St. John Ambulance

St John Ambulance East of England Region

Quality Report

One Fox Crescent
Chelmsford
Essex
CM1 2BN
Tel:(01245) 265678
Website: http://www.sja.org.uk/essex

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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 known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

St John Ambulance East of England Region is operated by St. John Ambulance. The service provides patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 31 October 2017, along with an unannounced visit to an organised event supported by the service on 3 November 2017.

St John Ambulance East of England Region is part of St John Ambulance, a national first aid charity. St John Ambulance provides a number of services including first aid at organised events for example firework displays and professional football matches, emergency and non-emergency PTS, and first aid training. St John Ambulance East of England Region uses a blend of employees and volunteer staff. The objective of the organisation nationally is the relief of sickness and the protection and preservation of public health.

St John Ambulance East of England Region provides ambulance services across a number of counties in the East of England Region, through a contract with a local NHS ambulance trust. The service also provides an Acute Neonatal Transfer Service (ANTS), commissioned through a local hospital trust. St John Ambulance East of England Region provides first aid at organised events in the local area. Events are not within our scope of regulation and we do not inspect events. However, at some events, the provider transfers patients from an event for further medical treatment. Patient transport falls into our scope of regulation and thus require inspection.

During our inspection, we visited three ambulance stations (Chelmsford, Ipswich, and Cambridge) as well as the ANTS at a local NHS hospital. We also attended one organised event where St John Ambulance East of England Region staff provided cover.

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

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

The main service provided by this service was Patient Transport Services (PTS).

Services we do not rate

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

We found the following areas of good practice:

- Vehicles and ambulance stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- Servicing routines, Ministry of Transport (MoT) and insurance for ambulances were all up to date.
- Staff knew how to report incidents. The provider had a system in place to report incidents, and made changes because of incident reviews.
- Staff demonstrated a good understanding of their responsibilities around safeguarding.
- Staff carried out structured patient assessments and clinical observations, appropriate for their level of competence.
- Staff followed evidence-based care and treatment and nationally recognised best practice guidance. All staff had access to the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines 2016.
- The majority of staff within the organisation had received a recent appraisal.
- All staff received training on the Mental Capacity Act and the Deprivation of Liberty Safeguards as part of their induction. During our inspection staff asked patients for consent before starting treatment.

Summary of findings

- St John Ambulance had recently launched the national continuing professional development (CPD) portfolio to ensure staff had up to date skills and knowledge to carry out their roles effectively.
- We observed good multidisciplinary working between ambulance staff and other NHS staff when treating patients. We noted good co-ordinated care and transfer arrangements when handing the care over to NHS staff.
- Staff showed compassion, kindness, empathy and treated patients with dignity and respect throughout their treatment or care
- Staff had access to translation services for patients who may not speak English as their first language.
- The provider had a national vision, strategy, and values, which most staff were aware of and shared.
- The provider had a publicly accessible website, which contained information for the public including details of services offered and how to make a complaint.

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

- Staff did not complete safeguarding training to required levels.
- Audits and reviews of patient journeys did not take place for one of the NHS services.

Following this inspection, we told the provider that they should take some actions even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We have only inspected and reported on patient transport services (PTS) provided at St John Ambulance East of England Region. Urgent and emergency care services were a very small ad-hoc proportion of the activity of this provider therefore we have not reported on it as a separate core service. We have not rated this service, as we currently do not have the legal duty to rate independent ambulance services. However, we found: • Staff knew how to report incidents, the provider shared learning from these incidents with staff. • Vehicles we inspected were visibly clean and serviced appropriately; equipment was serviced and appropriate for patient use. • Staff assessed patient needs appropriately and care planning took into account individual needs and choices wherever possible. • Staff supported patients in caring and respectful ways at all times and involved them in their care. • Staff valued local leaders and felt part of a team working towards putting the patient first. However, • Staff did not complete safeguarding training to satisfactory levels. • The service did not audit or review patient journeys for one of the NHS trusts to whom they provided services.

St John Ambulance East of England Region

Detailed findings

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Detailed findings

Contents

Background to St John Ambulance East of England Region

St John Ambulance East of England Region is operated by St. John Ambulance. The service opened in 2012. It is an independent ambulance service based in Chelmsford, Essex. The service primarily serves the communities of Essex, Suffolk, Norfolk, and Cambridgeshire.

The service has had a registered manager in post since 2012.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,an Inspection Manager and two other CQC inspectors. Fiona Allinson, Head of Hospital Inspection, oversaw the inspection team.

Facts and data about St John Ambulance East of England Region

The service is registered to provide the following regulated activities:

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

We visited the St John Ambulance East of England Region head office and ambulance stations at Ipswich and Cambridge. We interviewed the senior managers at head office. We travelled with an ambulance crew whilst they were transferring patients. We visited an organised event where transport would be provided where necessary and checked a patient transport ambulance.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. We have inspected this service twice; the most recent inspection took place in January 2014. This inspection found the service was meeting all standards of quality and safety it was inspected against.

We spoke with 22 staff including; ambulance drivers, emergency transport attendants, volunteers, administrative and support staff and management. We spoke with one patient and one carer. During our inspection, we reviewed two patient report forms.

During the reporting period October 2016 to September 2017, the service reported:

- No never events
- Thirty-one clinical incidents, the majority of which resulted in no harm.
- Four complaints

In the period June to July 2017, the service conducted 580 patient journeys.

Detailed findings

The service employed 44 paramedics, 28 emergency medical technicians (EMTs), two patient transport attendants (PTAs), and 166 emergency transport Attendants (ETAs).

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

We have only inspected and reported on patient transport services (PTS) provided at St John Ambulance East of England Region. Urgent and emergency care services were a very small ad-hoc proportion of the activity of this provider therefore we have not reported on it as a separate core service.

We have not rated this service, as we currently do not have the legal duty to rate independent ambulance services. However, we found:

- Staff knew how to report incidents, the provider shared learning from these incidents with staff.
- Vehicles we inspected were visibly clean and serviced appropriately; equipment was serviced and appropriate for patient use.
- Staff assessed patient needs appropriately and care planning took into account individual needs and choices wherever possible.
- Staff supported patients in caring and respectful ways at all times and involved them in their care.
- Staff valued local leaders and felt part of a team working towards putting the patient first.

However,

- Staff did not complete safeguarding training to satisfactory levels.
- The service did not audit or review patient journeys for one of the NHS trusts to whom they provided services.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- There were no never events in this service between October 2016 and September 2017. Never events are serious incidents, where 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. Although each never event has the potential to cause harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Between October 2016 and September 2017 there were 31 incidents reported relating to PTS. The top two incident categories related to vehicles and staff health and safety.
- The organisation had an incident management framework policy and an incident reporting policy that set out how the organisation would learn from and act on incident reports from all personnel to improve the quality and safety of its service delivery. The policy set out the accountability, responsibility, and reporting arrangements for all staff in relation to incidents. This policy was under review at the time of our inspection following organisational learning from an incident within this region.
- Staff reported incidents using incident report forms. Incident forms were available to staff on-line and blank copies were available in the ambulance stations. Staff told us they reported all incidents to their team leaders. In addition, staff told us they would report incidents relating to the service provided to the local NHS ambulance trust directly to them. However, staff told us that feedback and learning from the incidents reported by staff to the local ambulance trust was limited.
- Staff reported incidents to the regional quality risk and assurance group for review on a monthly basis. Any serious incidents were reported to the national quality risk and assurance group on a quarterly basis in order that the effectiveness of the incident management framework could be monitored.
- Staff told us learning from incidents was cascaded to them in several ways, for example, at quarterly team meetings, displayed on notice boards and through email. Staff told us that most common incidents involved problems with vehicles.
- 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' and provide reasonable support to that person.
- The provider had no incidents requiring duty of candour. However, leaders we spoke with were aware of the actions they should take should a duty of candour incident occur.
- All staff received training in the duty of candour as part of the St John Ambulance staff induction. Staff knew of the duty of candour and could give us examples of when this was required.
- Leaders in the organisation told us there would be joint responsibility with the commissioning NHS Ambulance trust and St John Ambulance for the application of duty of candour if an incident occurred that required duty of candour.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service did not have a formal, clinical dashboard in place to monitor safety. However, the service did have systems in place to monitor the safety of the service. For example, relevant specialist teams review clinical and health and safety incidents with formal reports presented to the Audit and Risk Committee.
- At the time of the inspection, the service did not monitor care episodes for patients. There were systems, for example, to monitor the use of medicines in terms of level of stock, and for ensuring that only appropriately trained staff had access to medicines.
- The manager working at an event showed us that staff produced a summary record noting the numbers of patients seen by staff and any treatment given to individuals alongside whether or not patient transport was required. The manager fed the summary information into debriefing meetings and internal safety meetings.

Cleanliness, infection control, and hygiene

Patient transport services (PTS)

- The ambulance stations we visited appeared visibly clean. We checked eight vehicles; all were visibly clean and tidy.
- A national St John Ambulance infection control policy was in use, supported by procedures for staff to follow, which was underpinned by annual training.
- Managers were required to complete a quarterly infection control audit of their station buildings and complete an infection, prevention and control (IPC) action plan at the end of the audit and escalate any concerns.
- We reviewed hand hygiene audits for September 2017. Managers observed staff undertaking washing and drying their hands and using sanitising gels to ensure effective decontamination. The audit identified that all staff complied with correct hand hygiene in the majority of tasks observed.
- All staff completed infection control training on their induction. They had an assessment of their infection prevention and control knowledge and skills as part of their annual revalidation.
- Staff used disinfectant wipes to decontaminate equipment in between patients. Staff also had access to decontamination packs, kept on all vehicles in the event of a spillage of blood or bodily fluids.
- Staff completed daily vehicle checks, which included reviewing vehicle and equipment cleanliness. If staff found any deficiencies, they rectified these at the time. We saw evidence of completed daily check sheets and observed staff completing the checks on vehicles .The provider allocated staff 30 minutes at the end of every shift for cleaning of vehicles and equipment. Cleaning materials were available for staff to use for daily cleaning. The service used colour-coded buckets and single use mop heads for cleaning the vehicles in line with best practice guidance.
- All vehicles had stocks of personal protective equipment and sanitising hand gel. We observed staff following good infection control principles; they had arms bare blow the elbow when giving direct clinical care, wore gloves when appropriate, and used the sanitising hand gel.
- The provider had a policy for all staff to follow with regards to decontamination of their uniforms which required staff to launder their own informs. All staff we observed during our inspection had visibly clean uniforms.
- All vehicles inspected had single use disposable linen, including pillowcases, sheets, and blankets.
- The provider contracted an external company to carry out deep cleaning on all vehicles every six to twelve weeks, depending on the use of the vehicle. The external company also provided emergency decontamination on a call out basis. The deep clean process involved steam cleaning of vehicles to eliminate harmful bacteria. Set locations on the vehicle were swabbed pre and post deep clean to check if the process was effective. We reviewed records of deep cleaning kept on each vehicle we inspected which showed all had been recently deep cleaned.

Environment and equipment

- St John Ambulance used an external nationwide inspection, service, repair and recovery company to support all vehicles through a network of repairers. The provider had an up-to-date agreement for the provision of vehicle fleet management services between St John Ambulance and the external provider. We reviewed up to date vehicle maintenance schedules.
- We checked four defibrillators on vehicles, all of which had been serviced in line with the manufacturers guidelines and provider policy. However, one vehicle did not have paediatric defibrillator pads. This was raised with the team leader at the time of the inspection who arranged for the correct equipment to be placed on the vehicle.
- We checked the mattresses on four vehicles, which were generally clean and in good working order. However, one vehicle had a mattress with a tear that was exposing the fabric. This was escalated to the team leader at the location at the time of the inspection who removed the mattress and arranged for a replacement.
- The provider had an effective system in place for the Ministry of Transport (MOT) checks and the servicing of vehicles. The provider made appointments with their nominated vehicle service agents to carry out any work.
- The provider allocated staff 30 minutes at the beginning of every shift for vehicle checks. Every vehicle was subject to a vehicle daily inspection by the driver who used it. Staff recorded and reported faults and certain defects rendered the vehicles unfit for service as defined in the fleet policy. The manager checked all vehicles prior to use, following any repairs.

Patient transport services (PTS)

- All equipment including fire extinguishers had been safety tested and checked with stickers on the equipment clearly indicating the next testing date.
- Containers for the disposal of clinical waste and sharps were in place on each vehicle and we observed staff use these correctly. There were suitable facilities at all stations or the disposal of clinical waste, at the end of a shift.
- Vehicles were fitted with radio systems so that staff could maintain contact with each other at organised events. In addition, staff working on the NHS ambulance service contract had mobile phones and trust Airwave radios on which they received information about the patient.

Medicines

- The provider had a medicines management policy (dated 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.
- The national Medicines Management Lead and the Medicines Management National Advisory Group (MM NAG) took overall responsibility for medicines management policy and procedures. Each individual station manager was responsible for staff training and ensuring correct stocks of medicines were kept on vehicles and at each station through audits. Results of audits were passed to the regional compliance team to review and escalate to the national lead where necessary.
- Each ambulance had a small stock of general sales list medications (items available to buy over the counter such as Paracetamol). Staff stored these medications on the ambulance at all times in a red pouch within one of the emergency equipment bags. Staff told us, and we observed staff checked medicines against a stock list as part of the daily vehicle checks. Staff ordered additional stock from the central store at Chelmsford when required, and securely transported this to the staff at outlying stations.
- Medical gases were stored securely on the vehicles. Staff told us and we observed these being checked daily on the vehicles by staff.
- At each station, we noted oxygen was stored appropriately, clearly labelled, and locked in secure location outside the vehicle station.
- The service did not use or store any controlled drugs (CDs).

Records

- Ambulance staff completed patient report forms (PRF), based on the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines
- We observed staff completing PRFs for two patients, which were legible, complete accurate, dated, and signed.
- Information about special notes, such as, Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPR), were included as part of the patient records. Staff understood the need to review and hand over any patient information, including hospital notes, when a patient was transferred to a new provider.
- Records were stored in locked cabinets at each location. Staff sent PRFs by secure post to a national scanning centre for auditing, storage and archive purposes.

Safeguarding

- St John Ambulance had a national safeguarding directorate who had oversight of the activities of the regional safeguarding managers, district safeguarding officer and safeguarding team. The regional safeguarding leads received an extra week of safeguarding training, but this had not yet been transferred across to the guidelines stipulated in the Royal College of Paediatrics and Child Health safeguarding Children and Young People: roles and competence for health care staff Intercollegiate Document.
- St John Ambulance East of England had a regional safeguarding manager in post.
- Frontline staff could describe the signs of abuse, knew when to report a safeguarding incident, and knew how to do this. Service leads gave us examples of when they had made safeguarding referrals and there was an effective system to report safeguarding incidents.
- Staff reported safeguarding concerns at the time that they occurred and the national safeguarding team was responsible for onward referral of these concerns to other organisations, such as local authorities.

- The provider was in the process of instigating a safeguarding training programme at the time of our inspection. At the time of our inspection, 100% of staff had completed adult and children safeguarding training to level one. We saw information that demonstrated at that 69% of the ambulance operations had completed adult and children safeguarding training to level two.
- The provider implemented the current safeguarding policy in June 2016. Staff had a pocket guide, which included local contact details for safeguarding referrals. The pocket guide included useful flow charts to support staff in decision-making.

Mandatory training

- Staff completed mandatory training, which was a mix of e-learning and practical assessed courses. Both employed and volunteer staff completed mandatory training.
- We spoke with a training standards manager who showed us how they had oversight of staff training compliance. The provider held a training standards spreadsheet with records of compliance for each member of staff. Staff discussed this at a monthly managers' meeting to track staff progress. The provider gave staff continuing professional development folders for recording their own training and professional development.
- Mandatory training modules included medicines management, conflict management, information governance, safeguarding level 1 and safeguarding level 2. Staff took additional modules relevant to their role. Following our inspection, the provider supplied up to date training rates for employed ambulance staff for the end of December 2017. The deadline for the completion of mandatory training was 21 March 2018, with a target of 80%. Compliance rates were variable; for example, 77% of staff had completed information governance. However, 83% of staff had completed the medicines management course and 99% had completed conflict management.The average completion rate of mandatory training across the service for employed staff was 88.2%.
- St John Ambulance had a team of volunteer driver trainers for operational driver training, including response (blue light) training. The national headquarters and the Royal Society for the Prevention of Accidents (RoSPA) approved the trainers. Driver revalidation training as of November 2017 was 100% and was scheduled to be retaken every 60 months.

Assessing and responding to patient risk

- The provider issued all ambulance staff with a current pocket guide of the Joint Royal Colleges Ambulance Liaison Committee protocols 2016. This gave assurance that staff assessed patients against appropriate protocols.
- Staff completed structured assessments and clinical observations on patients, as part of their care and treatment to assess for early signs of deterioration. If a patient deteriorated, ambulance staff informed the receiving hospital's emergency department, so that hospital staff knew before the patient arrived.
- Staff completed online training in conflict management. This meant that they were aware of the need to use minimal restraint or force in response to aggressive or violent patients.
- Staff understood Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders and regularly checked for the presence of these when working patients who were receiving end-of-life care.
- The provider had a policy for managing patients at risk of deterioration, which staff were aware of and understood.

Staffing

- The ambulance operations manager and station managers reviewed staffing levels as part of their key performance indicator monitoring. Data was collected on a weekly basis and analysed at monthly meetings to identify any concerning trends in staffing levels.
- The service had location hubs in Chelmsford, Ipswich, Norwich, Cambridge, and Stevenage. The service provided Acute Neonatal Transfer Service ANTS cover 24 hours a day seven days a week. Managers arranged staff rotas in advance as required by the local NHS hospital trust. The service had sufficient employed staff to cover the number of shifts contracted for by the local NHS ambulance trust. Staff told us they normally received sufficient notice regarding any shifts or shift changes and recognised they delivered an ad hoc service, which was difficult to plan in advance.

- We found the provider monitored levels of staff sickness and staff turnover. In the last 12 months, there had been a redundancy programme due to changes in contracts with external clients.
- In the 12 months prior to our inspection the staff sickness absence ratio was 2.8%, which equated to a total days sickness absence of 128.

Response to major incidents

- The provider had a national policy for emergency preparedness, resilience, and response. The provider had protocols in place for supporting and assisting other services, including the NHS, in the event of a major incident. Planning for events considered the risk associated with a major incident and responses to them.
- The service had a local business continuity plan, which managers implemented in the event of an unexpected disruption to the service.

Are patient transport services effective?

Evidence-based care and treatment

- Staff followed national guidelines, which included the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and National Institute for Health Care and Excellence (NICE) guidelines.
- Staff showed us they carried copies of the JRCALC guidelines with them. They told us they regularly used these documents as a point of reference for providing patient care.
- We observed staff had access to information on specific care pathways and protocols in the staff room. For example, printed documents were available describing end-of-life care guidance, stroke and asthma management, as well as hypoglycaemic warning signs and treatment. The staff we spoke with knew of these guidance documents.
- The organisation had received accreditation from The International Organisation for Standardisation (ISO) 9001:2008 for quality management systems. This included the design and development of training courses in health and safety related topics.

Assessment and planning of care

- Patient transport journeys were co-ordinated through an internet-based system when the provider was working with an NHS trust contract. Key information about the patient was supplied by the service user or their healthcare provider and call centre staff reviewed this information to ensure a safe transfer. For example, staff noted Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, requirements for oxygen therapy, or diagnoses that might affect the type of care provided, such as the presence of dementia or mental health diagnoses. Staff used this information, together with discussions with staff at the discharging service, the patient, and their relatives, to plan each journey and complete the transfer safely and with minimum discomfort to the patient.
- The provider did not transport patients who were detained under the Mental Health Act.
- The staff we spoke with knew of a range of different protocols for supporting patients with different diagnoses, or complex needs, including mental health issues. We observed information was available at each ambulance station to support this process.

Response times and patient outcomes

- We asked the provider how they monitored response times and patient outcomes. They confirmed that they monitored this data for the NHS ambulance trust. However, the trust did not audit or review the results of the data.
- The service monitored some relevant activities as part of their internal key performance indicators. This included the number of patient journeys completed, the number of cancelled shifts, any variance in contracted hours, staff sickness rates, and numbers of vehicles out of operation. The management team regularly reviewed this data to identify areas for action.

Competent staff

- The service had an induction policy for all new staff. Records showed that staff were required to complete key areas of training, in line with the induction policy, prior to becoming operationally active. Staff we spoke with had completed the induction process in line with the policy.
- Line managers were responsible for checking the Health and Care Professions Council registration and revalidation of qualified staff.
- Staff completed two full Continuing Professional Development (CPD) days training each year. This covered parts of the mandatory training and tests for

revalidating skills. There were additional online training modules which staff were required to complete. The provider set an 80% target for staff completion of CPD for the period January to December 2017. For the period January to June 2017, 52% of staff had completed the required CPD, which was above the provider target of 40% for this period.

- The content of the CPD days and mandatory training programmes were tailored to meet staff needs based on an annual training review. During the review, the training standards manager collated information from staff at all levels of the organisation to plan what additional training would be most beneficial for staff. For example, this had led to the provision of additional training in relation to some incidents, and training in completing patient report forms.
- If staff failed to complete the revalidation programme, or any other required training elements, this linked to a performance pay award and resulted in individuals becoming non-operational.
- All staff had an annual performance development review, alongside an interim review every six months, one to ones, and supervision sessions. These reviews gave staff the opportunity to discuss any training needs and areas for development.
- The provider had a process in place to complete driving license checks and recorded drivers in the provider's National Driver and Fleet register (NDFR). The system recorded their full details including qualifications, medical status and eyesight tests and contained scanned copies of the relevant documents. It also stored information regarding driving infringements, incident investigation, and outcomes. The NDFR system emailed reminders of pending licence expiries to regional managers, and the specific drivers. The managers reviewed this information at monthly meetings to address any concerns.
- The provider expected volunteers to meet the same standards for training as employed staff

Coordination with other providers and multi-disciplinary working

- Staff completed the NHS ambulance trust's patient report forms. However, the local trust did not provide audit results or feedback on the quality and accuracy of the forms.
- We observed good multidisciplinary team working between ambulance staff and other NHS staff when treating patients. We noted good co-ordinated care and transfer arrangements when handing the care over to NHS staff.
- We spoke with staff at a hospital where the St John Ambulance staff worked on the day of the inspection. They were happy with professionalism of staff on the day and commented that they were satisfied with St John Ambulance staff on all previous occasions.
- We observed that the ambulance staff asked hospital staff appropriate questions to make sure they understood the patient`s needs.
- Staff checked they had received the correct documentation at handover points and knew how to raise issues about the completeness of patient information, if necessary.

Access to information

- Staff had access to policies and standard operating procedures at each ambulance station.
- The call centre provided ambulance staff with key information and special notes regarding care plans. For example, staff were explicitly made aware if a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place.
- Vehicles used an airwave handset and a satellite navigation system, linked to the local NHS ambulance trust. This meant that staff liaised promptly with the service about vehicle and staff whereabouts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had formal policies describing consent processes, as well as protocols for following the terms of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The service provided staff training on these topics as part of the package of Level one and Level two Safeguarding courses. However, compliance with training rates was below acceptable levels. Which was?
- Staff we spoke with had good knowledge about the importance of understanding patients' mental capacity, how they could act in line with 'best interest' decisions, and the importance of involving patients in decisions about their own care, wherever possible.

Patient transport services (PTS)

Are patient transport services caring?

Compassionate care

- Two of our inspectors travelled in patient transport service (PTS) ambulances during the inspection. At all times during the journeys the ambulance care assistant interaction with patients and relatives was respectful and positive.
- Information recorded by call handlers in the call centre during their initial contact with the service users ensured that care was patient centred and took into account of holistic health needs in order to provide a journey that took account of patients needs.
- We observed staff maintaining patients with dignity and privacy, for example by using privacy curtains and keeping ambulance doors closed while treating patients.

Understanding and involvement of patients and those close to them

- At all times during interactions with patients, ambulance care assistants encouraged patients to engage with them and make decisions about their own care. We observed staff encourage patients to fasten seat belts, choose their seating position, and check their comfort levels.
- Ambulance care assistants spoke respectfully with patients to explain what they were doing with the patient and why, including safety details regarding the vehicle journey and offered reassurance where necessary.

Emotional support

- Staff described how they would provide support to patients and relatives during transfers, for example, by offering extra emotional support to service users that were particularly anxious or nervous about their journey or appointment.
- The service did not routinely transport deceased patients. However, all patient transport staff completed a training module on care of the deceased and management of bodies, which focused on looking after the deceased with care and dignity and behaviour with relatives and friends should they transport a deceased patient.
- We reviewed the complaints and compliments register for 2017, which included 15 compliments for staff on their support during journeys to hospital.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- At the time of inspection, the service held contracts with two local NHS trusts to transport patients from home to hospital or between hospital sites. The number of vehicles provided varied on a day-to-day basis depending on the needs of the service.
- The NHS trusts and St John ambulance checked that they were meeting the agreed number of contracted hours and reviewed the number of patient journeys made at contact meetings.
- The provider adjusted staffing levels, shift patterns, and availability of vehicles in line with the NHS trust contract's requirements.
- The managers monitored resource issues including staff availability, staff sickness rates, and numbers of operational vehicles at each location. Managers checked if the service met the correct number of contracted hours stated in the NHS contracts, as well as the number of patient journeys made. Senior staff reviewed the journeys each month to ensure contract fulfilment.

Meeting people's individual needs

- All information received as part of the patient booking process was communicated by the call centre booking team to the ambulance staff and additional conversations were held between ambulance staff from different services at handover points.
- A telephone interpreting service was available at all times and staff knew how to arrange the service.
- The staff we spoke with showed sensitivity in balancing patients' health, spiritual and cultural needs.
- Staff told us, and we observed staff discuss patient's requirements and preferences and made practical adjustments, to meet individual needs prior to transporting patients. For example, staff planned longer journeys with comfort breaks, and provided both seated and stretcher vehicles.

- All vehicles carried communication aids, such as picture charts, to support non-verbal communication.
- The provider arranged for staff to complete specific training, such as in dementia care, to meet their patients' needs. This training included discussions around managing and supporting vulnerable adults. However, no staff at this location had completed the training at the time of the inspection.

Access and flow

- The provider collected data for the Acute Neonatal Transfer Service (ANTS) with emphasis on shift over runs for service safety. This allowed the provider to change shift allocations, maintaining staff wellbeing and patient safety.
- The NHS trust was responsible for monitoring of delivery of the second contract. However, the trust has not shared this data with the provider. The trust concerned have not raised any concerns regarding the delivery of the service. At the time of the inspection, St John Ambulance did not perform monitoring of access and flow for this contract themselves.
- The service had additional vehicles at each location we visited to ensure that the service could continue in the event of vehicle breakdown.
- Call handlers at the Ipswich location handled bookings from the local NHS ambulance trust to ensure the service had sufficient and appropriate vehicles and staff to transport the patients. A request would then be sent to station managers to allocate appropriate vehicles and rota staff to fulfil the required shifts.

Learning from complaints and concerns

- The provider had a formal complaints policy. Staff responsible for managing complaints knew of this policy and evidenced they acted in line with it when we interviewed them at the time of the inspection.
- Ambulance staff carried leaflets with them to hand out to patients on how to complain or provide service feedback.
- The ambulance trusts that the provider worked with forwarded information about any complaints they received in relation to St John Ambulance staff.
- The provider had a regional assurance manager with overall responsibility for ensuring the service responded to formal complaints within the agreed timeframe, and for keeping the complainant updated if there was a delay.
- The local ambulance station manager was responsible for investigating complaints at their station, such as collecting evidence and statements from staff. They reported the outcome of the investigation to the assurance manager.
- The policy stated the provider would send a complaint acknowledgement to patients within three working days of receiving the complaint. The provider would complete a root cause analysis (RCA) investigation and provide a full response to patients within 20 working days.
- If one of the NHS ambulance trusts received a complaint, which involved St John staff, then there was a process for sharing the information in a timely manner. Staff told us that, where necessary, there was a process for joint investigation and learning. The provider had a process for involving a sub-contracting organisation such as the NHS ambulance trust in complaints investigation and learning.
- We noted that the service had received four formal complaints in the past year and the provider dealt with all of them in line with its complaints policy.
- Staff told us that the provider shared learning at team meetings and supervisions from complaints and arranged any additional training.

Are patient transport services well-led?

Leadership / culture of service related to this core service

- The provider had carried out a review and reorganisation of the senior management and regional management structures within the organisation; this led to the formation of four "Super regions" including the East of England region.
- The management team in this region consisted of a sector manager for Ambulance Operations and a sector manager for Events Operations; supported by a station managers, service delivery co-ordinators, and station team leaders.
- We spoke with the registered managers who had oversight of all operations in the East of England and were accountable for providing good quality of care. The registered manager was aware of the current risks to the provider and understood the challenge to staff going through an uncertain period of change.

Patient transport services (PTS)

- There had been a period of service transformation, due to restructuring by the provider and changes to local contracts. This had a direct impact on frontline staff, which included some redundancies and staff transferring within the organisation.
- Staff we spoke with were positive about the leadership team, and were able to identify their roles and responsibilities. Staff told us the management team were approachable and they were comfortable escalating any concerns.
- One member of the management team told us he also volunteered for active work on ambulances at events, which gave him an appreciation of the wider work of the service.
- We observed members of staff interacting well with the management team during the inspection.
- The provider had appropriate reporting procedures for staff to escalate concerns about co-workers and colleagues through a whistleblowing policy.

Vision and strategy for this this core service

- St John Ambulance is a national organisation, which promotes itself as "The nation's leading first aid charity". The overall mission for the organisation is, "Everyone who needs it should receive first aid from those around them. No one should suffer for the lack of trained first aiders."
- In 2016, the provider launched a new five-year strategy to support the direction of changes to the organisation. The strategy included further reorganisation to the business. For example, in the past year there has been a review and reorganisation of senior management and regional management structures.
- The provider has also developed a set of core, organisational values to share and promote with staff at all levels including humanity, excellence, accountability, responsiveness, and teamwork (HEART). The staff we spoke with knew the core values, and these were widely advertised on posters throughout the locations that we visited.
- Staff at all levels had an awareness of the structural reorganisations and associated changes to the planning of the business and felt they were helping to improve performance and mitigate risks, for example by ensuring sufficient and appropriate vehicles and equipment were accessible when required.
- Staff and management acknowledged difficulty around retaining staff and managing morale during a period of change in the organisation. However, the majority of staff we spoke with were content with how these changes were being managed by the organisation.

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

- The provider had a governance framework in place with associated staff policies and protocols. Staff understood these frameworks and procedures well. This ensured, for example, the timely reporting, and investigation of incidents and safeguarding concerns.
- The provider held monthly governance meetings locally, which fed into the national governance meetings. Content of the governance meetings was sufficient to ensure that the discussions held supported the delivery of good care.
- The service had undergone restructuring in 2016 and the new quality and standards directorate had recently commenced work. The service told us this directorate focussed on consolidating and strengthening the activities of the health and safety, clinical and audit and assurance functions under one directorate, this would provide a stronger governance framework.
- The provider held risk registers for each specific directorate within St John Ambulance, these fed into the national St John Ambulance risk register when the risk was high.
- We looked at the national and the regional risk register for ambulance operations. The registers we reviewed were up to date and included actions assigned to staff members to mitigate the risks highlighted. Progress against the actions to mitigate risks was recorded and up to date. The regional assurance manager met regularly with the registered managers to review the risk registers and ensure mitigating actions remained appropriate. Safeguarding training was one of risks that had been identified as a risk and plan had been put in place to roll out the new training package to all staff to ensure they met the national guidelines.
- The provider managed maintenance contract for vehicles through a set of key performance indicators (KPIs). KPIs are measurable and demonstrate how well

an organisation is performing. The provider reviewed KPIs monthly and acted upon them appropriately. The regional teams handled extraordinary incidents through a direct contact with the contract provider.

- The provider undertook other of audits to identify areas for improvement, for example, audits for infection control and maintenance of vehicles. The provider shared learning from audits through the intranet and via posters.
- We found that the service had limited systems for monitoring the quality of the clinical care provided. We also noted the service did not routinely monitor the promptness of their service, for example, in terms of turnaround or response times for all patients. However, the service had not received any complaints regarding response or turnaround times for patients. The systems the service did have in place to monitor the safety of the service, included an incident management framework in which the relevant specialist teams review clinical, health and safety incidents, with formal reports presented to the Audit and Risk Committee.
- The provider was piloting a clinical audit tool based on clinical outcomes at the time of our inspection, which can map and review across both events and patient transport.
- Staff knew how to escalate concerns to the NHS or St John clinical teams to access advice if a patient's health rapidly deteriorated during transfer so that an appropriate plan for management could be made.

Public and staff engagement (local and service level if this is the main core service)

- The provider had a number of systems in place to keep staff informed and receive feedback from their staff. For example, there was a monthly staff newsletter, staff intranet, and regular staff meetings at all levels of the organisation.
- The provider identified staff requiring extra support through supervision and appraisal procedures, as well as through ad hoc contact with line managers. The provider ensured staff had access to services that supported their mental wellbeing, for example, following attendance at a traumatic patient transport event.
- Ambulance crews carried feedback forms, as well as copies of the complaints procedures to distribute to patients, as required. Patients had the option to return written feedback by post to the main location base. The station manager monitored the information received monthly. In addition, monthly reports were produced from patient feedback and relevant information shared with staff to facilitate improvements in the quality of the service.

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

- The service created a national continuing professional development portfolio, which the provider was rolling out nationally for use by all full time and volunteer staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should take appropriate actions to consistently monitor the quality of services, including the audit and monitoring of staff performance.
- The provider should take actions to improve compliance in safeguarding training.