service continued to identify additional events or contracts that the service could support. Also, some previous clients contacted the service to request working with St John Ambulance again. A review of staffing always took place prior to any discussions to ensure the service could safely meet the needs of all patients.
- The events service had introduced a national standardised tariff. This provided consistency for customers and helped the events management team better forecast and manage the sustainability of the service. If the profits from the event where going to charity then a discounted rate was offered.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Review the safeguarding training programme to ensure it meets all national recommendations and staff have completed the correct level of safeguarding children training for their role.
- Ensure policy and procedures are followed when vehicle defects are reported, to keep patients and staff safe.

Action the hospital SHOULD take to improve

- Provide a target compliance rate for mandatory training and appraisals and monitor compliance against this target.
- Ensure all volunteers have completed their mandatory training and received an appraisal.
- Provide a review process for staff working for the service on a casual basis.
- Review the provision of equipment for the safe transportation and care of children.
- Ensure all medicines are stored in accordance with regional policies and procedures.
- Ensure the multi-lingual phrase book is stored on all vehicles at all times to support patients to receive safe care and treatment.
- Consider providing a communication aid to support patients who are unable to communicate verbally.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance Regulation 17 (1)(2)(b) You are failing to comply with this regulation because the systems and process to mitigate the risks to the safety of service users had not been followed when staff reported a vehicle defect.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing Regulation 18 (1)(2)(a) You are failing to comply with this regulation because there was insufficient assurance the safeguarding children training programme met national recommendations. There was a potential risk staff had not received appropriate training for their role.