British Red Cross Society

British Red Cross Paddock Wood

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.

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

British Red Cross Paddock Wood is operated by British Red Cross Society. This location provides emergency and urgent care only. British Red Cross Paddock Wood has two satellite sites based at Redhill and Canterbury.

We inspected this service using our comprehensive inspection methodology. We carried out this announced inspection on 22 February 2018.

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.

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:

- Staff prided themselves on giving compassionate care and treating patients in an empathetic way, with a strong ethos of humanism. We observed staff providing compassionate care in all interactions with patients. Patient feedback we reviewed demonstrated a high level of patient satisfaction.
- The service took action to meet patients' individual needs. This included patients that did not speak English, refugees and patients with learning disabilities.
- All staff had undertaken a comprehensive induction programme and mandatory training in key areas to provide them with the knowledge and skills they needed to do their jobs safely.
- All crew members completed regular continuing professional development to refresh their clinical skills and allow them to develop new ones. A crew member had developed a preceptorship programme for emergency care support workers, which the provider was considering rolling out to all locations.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. All vehicles we inspected were visibly clean, and we saw evidence of deep-cleaning every eight weeks or sooner if needed. Staff demonstrated clear understanding of their daily duties in relation to cleanliness and infection prevention and control, which was in line with the provider's infection prevention and control policy. Vehicle and premises audits provided monthly assurances around cleanliness.
- Staff understood how to protect patients from abuse and the service worked well with the subcontracting NHS ambulance trust to do so. All staff had training on how to recognise and report abuse and gave examples of times they had raised safeguarding concerns.
- Staff completed clear and thorough records of patients' care and treatment. The service stored records securely to protect confidentiality. Monthly records audits provided ongoing assurances around clinical practices and standards of record keeping.
- We saw evidence the service had clear processes to keep vehicles and equipment safe and to meet the legal requirements relating to vehicles. This included evidence of annual MOTs, and regular servicing and maintenance.

Summary of findings

- The culture of the service encouraged openness and candour. Staff demonstrated a willingness to report incidents and raise concerns. Staff received feedback and any relevant additional training to ensure the service learned from incidents to improve patient safety.
- All staff spoke highly of the local leadership and culture. The service took concerns seriously and took action to address them.
- Managers demonstrated an understanding of risks related to the service. We reviewed the risk register and regional management meetings minutes, which demonstrated ongoing oversight of quality and governance issues such as policies, risk management and human resources.

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

- The British Red Cross pocketbooks staff used for clinical guidance did not reflect up-to-date national guidance in one area by not specifying that ibuprofen was contraindicated for patients with suspected chicken pox. However, the service delivery manager told us, and we saw on the provider's risk register, that the provider was in the process of reviewing all clinical guidance to ensure it met the most up-to-date national guidance and best practice.
- The trolley harness had visible signs of wear and fraying on one ambulance we inspected. In another ambulance, we saw the excess ends of the trolley harness were also beginning to show signs of wear. However, we raised this issue with the registered manager, who immediately ordered replacement trolley straps.
- In 10% of "vehicle and equipment check sheet and cleaning logs" we reviewed, there were some gaps where staff had not documented every check. This meant the service did not have assurances all staff completed every daily vehicle check on every shift in line with the target of 100%. However, the remaining 90% of check sheets were fully completed.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South), 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?
Emergency and urgent care services		The only core service provided was urgent and emergency services. The service had a contract with an NHS ambulance trust, and 100% of the service's activity was subcontracted from the commissioning trust.The commissioning NHS ambulance trust triaged 999 calls and allocated appropriate jobs to British Red Cross Paddock Wood crews as part of a subcontracting agreement. Between January and December 2017, British Red Cross Paddock Wood carried out 10, 053 ambulance responses. We found many areas of good practice, including highly compassionate care, meeting patients' individual needs and a culture that encouraged openness and candour. Staff demonstrated a willingness to raise concerns, report incidents and learn from them. The service took concerns seriously and took action to address them. All staff we met spoke positively of the local leadership and culture. Where we identified areas the service should improve, such as two trolley harnesses showing signs of wear and tear, we saw the service took immediate action to rectify these issues following our feedback.

British Red Cross Paddock Wood

Detailed findings

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Detailed findings

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Background to British Red Cross Paddock Wood

British Red Cross Paddock Wood is operated by British Red Cross Society. The service registered at this location in April 2017. The service previously operated out of a registered location in Canterbury between 2014 and 2017. Before this, the service operated out of a registered location in Worthing after it first registered with the Care Quality Commission in 2013. It is an independent ambulance service in Paddock Wood, Kent. The service primarily serves the communities of Kent, Surrey and Sussex.

The service has a registered manager, Claire Hewett, who had been in post since April 2017.

We carried out an announced inspection on 22 February 2018. This was the service's first inspection since it moved to the registered location in Paddock Wood in April 2017.

Twenty-six members of staff worked at the service. There were 20 crew members consisting of emergency care support workers and technicians, three crew team leaders, two coordinators and a service delivery manager.

The service used 12 ambulances to carry out the regulated activities from the registered location in Paddock Wood and two satellite sites in Redhill and Canterbury. The ambulance station at Paddock Wood operated 24 hours a day, seven days a week. Eighteen members of staff were contracted to work from Paddock Wood, and seven vehicles were based there.

The ambulance station at Redhill operated seven days a week, with three vehicles allocated to this base, responding to patients in the Redhill and Crawley areas. Eight members of staff were based at Redhill. The ambulance station at Canterbury operated between the hours of 7am and 10pm as needed according to the commissioning NHS trust's need for cover in this area. The remaining two ambulances were based in Canterbury.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise as a paramedic. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Detailed findings

How we carried out this inspection

During the inspection, we visited the registered location and ambulance station in Paddock Wood. We spoke with six members of staff including emergency care support workers, technicians and the service delivery manager, who was also the registered manager. We observed two patient journeys. We also received five 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed five sets of patient records and other information including policies, training records and performance data.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The only service provided by this location is emergency and urgent care. All the service's activity is subcontracted through a local NHS ambulance trust. The service is registered to provide the following regulated activities:

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

During the inspection, we visited the registered location and ambulance station in Paddock Wood. We spoke with six members of staff including emergency care support workers, technicians and the service delivery manager, who was also the registered manager. We observed two patient journeys. We also received five 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed five sets of patient records and other information including policies, training records and performance data.

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

Activity (January to December 2017)

- In the reporting period January to December 2017, the service made 10,053 ambulance responses. Calls to 999 came into the commissioning NHS ambulance trust's emergency operations centre. Staff at the commissioning trust triaged calls and dispatched British Red Cross Paddock Wood crews where appropriate, as part of their subcontracting agreement.
- The service did not administer or store any controlled drugs because it did not employ any registered healthcare professionals such as paramedics.

Track record on safety

- The service reported no never events during the reporting period January to December 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service reported 112 incidents during the reporting period January to December 2017. Of these, 28 resulted in no harm, 59 resulted in low harm (classed by the service as resulting in minimal harm) and 23 resulted in moderate harm (classed by the service as resulting in short-term harm). There were no serious injuries during the reporting period.
- The service received no complaints during the reporting period January to December 2017.

Emergency and urgent care services

Summary of findings

The only core service provided was urgent and emergency services. The service had a contract with an NHS ambulance trust, and 100% of the service's activity was subcontracted from the commissioning trust.The commissioning NHS ambulance trust triaged 999 calls and allocated appropriate jobs to British Red Cross Paddock Wood crews as part of a subcontracting agreement. Between January and December 2017, British Red Cross Paddock Wood carried out 10, 053 ambulance responses.

We found many areas of good practice, including highly compassionate care, meeting patients' individual needs and a culture that encouraged openness and candour. Staff demonstrated a willingness to raise concerns, report incidents and learn from them. The service took concerns seriously and took action to address them. All staff we met spoke positively of the local leadership and culture.

Where we identified areas the service should improve, such as two trolley harnesses showing signs of wear and tear, we saw the service took immediate action to rectify these issues following our feedback.

Are emergency and urgent care services safe?

Incidents

- The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Staff reported incidents using an electronic incident reporting system. Crew members all had a login for the electronic system and submitted details of incidents from one of the computers at the office. Crews also told us they could alternatively complete a paper incident form and place this in a secure post box in the office at the end of their shift. The service delivery manager or a coordinator subsequently transferred details of the incident onto the electronic system. All staff we spoke with could describe the process for reporting incidents and gave examples of incidents they had reported.
- The service investigated incidents and shared lessons learned with the whole team where appropriate to help improve safety. The service delivery manager reviewed all incidents and either investigated them herself or assigned them to a relevant investigating officer. For example, the provider's national clinical governance lead investigated any incidents concerning clinical practices. Staff told us the service delivery manager gave feedback verbally and by email and shared any relevant learning following incidents. Staff could give examples of learning and changes to practice following incidents. This included setting up defibrillators in manual rather than automatic mode to prevent any delays in assessing patients, and manual handling refresher training following several incidents of staff experiencing back strains. This demonstrated the service took action to learn from incidents to improve patient and staff safety.
- The service's incident log showed the service reported 112 incidents in the period January to December 2017. Of these, 28 resulted in no harm, 59 resulted in low harm (classed by the service as resulting in minimal harm) and 23 resulted in moderate harm (classed by the service as resulting in short-term harm). We saw that most of the moderate harm incidents involved injuries to staff or vehicles and equipment rather than patients. No incidents resulted in severe harm. There was one

serious incident involving inappropriate use of blue lights. We saw that the service took action against the staff member responsible and reported to the relevant professional body to ensure this did not happen again.

- The remaining two incidents between January and December 2017 involved patient deaths. However, we reviewed both incidents and saw that for one incident, the patient had already died when the crew arrived on scene. There were no delays in the service's response. For the other incident involving a patient death, the patient died under the care of a local hospital following a cardiac arrest after transfer to the hospital emergency department. We saw that the crew had transferred the patient to hospital appropriately, monitored the patient and immediately escalated the patient's deterioration while waiting to handover to hospital nurses.
- The service did not report any never events in the reporting period January to December 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The registered manager demonstrated their understanding of regulatory duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. 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 them with reasonable support. No incidents during the reporting period had triggered duty of candour. However, the service delivery manager was able to describe the process for applying duty of candour should the need arise. This included providing support to the patient and their family, and the British Red Cross UK director sending a letter of apology. This was in line with Regulation 20 of the Health and Social Care Act (Regulated Activities Regulations) 2014.

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. All staff attended two mandatory continuing professional development days per year and three additional training days. As part of this, the service required all staff to undertake an annual assessment in basic lifesaving. Data provided by the service showed 100% of staff attended mandatory training sessions between January and December 2017. Mandatory training included the following areas: Infection prevention and control, safeguarding vulnerable adults, safeguarding children, mental health (two-day course), conflict resolution, resuscitation, trauma, medical conditions, first aid updates, chronic conditions and clinical waste management. The mandatory training sessions included medicines updates. We also saw copies of training certificates providing evidence of training updates in all four staff files we reviewed.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with the subcontracting NHS ambulance trust to do so. Staff had training on how to recognise and report abuse and knew how to apply it. The service raised 56 safeguarding concerns between January and December 2017. All staff we spoke with gave examples of safeguarding concerns they had identified and reported. This demonstrated staff were able to recognise and respond to safeguarding concerns to protect adults or children at risk.
- Data provided by the service showed 100% of staff completed safeguarding vulnerable adults level two and safeguarding children level two training. As the service did not employ any paramedics, this was an appropriate level of training in line with the national intercollegiate, "Safeguarding children and young people: roles and competences for health care staff" (third edition: March 2014). The intercollegiate guidance outlines level two as being the relevant level of safeguarding children training for ambulance staff excluding paramedics (as paramedics additionally required level three training). This meant all staff had the relevant level of safeguarding training in line with national guidance to allow them to recognise and respond to safeguarding concerns.
- All staff we spoke with could describe the process for reporting safeguarding concerns. Crews completed a "vulnerable person's report form", and we saw blank copies of these forms available on vehicles we inspected. Crews submitted the vulnerable person's

report form with the patient report forms and other paperwork for that shift into the secure post box inside the office. The service delivery manager or a coordinator transcribed details of the concern onto the electronic incident reporting system. This ensured the service retained details of all safeguarding concerns raised. The service delivery manager or a coordinator subsequently delivered the vulnerable person's report form to the nearby make ready centre belonging to the subcontracting NHS ambulance trust.

- The subcontracting NHS ambulance trust investigated all safeguarding concerns and made onward referrals to the relevant local safeguarding authority where applicable. For any safeguarding concerns where a patient was at immediate risk, staff told us they would convey the patient to hospital so they were in a place of safety and handover details of the concern to hospital staff. Alternatively, they would contact the clinical support hub at the subcontracting NHS ambulance trust and request for a paramedic to review the patient and make an immediate onward referral to the local safeguarding authority or police. Staff could also contact the British Red Cross national safeguarding leads for vulnerable adults or children for advice. All staff we spoke with could identify the safeguarding leads, who were trained to national safeguarding level four.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. We inspected three ambulances, which were all visibly clean and tidy. We also inspected equipment and medicines stores and the sluice, which were all visibly clean and tidy. Staff were able to describe the daily and weekly cleaning tasks they undertook to keep vehicles and equipment clean. We saw that this was in line with the provider's corporate infection prevention and control policy. We also observed staff cleaning ambulance equipment such as trolleys in between patients in line with the infection prevention and control policy.
- Staff completed a section on the daily "vehicle equipment check sheet and cleaning log" to confirm they had cleaned the inside and outside of their vehicle after every shift. We reviewed copies of completed check sheets, which provided assurances of daily cleaning.
- All ambulances had a deep clean every eight weeks through an external cleaning company, or sooner in the event of any significant contamination with blood or bodily fluids. This was in line with the provider's corporate infection prevention and control policy, which specified each vehicle should have a deep clean at least once every three months. We saw the deep-clean schedule, which showed the service had scheduled deep cleans for all vehicles every two months for the rest of the year. We also saw deep cleaning reports, which provided evidence of deep cleaning in line with the policy. This provided assurances around vehicle cleanliness.
- Audits showed a high level of cleanliness and compliance with the infection prevention and control policy. The service randomly selected one or two vehicles for audit each month. Vehicle audits for November 2017 to February 2018 showed 100% compliance with interior and exterior cleanliness. This provided further assurances around vehicle cleanliness.
- The service carried out monthly premises infection prevention and control audits at the registered location. These audits assessed the cleanliness of the equipment and medicines stores, crew areas, the availability of personal protective equipment and the vehicle cleaning areas. We reviewed audit results for November 2017 to February 2018, which showed 100% compliance in all areas. This provided assurances around the cleanliness of the ambulance station.
- Staff used control measures to prevent the spread of infection. Alcohol hand sanitiser was available on all vehicles we inspected. We saw staff cleaning their hands in line with the World Health Organisation's "Five moments for hand hygiene", such as before and after direct contact with patients. Staff were 'bare below the elbows' to allow effective hand cleaning in line with best practice. This helped protect patients from infection.
- The service carried out monthly hand hygiene audits where they randomly observed a member of staff decontaminating their hands. As the audit took place at the ambulance station rather than out on the road, crews were also required to describe when they would decontaminate their hands to demonstrate ongoing knowledge and understanding of corporate policy and best practice. The audit also included a 'bare below the elbows' assessment. Audit results for November 2017 to

February 2018 showed 100% compliance. This meant the service had assurances staff decontaminated their hands effectively and were compliant with policies and best practice to protect themselves and patients from infection.

- We saw a range of personal protective equipment available on the ambulances we inspected. This included disposable gloves, aprons, and helmets. We also saw spill kits for the cleaning of bodily fluid spillages.
- All crew members we spoke with wore clean uniform. Staff had clean uniform and shower facilities available at the ambulance station should they need to change partway through a shift following contamination with blood or bodily fluids.
- We saw clinical and non-clinical waste was segregated correctly into different coloured bags. We saw that staff had correctly assembled, dated and labelled sharps bins that were in use and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks. These practices were in line with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.

Environment and equipment

- The service maintained its ambulances to keep them safe and fit for purpose. We saw evidence of up-to-date MOT testing for all vehicles, which provided assurances they met the minimum legal requirements. We saw evidence of servicing and maintenance for all except two vehicles. The registered manager explained that the service purchased these vehicles already serviced in September 2017. Therefore, these two vehicles were not yet due an annual service at the time of our visit. We saw the service's tracker for vehicles and equipment servicing. This helped the service ensure they booked all vehicle and equipment servicing in a timely way.
- The service maintained all equipment to keep it safe and fit for purpose. We saw servicing stickers on equipment such as trolleys, oxygen ports, defibrillators and stretchers in all vehicles we inspected, which provided evidence of recent servicing in 2018. We also reviewed equipment-servicing records, which demonstrated all equipment received a service within the last 12 months.
- The service used adjustable five-point harnesses to secure children in their ambulances during transport to hospital. The manufacturer's instructions specified that this equipment was suitable for the transport of young children and babies weighing 4.5kg and above. We also saw a suitable range of paediatric equipment, including paediatric oxygen masks and resuscitators. This meant the service had appropriate equipment to treat and transport children of all ages.
- We randomly checked 30 items of single-use equipment on the vehicles we inspected. All 30 items were contained within sealed packaging and within the manufacturer's recommended use-by dates. This provided assurances single use items were safe and fit for purpose.
- Crews completed a "vehicle and equipment check sheet and cleaning log" for every shift. This included vehicle-critical checks such as fuel, lights and tyres, and checks of critical equipment such as defibrillators. We reviewed completed check sheets for the two weeks before our visit. We saw that for 45 out of 50 checklists, crews had fully completed all areas of the checklist. This provided assurances the vehicle and equipment were safe and fit for purpose at the start of the shift. However, five of the 50 checklists had some incomplete areas, such as checks of tyres and lights. We raised this issue with the registered manager, who immediately fed back to crews and highlighted the requirement to complete all checks at the start of every shift.
- The ambulance station at the registered location was secure to keep the premises and equipment safe. The service stored all vehicle keys, mobile data terminals and radios in a locked, electronic safe accessible only to crews and the registered manager. We saw that the clinical waste hold was padlocked to prevent unauthorised access.
- On one of the ambulances we inspected, we saw the trolley harness had visible signs of wear and fraying. In another ambulance, we saw the excess ends of the trolley harness were also beginning to show signs of wear. We raised this issue with the registered manager, who immediately ordered replacement trolley straps. The registered manager sent a copy of the purchase

order to us as evidence of this order. The registered manager told us they would inspect the harnesses on all remaining vehicles and replace any further harnesses showing signs of wear and tear.

- The fire extinguishers on the vehicles we inspected did not have stickers showing evidence of servicing. We raised this with the registered manager, who told us all fire extinguishers received a service in November 2017. The registered manager later confirmed the servicing organisation had been unable to provide a record of servicing undertaken in November 2017. The registered manager had subsequently arranged repeat servicing in April 2018 to obtain documented assurances of servicing for all fire extinguishers on vehicles. We saw evidence the service had booked fire extinguisher servicing for 12 April 2018.

Medicines

- The service gave, recorded and stored medicines well. The service stored medicines at the ambulance station in a locked cupboard. Only the registered manager, service coordinators and crew members had access to the keys to prevent unauthorised access to medicines.
- The service did not hold or administer any controlled drugs. This was because the service did not employ any paramedics, which is the grade of ambulance staff needed to administer controlled drugs. Controlled drugs are medicines liable for misuse, which require special management. The service also did not hold any medicines requiring refrigeration.
- The service kept an electronic tracker containing the names, batch numbers, quantities and expiry dates of all medicines. Staff recorded which vehicle each medicine was allocated to. Each vehicle had their own medicines basket in the locked storage cupboard, with each medicine placed in its own envelope clearly labelled with the name and expiry date. Crews logged all medicines they used, and we saw medicines logs on all ambulances we inspected. Each medicine had its own separate page in the log. When a vehicle was running low on a particular medicine, crews restocked their vehicle with medicine from the cupboard at the ambulance station. Crews detached the relevant page from the medicines log in their vehicle and posted it into the secure post box in the office along with the other paperwork from their shift. This triggered an audit, and the registered manager or a coordinator subsequently checked the quantities of the medicine on the vehicle and in the stock cupboard and updated the electronic tracker. This meant the service had assurances around the use of medicines.
- We saw that medicines bags on vehicles were checked and tagged before each shift. We checked all medicines on one vehicle we inspected and saw that they were all sealed and within the manufacturer's recommended use-by dates. We checked a further six medicines in the medicines storage cupboard and saw that all were sealed and within the manufacturer's recommended use-by dates. This meant medicines were safe for use.
- The service stored medical gases safely. The oxygen cylinders on all three vehicles we inspected were in-date and secured to prevent injury to patients or staff. The service stored additional medical gas cylinders securely at the registered location inside a padlocked area. We saw clear, marked segregation of full and empty cylinders to prevent crews accidently taking an empty cylinder onto a vehicle.
- The service disposed of expired medicines into medicines disposal bins, or sharps bins for glass vials. These were kept in a locked cupboard before collection by a waste management company.

Records

- Staff completed clear and thorough records of patients' care and treatment. Crews completed the same paper-based patient report forms used by the commissioning NHS ambulance trust. We reviewed five completed patient report forms and saw crews had completed all five to a high standard. These included clear documentation of detailed history-taking, assessments, examinations, and medicines administration.
- The service carried out monthly records audits to obtain ongoing assurances around record keeping. A paramedic at the commissioning NHS ambulance trust audited two patient report forms for each crew member every month. The service delivery manager told us, and we saw copies of audits showing the auditor gave feedback to staff around any areas for improvement. For

example, one monthly audit found crews were sometimes missing pupil checks when assessing patients. Following feedback from the auditor, there was a significant improvement in this area.

- The service kept records securely to maintain patient confidentiality and data protection. The patient report forms had three carbon-copy layers. Crews detached one copy and gave it to staff at the receiving hospital when handing over a patient to allow continuity of care. Crews put the other two copies in an envelope with all the paperwork for their shift. On the front of the envelope, crews recorded the incident number for each job and any associated records such as the patient report form, a vulnerable persons report form, or an incident report form. Crews subsequently placed the envelope into the locked post box inside the ambulance station office. The registered manager or a service coordinator retained the carbon copy of the patient report form, logged any incidents or safeguarding referrals onto the reporting system, and delivered the master records in person to the commissioning NHS ambulance trust's nearby make-ready centre. Carbon copies of records retained by the service were held in a locked cabinet.
- We saw there were no completed patient records left on any of the vehicles we inspected. The service also carried out monthly "records management and confidentiality" audits to obtain ongoing assurances around records security. The results for November 2017 to January 2018 showed 100% compliance, with all records stored safely and securely to maintain confidentiality. This meant the service has assurances around record security.

Assessing and responding to patient risk

- The service assessed patients and responded accordingly in line with national scoring tools. The service used the Glasgow Coma Scale, National Early Warning Scores and Paediatric Early Warning Scores to monitor and detect deterioration in patients. The Glasgow Coma Scale is a national tool used by ambulance crews to measure eye-opening response, verbal response and motor response following injury or trauma. The tool allowed calculation of a numerical score to enable crews to recognise any deterioration. National and Paediatric Early Warning Scores are simple scoring systems of physiological measurements (for example, blood pressure and pulse) for monitoring of adults and children, respectively. This allowed staff to identify deteriorating patients and provide them with additional support.
- We saw clear documentation of patient observations, and escalation in line with the associated guidance where applicable, in all five patient report forms we reviewed. We also observed crews carrying out patient observations and responding in line with the associated guidance. This demonstrated crews assessed patients and responded appropriately.
- If crews had any concerns about a patient, they could contact the clinical support hub at the commissioning NHS ambulance trust for clinical advice or support at any time. Crews described doing this regularly on shifts and we saw contact numbers for the clinical support desks printed on the back of all patient report forms for reference. The commissioning NHS trust required technician crews to telephone the clinical hub for authorisation every time they made a decision not to convey a patient to hospital. This meant all patients had a review by a paramedic or other registered healthcare professional to ensure it was safe for them to remain at home.
- Staff had skills and training to respond appropriately to violent or disturbed patients. Crews received training in conflict resolution and mental health as part of their mandatory training. Crews described taking using their values of humanism, taking an empathetic approach and de-escalating situations where patients were disturbed or highly anxious. The service's ambulances contained a "man down" button, which crews could press to request police back up in the event of a violent patient presenting a danger to crews. We saw two incident reports where crews had needed to use this facility when attending to patients who were violent towards the crew.

Staffing

- The service had enough staff with the right qualifications, skills and training to keep patients safe. The service had 26 members of staff, including three crew team leaders, two coordinators and a service delivery manager. Crew members were mostly emergency care support workers plus some technicians. The service did not employ any paramedics. There were

five full-time equivalent emergency care support worker vacancies at the time of our visit. The service delivery manager told us they had a selection day booked for 21 March 2018 to recruit new staff to fill these vacancies.

- The service recruited emergency care support workers, who could later train to become ambulance technicians if they wished, through the British Red Cross technician training programme. At the time of our visit, six members of staff had enrolled on the technician training programme to start their technician training in March 2018. The service planned to increase the ratio of technicians to emergency care support workers by developing their own staff. The service's long-term plan was to have 70% technicians and 30% emergency care support workers.
- The service contracted its crew members to work three 12-hour shifts each week. The service delivery manager had an ongoing dialogue with the commissioning NHS ambulance trust around the commissioning trust's requirements and the service's capacity. A service coordinator was responsible for allocating rotas. The coordinator always ensured staff had a minimum of 11 hours rest between shifts. Staff told us they could start later the next day if a shift overran. This ensured they had the minimum 11 hours rest for staff and patient safety.
- The service covered any unfilled shifts by offering crews overtime. The service did not use any bank or agency staff. The service only allowed crews to work one additional 12 hour shift a week. This ensured crew members did not exceed 48 working hours in any week for staff and patient safety and in line with the EU Working Time Directive.

Anticipated resource and capacity risks

- The service was able to cover staff sickness in most cases to allow service continuity. The service delivery manager told us they usually managed to cover crew sickness by sending a group text message to all staff offering overtime for the additional shift. Crew members told us they were always willing to take on additional shifts wherever possible. If the service was unable to cover crew sickness, the service delivery manager told us they would inform the commissioning NHS ambulance trust, who would arrange alternative cover for the shift. However, this rarely happened because of the willingness of crews to cover additional shifts as overtime.
- The service had continuity measures for anticipated adverse weather such as snow. The service had "snow socks" for its vehicles, which they kept at the registered location. Snow socks fitted around the tyres as an alternative to snow chains to prevent the ambulances getting stuck in snow. In the event of heavy snowfall, the service had access to four-wheel drive ambulances at one of the provider's other registered locations. The service delivery manager also told us they would liaise with the commissioning NHS ambulance trust around joint working with the commissioning trust's four-wheel drive ambulances in snowy conditions to allow service continuity.

Response to major incidents

- All staff attended major incident training as part of their initial induction and continuing professional development. The service delivery manager told us an example of a time when the service had assisted the commissioning NHS ambulance trust with a major incident in August 2017. This involved a chemical gas cloud on the coast of East Sussex, which caused 150 people to seek medical attention after breathing in the chemicals in the air. The service attended to patients who were affected by the gas cloud and had called 999. The service delivery manager described how this had worked well.
- The service had continuity arrangements for emergencies if one should happen. The service used the provider's corporate "Ambulance support (south) business continuity plan" (dated June 2017), We reviewed the business continuity plan and saw it had measures to allow business continuity in various situations, including loss of vehicles, technology, and incidents involving premises. These measures would minimise disruption to the service should a business continuity incident, such as loss of power or damage to premises or vehicles, occur.

Are emergency and urgent care services effective?

Emergency and urgent care services

(for example, treatment is effective)

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Staff followed clinical guidance in the British Red Cross pocketbooks. All crew members had a pocket book they could use for reference. We reviewed the pocketbook and saw this contained comprehensive guidance in line with evidence-based sources such as the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and the National Institute for Health and Care Excellence (NICE).
- However, we saw that the pocketbook did not reflect up-to-date national guidance in one area by not specifying that ibuprofen was contraindicated for patients with suspected chicken pox. This was not in line with the National Institute for Health and Care Excellence's "Clinical Knowledge Summary: Chickenpox" (revised October 2016), which states, "Avoid nonsteroidal anti-inflammatory drugs" for the treatment of chicken pox symptoms. This meant there was a risk crews might not have worked to the most up-to-date national guidance in this area. We raised this issue with the service delivery manager, who told us the provider was in the process of revising the pocket book guidance. The corporate risk register also reflected this review was underway.
- The service used the corporate British Red Cross policies and standard operating procedures. We reviewed 13 policies and saw that all except one were within their review dates. The equality and diversity policy had recently passed its recommended review date of December 2017. The service delivery manager checked electronically and confirmed that the corporate team were reviewing the equality and diversity policy at the time of our visit. The service delivery manager explained that the existing policy remained in use until the corporate team completed their review and made any required updates. We saw that policies and standard operating procedures reflected up-to-date national guidance and best practice. For example, we saw that the infection prevention and control policy reflected best practice regarding the cleaning of equipment between patients and the deep cleaning of vehicles.
- The service had assurances staff carried out care and treatment in line with evidence-based guidance and best practice. The service carried out monthly audits to obtain ongoing assurances of crew compliance with policies in key areas. We reviewed monthly audits in the following areas for the four months before our visit: Infection prevention and control (vehicles), infection prevention and control (premises), hand hygiene, clinical waste, medicines management, and records management and confidentiality. We also reviewed patient care records audits for October to December 2017. Audits demonstrated a high level of compliance with policies that met locally agreed targets.
- The service also had an annual provider audit carried out by external staff. We saw the last provider audit dated April 2017. The audit showed a high level of compliance overall. The service scored 87% for the records management system; 100% for driving standards, 100% for medicines management, 100% for vehicle infection prevention and control, 100% for waste disposal and personal protective equipment,100% for cleaning stores, 73% for storage areas and 61% for general facilities. The service met or exceeded the provider target of 75% for all areas except storage areas and general facilities. We saw that the auditor gave feedback to the registered manager around the storage and facilities cleanliness scores for improvement. On our visit, we saw that these areas were clean and maintained, demonstrating that the service had acted on the auditor's feedback and subsequently continued to maintain cleanliness.

Assessment and planning of care

- We observed crews making thorough assessments of patients. Crews used nationally recognised tools, such as the Glasgow Coma Scale, National Early Warning Scores and Paediatric Early Warning Scores. As most of the service's activity was intermediate care provided by emergency care support workers, this group of staff did not have authorisation from the commissioning NHS trust to provide "see and treat" care and leave a patient at home. Therefore, due to the nature of the service provided, crews conveyed most patients to a hospital or another appropriate service such as a hospice. Where crews contained a technician, the technician

telephoned the clinical support desk at the commissioning NHS ambulance trust for authorisation not to convey a patient to hospital when this was clinically appropriate.

- As part of the primary assessment, crews assessed patient status and noted whether patients were anxious, violent, or suspected to be under the influence of alcohol or drugs. We saw crews had fully completed all assessments in the patient care records we reviewed. Crews also noted in the primary assessment any concerns around mental capacity, safeguarding, or known physical or learning disabilities. This allowed crews to plan the patient's care accordingly, for example, by requesting back up for any violent patients or contacting the clinical support desk for assistance with a mental capacity assessment.
- The service assessed and recorded patients' pain using a numerical scale from zero to 10, with zero meaning no pain and 10 meaning unbearable pain. We saw a pictorial scale of smiley faces printed on patient care records, which crews used for pain assessment in children. We observed crews assessing patients' pain and saw pain scores recorded as part of observations in the patient care records we reviewed. Crews carried over-the-counter pain relief such as ibuprofen and paracetamol, which they offered to patients where clinically appropriate to help manage their pain before transfer to hospital.
- The service used the "code yellow" sepsis pathway used by the commissioning NHS ambulance trust. We saw code yellow forms, including flowchart guidance for staff, in ambulances we inspected. Crews we spoke with were able to describe how they used the pathway to identify suspected sepsis and respond immediately by escalating to the clinical hub at the commissioning NHS trust for advice and referral. This demonstrated crews assessed patients and responded to patients where there were concerns around suspected sepsis in line with local guidance.
- We saw bottled water available for patients on the ambulances we inspected. This allowed patients to stay hydrated.

Response times and patient outcomes

- The commissioning NHS ambulance trust collated performance data for the service in the following areas: Mobilisation time, time at the scene with patients conveyed to hospital, time at the scene with patients not conveyed, wrap-up times, time spent at hospital, and non-conveyance rates. This meant the commissioning trust monitored the service's performance at every stage from receiving a job to leaving a hospital after conveying a patient.
- The commissioning trust produced an updated report of the trust's performance over the previous 91 days and shared this with the service every fortnight. We saw copies of these reports, which showed the service was performing well and meeting or exceeding the key performance indicators set by the commissioning trust.
- The commissioning trust also shared performance data with the service on return of spontaneous circulation following cardiac arrest. This was shared performance with the commissioning trust because the trust's paramedic crews always attended cardiac arrest cases where a British Red Cross Paddock Wood crew provided the first response.

Competent staff

- The service made sure staff were competent for their roles. The service delivery manager checked crew members' driving licences every year and we saw evidence of this in all four staff folders we reviewed. All new staff completed an induction to ensure they were familiar with the facilities, equipment, policies and procedures. We saw copies of completed induction checklists in all four staff folders we reviewed. This provided assurances staff had the necessary knowledge and information they needed to do their jobs.
- The service required every new staff member to attend a mandatory four-week intensive emergency driving course as part of their induction. This course included driving under blue lights. Data provided by the service showed 100% of staff had completed this training. We also saw copies of certificates providing evidence staff completed emergency driving training and assessment in the four staff files we reviewed. This provided assurances all staff were competent to drive under blue light conditions.
- The service ensured staff were fit to work with patients and vulnerable people. The service carried out enhanced Disclosure and Barring Service (DBS) checks on all staff. We saw evidence of enhanced DBS checks

for all staff. We also saw copies of up-to-date DBS certificates in all four staff folders we reviewed. The service delivery manager kept a spreadsheet with the issue dates, expiry dates and certificate numbers for all staff DBS checks. The service delivery manager reviewed the spreadsheet every month to ensure all staff had an up-to-date certificate and to arrange an updated check for any staff members whose DBS certificate was approaching expiry.

- Managers appraised crews' work performance and held regular one to one meetings with them to provide support and monitor the effectiveness of the service. Service data showed 100% of service delivery managers, service coordinators and crew team leaders had an up-to-date annual appraisal at the time of our visit. Ninety-two per cent of crew members had an up-to-date appraisal. We saw records of staff appraisals and one to one meetings in the four staff folders we reviewed. These were comprehensive and identified personal development and learning goals. Appraisals also benchmarked staffbehaviours against the British Red Cross behavioural framework. This meant the service had assurances around staff performance and behaviour at work.
- In addition to two mandatory training days each year, staff attended three continuing professional development "play days". These focused on areas such as resuscitation, trauma, medicines management and specific medical conditions and gave crews the opportunity to practice skills that may not have been used on the road for a period of time. Staff described continuing professional development sessions they had attended and we saw copies of training certificates in the staff folders we reviewed. This meant the service had assurances staff had relevant, up-to-date training to keep their clinical skills refreshed.

Coordination with other providers

- The service coordinated all care and treatment it provided with the commissioning NHS ambulance trust. Crews received jobs from dispatchers at the commissioning trust through their mobile data terminal. Staff described working with the commissioning trust on every shift, for example, by contacting the clinical support desk for advice or requesting paramedic back up. Staff described positive working relationships with clinical advisors at the commissioning trust.
- Crews sometimes conveyed patients to services other than hospitals that they were under the care of, where this was clinically appropriate. For example, we observed a crew convey a patient who was receiving end of life care to a hospice during our visit.
- The service also sometimes coordinated with police, for example, when attending to violent patients that may pose a danger to others.

Multi-disciplinary working

- Handovers to other services were effective to allow continuity of patient care. During our visit, we observed one patient handover to another service. The crew carried out an effective handover and shared relevant verbal and written information. Crews routinely gave a carbon copy of the patient care record to the receiving service to enable continuity of care.

Access to information

- Crews had a mobile data terminal for each vehicle. Dispatchers at the commissioning trust provided information through the mobile data terminal so crews could arrive prepared with background information about the patient and their emergency. This included special notes such as any complex needs, do not attempt cardio pulmonary resuscitation (DNACPR), and risk information if there was a scene safety concern.
- All crews had access to a satellite navigation system through their mobile data terminal. We also saw manual map books in vehicles we inspected, which crews could use in the event of mobile data terminal failure during a job. The service updated its satellite navigation maps shortly after our visit in March 2018. Regular map updates help ensure satellite navigation systems contain any new roads or addresses to ensure crews can reach patients without delay.
- Crews had an airwave radio in each vehicle, which was linked to the emergency operations centre at the commissioning NHS ambulance trust. This allowed dispatchers at the commissioning trust to communicate with crews. Crew members also had mobile telephones to allow them to contact the clinical support desk for advice and support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff obtained patient consent in line with national guidance and best practice. Crew members had attended training in consent and capacity as part of continuing professional development sessions, and we saw a copy of the training presentation. During our visit, we observed that crews always obtained verbal consent before carrying out observations or conveying patients. We saw that crews obtained consent from patients, or parents on behalf of young children that lacked Gillick competence to provide consent. Gillick competence is the statutory process for assessing that children under the age of 16 are competent to make decisions about their own care and treatment.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. Crews had clear, flowchart guidance on capacity printed on the back of patient care records. Crews referred to this if they had any concerns about a patient's capacity. This included a capacity assessment tool. Crews described how they always contacted the clinical support desk at the commissioning NHS ambulance trust if they had any concerns about a patient's capacity to consent to care and treatment. The commissioning trust subsequently dispatched a paramedic to complete a capacity assessment. Alternatively, a paramedic from the clinical support desk supported the British Red Cross Paddock Wood crew to complete a capacity assessment using the capacity assessment tool. We saw capacity assessment forms for crews to document this process.
- The mental capacity guidance printed on the back of patient care records specified crews should "treat the patient under the doctrine of emergency" if it was not possible to wait until a patient regained capacity to consent. This included patients who were unconscious and meant crews could make best interests' decisions in providing necessary emergency care to unconscious patients. We also saw best interests' decisions forms for crews to document the best-interests decision-making. This was in line with the Mental Capacity Act 2005.
- Staff understood their roles and responsibilities under the Mental Health Act 1983. Service data showed all staff had attended a two-day mental health training course in the year before our inspection. We saw the provider's guidance on restraint, titled "Appropriate use of restraints- a quick guide". This provided clear guidance to staff on when restraint can and cannot be used. One crew member we spoke with described a time they had needed to restrain a suicidal patient to prevent them from harming them self. The crew member described how they and a colleague had used the least restrictive option for the minimum amount of time. This was in line with the Mental Health Act 1983 and the provider's guidance on appropriate use of restraint.

Are emergency and urgent care services caring?

Compassionate care

- Staff cared for patients with compassion. We observed staff treating patients with compassion and empathy throughout our visit. Feedback from patients confirmed that staff treated them well and with kindness. We received five patient comment cards, and all patients were positive about the compassionate care they received from staff. Patient comments about staff included, "Caring and respectful", "Very kind, polite [and] nice", and "My wife was treated with great care". This reflected the compassionate care we observed during our inspection.
- We reviewed fifteen patient feedback forms and two other items of patient feedback the service received in the three months before our visit. All patients that completed the feedback forms said they would be "extremely likely" to recommend the service to family and friends. All patients that completed the feedback forms also said they "strongly agreed" that staff treated them with dignity and respect. We also saw a patient feedback letter from June 2017, which stated, "[Staff] treated me with the utmost respect and dignity". This further demonstrated the compassionate care staff provided to patients.
- Staff we spoke with were able to describe how they provided compassionate care by being empathetic, open-minded and "treating people as people". Staff described how this was part of the British Red Cross' values. Staff talked about the importance of treating each patient as an individual. One crew member said, "Everyone's crisis is personal to them. They have called [999] for a reason". Another described a time they conveyed a patient receiving end of life care to a hospice. The crew member described how the patient

thanked them for treating the patient as a person, and not a dying person. This demonstrated staff brought the provider's values of humanity and compassion to life to provide compassionate care.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment. We observed crews appropriately involving patients and their relatives in discussions about their care during our visit. We also saw crews allowed family members to accompany patients in the ambulance.
- Patient feedback reflected staff involved patients and their relatives in their care. Patient comments we reviewed included, "We were fully informed of every step taken", "[Staff] listened to my views", "They listened with patience to him and us", and "They informed us throughout of the options".
- A crew member we spoke with described a time when they spent time talking with the family of a patient suffering with anxiety. The crew member helped arrange alternative accommodation for a relative whose stay had increased the patient's anxiety. This helped the patient feel less anxious.

Emotional support

- Staff provided emotional support to patients to minimise their distress. Crew members described times they had provided emotional support to patients. This included emotional support to the relative of a patient who had died suddenly. A crew member described attending a cardiac arrest call, where a patient had died in a public place. The crew member described how afterwards, they had provided support over a cup of tea to staff working in the building who witnessed the cardiac arrest. This demonstrated the emotional support staff provided, not only to patients and their relatives but also to others who may have been affected by traumatic events.
- Feedback from patients demonstrated staff supported them emotionally. We saw that all patients who completed the feedback forms we reviewed for December 2017 and January 2018 "strongly agreed" that the support they received from staff reduced their stress. Patient comments we received described staff as "calming", and one patient commented on the "amazing [crew] who reassured me".

Supporting people to manage their own health

- The provider had a volunteer-run "support at home" service to help provide short-term support to vulnerable people to help them manage independently in their own home. The provider also had a loan service for mobility aids, which patients could access free or for a small donation. Crews described how they signposted patients to this service to help them manage their own health and independence at home.

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

Service planning and delivery to meet the needs of local people

- Data showed the service responded to 10,053 calls to 999 between January and December 2017. Of these, 289 were category one calls (life-threatening events), 2,363 were category two calls (emergency, potentially serious conditions), 1,848 were category three calls (urgent problems) and 1,585 were category four calls (less urgent problems). A further 1,658 were urgent responses, which were calls from doctors or healthcare professionals to convey patients to hospital for urgent treatment. The remaining calls resulted in crews being "stood down", for example, because the commissioning NHS ambulance trust's crew had arrived on the scene first.
- The service had increased the number of journeys it provided by 108% since January 2017. The service delivery manager told us the service planned further expansion to allow them to provide further support to the commissioning trust. The service planned to recruit an additional 12 emergency care support workers in 2018 to facilitate the planned expansion.
- British Red Cross Paddock Wood worked with the commissioning NHS ambulance trust to plan and deliver services. The service delivery manager spoke with the commissioning trust three times a week to plan

service delivery. The service told the commissioning trust about their capacity for the coming month, and the commissioning trust submitted their requirements for shifts. The service delivery manager reported this worked well. Previously, the commissioning trust had submitted their requirements for cover 14 days in advance and only given the service two days to produce staffing rotas. This had sometimes been difficult for the service coordinators to arrange staffing rotas in a short timescale.

Meeting people's individual needs

- The service took account of patients' individual needs and took action to meet them. Crews could access telephone interpreters through the commissioning NHS ambulance trust for patients that spoke limited English. Staff told us examples of times they had done this. Crews also had multi-lingual phrase books on the ambulances to help them communicate with patients that spoke limited English.
- Crews described strategies they had used to help them meet the individual needs of different patient groups, such as patients living with dementia or those with learning disabilities. This included using pen and paper to help patients with difficulties communicating their needs. A crew member described their colleague blowing up a clean clinical glove and drawing pictures on it to lessen the anxiety of a child with learning difficulties. Another crew member described how they had referred a refugee to the provider's refugee support service for further support. This demonstrated the service took action to meet the needs of a variety of patient groups.
- At the time of our visit, the service was unable to transport bariatric patients (those with a body mass index above 40). However, the service was taking action to allow them to meet the needs of this group of patients. The service had commissioned the building of a proof of concept "box back" 3.5 tonne vehicle. The new vehicle, which was scheduled to be completed ready for the service to trial in July 2018, would be bariatric-capable and fitted with bariatric equipment. The service planned to train crews in bariatrics to allow them to use the new vehicle to transport bariatric patients.

Access and flow

- The commissioning NHS ambulance trust was responsible for allocating jobs and dispatching crews. The commissioning trust monitored on-scene and turnaround times and gave the service feedback on their performance in this area on a fortnightly basis.
- Crews communicated any delays to the commissioning trust through their airwave radios and mobile data terminal. We saw incident reports showing crews had reported any delays, for example, due to their satellite navigation system taking them on a longer route. This demonstrated the service kept the commissioning trust informed of any issues causing delays that needed investigation.

Learning from complaints and concerns

- The service actively sought feedback from patients and those close to them. As well as using patient satisfaction surveys, we saw complaints leaflets available for patients in the vehicles we inspected. The complaints leaflets gave details of how to make a complaint or give feedback. We also saw patients could access complaints information and make a complaint through the provider's website. The service had not received any complaints between January and December 2017.
- The service used the provider's corporate complaints policy. The target response time set out in the complaints policy was 28 days. If this timescale were to be exceeded, then the service would contact the complainant to explain the reasons for delay and agree a revised timescale with them. As the service received no complaints in the year before our visit, we were unable to assess whether the service met the 28-day target for providing a written response to complaints.

Are emergency and urgent care services well-led?

Leadership of service

- Crew members reported to their team leader, who, in turn, reported to the service delivery manager. The two service coordinators also reported to the service delivery manager, who was also the registered manager. The service delivery manager reported to the operational lead for the south of England, who reported to the provider's national director of ambulance support.

- All staff we met spoke positively about the local leadership. Staff said they felt appreciated by the service delivery manager, who always thanked them when they had done something well. Crews also described how their manager sometimes rewarded staff with a box of chocolates for performing particularly well or going "above and beyond" for patients or colleagues. One staff member we spoke with said they were more likely to accept overtime because they "felt appreciated". They also told us about an occasion when the service delivery manager came out to a crew in the middle of the night to check they were okay after a vehicle broke down. This demonstrated the manager cared about staff wellbeing and modelled behaviour of going "above and beyond" for colleagues.
- Staff told us they felt confident to raise concerns. The service delivery manager described how they had dealt with staff concerns. This included addressing a concern about a crew member using offensive language in front of colleagues. We also saw an incident report demonstrating staff had raised a concern about a colleague driving under blue lights when not permitted to do so. We saw the service dealt with this concern, including escalating it as a serious incident and reporting the crew member, a registered paramedic, to the Health and Care Professions Council. This demonstrated leaders took appropriate action in response to concerns.
- However, some staff expressed frustration around decisions at corporate provider level taking a long time. One example of this was around additional pay for unsocial hours and dual roles.

Vision and strategy for this this core service

- The service had a vision for what it wanted to achieve and workable plans to turn it into action. The service's strategy for 2018, as set out in the provider's "Ambulance Support Development Plan – 2018", was to expand the service to 1,800 hours cover per month. This represented an increase of 700 hours per month. To achieve this, the service planned recruitment of new staff and further training of some existing staff to technician level. The service delivery manager described progress against the strategy. This included a recruitment day scheduled for March 2018 and the enrolment of six emergency care support workers on a technician training course.
- Staff knew the provider's values and incorporated them into their day-to-day work. The service followed the provider's corporate values and the fundamental principles that underpinned them. The values were "compassionate, courageous, inclusive and dynamic". The seven fundamental principles were "humanity, impartiality, neutrality, independence, voluntary service, unity and universality". Staff we spoke with described the values and fundamental principles and how they brought them to life while wearing the British Red Cross uniform. This included being open-minded towards people from all walks of life, humanistic and empathetic.

Governance, risk management and quality

- The service's operational lead took responsibility for the governance of the service. The provider's national clinical governance lead supported with clinical governance issues and oversaw the governance of the service.
- The operational lead and service delivery manager represented the service at monthly regional management team meetings. We reviewed copies of meeting minutes and saw managers reviewed governance issues such as key performance indicators, incident reports and safeguarding. The operational lead also represented the service at national ambulance leadership group meetings held every two months. We reviewed copies of the national ambulance leadership meetings, which demonstrated managers reviewed governance items such as risk registers and standard operating procedures through this group.
- The service had effective systems for identifying risks and planning to eliminate or reduce them. The operational lead maintained the service's local risk register, which fed into the national risk register. We saw that the risk register was comprehensive and the service used control measures to lessen risks wherever possible. For example, the service recognised a risk of crew members leaving the service due to lack of clinical development pathway. To mitigate this risk, the service was funding more staff to attend the provider's technician training course with the aim of increasing the proportion of technicians to 70% of the workforce.
- The service delivery manager demonstrated their understanding of risks to the service and we saw risks

on the register matched with risks we identified. This included the risk of some clinical guidance in the "pocketbooks" not being aligned with more recent national guidance. We saw that the provider was reviewing systems and processes to ensure clinical practice guidelines and protocols remained current and reflected best practice.

- The service received a fortnightly report on its performance against key performance indicators from the commissioning NHS ambulance trust. Performance reports we reviewed demonstrated the service was performing well against its key performance indicators. Fortnightly performance reports allowed the service to identify areas for continuous improvement and to work with the commissioning trust to achieve this.

Culture within the service

- The service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff we spoke with were positive about the culture of the service. Staff described positive working relationships with each other and told us colleagues supported them whenever they were having a bad day. One crew member we spoke with described their colleagues as a "second family". Another said they "would not want to work for another provider".
- The service promoted a culture of openness, candour and honesty. Crews told us the supportive culture encouraged them to be open and admit to mistakes without blame. The service delivery manager described always communicating openly and honestly with staff.
- Crew members supported each other after traumatic events and staff had access to psychological support through the commissioning NHS ambulance trust. Additionally, the provider had its own employee assistance programme for counselling and we saw posters advertising this service to staff.

Public and staff engagement

- The service had an active staff social group, which was set up by two crew members. Staff told us about cinema trips, meals and board games nights they had attended. This helped increase the strong team ethic we observed.
- The service gave existing staff the opportunity to attend selection days to meet potential new staff. Staff described playing team games at the selection days to help assess applicants' team working skills. This also allowed the service the opportunity to see whether applicants would fit with the values and culture of the service.
- The service engaged with the local community by visiting local primary schools to give talks to children about the role of ambulance services. Staff described primary school visits and we saw two letters from local schools thanking staff for showing them their ambulances.

Innovation, improvement and sustainability

- The service commissioned the building of a proof of concept 3.5 tonne "box back" ambulance with bariatric capability. Once built, the new vehicle would be environmentally friendlier due to the reduced fuel consumption because of the lower weight. Solar panels on the vehicle would reduce electrical usage. Additionally, the new vehicle would have more space and allow the transport of wheelchair-users in their own wheelchairs, increasing patient dignity and inclusion.
- A crew team leader developed a preceptorship programme for new staff. We saw in regional management team minutes that there was discussion around implementing this programme nationally across the provider's other ambulance support locations.
- The service has a garage area that was scheduled to be converted into a "dummy" flat. This would allow crews to practice their skills of moving patients out of small spaces as part of continuing professional development sessions.
- In response to the needs of the local community, we saw a business case the service had submitted to provide a dedicated ambulance transport resource for palliative and end of life care patients. Staff (both volunteers and employees) with additional clinical and support skills would support this. This service would be flexible and able to respond to short notice requests. The service had sought feedback from the chief executives of local hospices in the development of the business case to ensure the proposed service would fully meet the needs of this group of patients. At the time of our visit, the business case was awaiting corporate approval.

Outstanding practice and areas for improvement

Outstanding practice

- We identified the service's commitment to continuing professional development as an area of outstanding practice. This included three protected days for continuing professional development each year for all emergency care support workers and technicians, with development sessions tailored to the learning needs of crew members. A preceptorship programme for emergency care support workers, developed by a crew team leader, also contributed to this area of outstanding practice.
- The arrangements for meeting the needs of vulnerable groups was an area of outstanding practice. This included access to the provider's refugee support services and the provider's "support at home" and mobility equipment loans services to help patients live independently at home.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should complete their review of all clinical guidance provided in the British Red Cross "pocketbooks" to ensure all guidance meets the most up-to-date national guidance and best practice.
- The service should take action to ensure all staff fully complete all areas of the "vehicle and equipment check sheet and cleaning log" on every shift to provide assurances of every check.
- The service should take action to inspect the trolley harnesses on all vehicles and replace any harnesses showing signs of wear and tear.