British Red Cross Society

British Red Cross (North East)

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The British Red Cross (North East) is operated by the British Red Cross Society. The British Red Cross (North East) provides emergency and urgent care. We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 8 and 9 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:

- The service had a system in place to record and report incidents. Staff were aware of their roles and responsibilities in the reporting of incidents, near misses and concerns.
- There were systems in place to maintain cleanliness of vehicles and equipment.
- Staff maintained infection control and prevention practices through the effective use of personal protective equipment.
- Policies and procedures were in place to protect vulnerable adults and children. Staff knew how to report safeguarding concerns.
- Staff stored confidential patient records in locked cupboards.
- Staffing level and skill mix was planned and reviewed to ensure that people were safe from avoidable harm and received safe care and treatment.
- The service had effective systems in place to monitor staff's compliance with mandatory training.
- Infection prevention and control and patient record audits were undertaken.
- All equipment had been service tested.
- Policies and guidance were based on national guidance and recommendations. Staff had access to policies and procedures on the electronic recording system.
- The service had systems in place to ensure staff competence prior to completing any roles. All staff completed a 12-week induction programme, which included examination.
- There was a system in place to demonstrate that policies had been developed, reviewed, and updated to reflect current practice.
- Systems were in place for staff to seek patient's consent, and assess capacity to agree to treatment when required.
- We saw staff had the appropriate qualifications and experience for their role within the service.
- We observed that staff received a comprehensive induction to ensure they had appropriate training and awareness of policies and procedures.
- Staff used clean blankets to maintain patients' privacy and dignity.
- All staff we spoke with demonstrated a consideration for the emotional wellbeing of patients and their relatives.
- Staff were understanding and sympathetic towards patient needs, adapting as required.
- Feedback forms/cards were available on all vehicles to obtain patient views.
- The service planned to meet the needs of local people, and provided a service based on risk assessments.
- Staff were experienced at dealing with patients living with a learning disability and people living with dementia.
- There was guidance available for patients to make a complaint or express their concerns.
- Patients had access to timely care and treatment.
- British Red Cross (North East) had a multi-lingual phrasebook on each ambulance as well as access to the NHS language line.

Summary of findings

- The registered managers had the appropriate skills and experience to manage the business, and were supported by senior managers to provide a safe service.
- There was a positive culture within the service and both ambulance staff and managers displayed the service values when speaking about their work, strategy and motivations.
- Staff demonstrated learning and a positive approach to practice and care delivery.
- The service had a detailed risk register, which meant there was a robust system in place to follow up identified risks within the service.
- Vehicles were not designed to meet the needs of bariatric patient as there was no requirement to provide a bariatric service on the existing contract. Despite this, recent investment was made in upgrading two vehicles to be bariatric capable in the North East. Full training and operating procedures were written and were being delivered.
- The service obtained service user feedback through friends and family feedback forms.
- All response times were taken and collated directly by the local NHS ambulance trust as the information was not required by the Red Cross. If required the service could request audits of response times for discussion in meetings with the commissioner when reviewing performance.
- The service did collate detailed performance information relating to the number of responses, type of response and treatment of patient.

Ellen Armistead
Deputy Chief Inspector of Hospitals (North) 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		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.

British Red Cross (North East)

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to British Red Cross (North East)

British Red Cross (North East) is operated by the British Red Cross Society. The service first registered with the Care Quality Commission in 2013. It is an independent ambulance service in Newcastle upon Tyne. The service primarily serves the communities of the County Durham and Teesside, Northumbria and Cumbria.

At the time of the inspection, the current service managers had been the registered managers with the CQC since 06 December 2017.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in emergency and urgent care.

Sandra Sutton, Head of Hospital Inspection, oversaw the inspection team.

Facts and data about British Red Cross (North East)

British Red Cross (North East) is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC, which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC regulates the emergency and urgent care service provided by British Red Cross (North East). The other services provided are not regulated by CQC, as they do not fall into the CQC scope of registration. The areas of British Red Cross (North East) that are not regulated are events.

The service is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the service during the 12 months before this inspection. The service had been inspected once previously by CQC in October 2013 when it was found to be meeting all of the standards of quality and safety it was inspected against.

British Red Cross (North East) provides services to NHS ambulance trust. This is delivered by qualified, trained staff and volunteers.

The service employs 36.5 whole time equivalent (WTE) staff, including ambulance crew and ambulance technicians with shifts seven days per week. There were also 7.5 WTE office and managerial staff.

Detailed findings

Activity

There were 19,264 (approximately 1,605 per month) emergency responses in 2017 with 4,758 responses stood down by the trust. The British Red Cross (North East) attended 14,506 patients in 2017. All responses were commissioned by a local NHS ambulance trust.

During our inspection, we interviewed 16 members of staff including the registered managers, operational lead, safeguarding officer, technicians, advanced technicians, trainees, ambulance care assistants, and office service co-ordinator. We reviewed six patient record forms and eight staff records.

Track record on safety

There had been no reported never events. 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.

Between October 2016 and October 2017 there were:

- 291 reported incidents logged.
- 0 reported serious injuries.
- 39 internal and external complaints.
- 136 safeguarding concerns raised.

Notes

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.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

British Red Cross (North East) provides support to NHS ambulance trusts. This is delivered by qualified, trained staff and volunteers.

The service employs 36.5 whole time equivalent (WTE) staff, including ambulance crew and ambulance technicians with shifts seven days per week. There were also 7.5 WTE office and managerial staff.

There were 13,890 (approximately 1,157 per month) emergency responses in 2017. All responses were commissioned by a local NHS ambulance trust.

Summary of findings

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

We found the following areas of good practice:

- The service had a system in place to record and report incidents. Staff were aware of their roles and responsibilities in the reporting of incidents, near misses and concerns.
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Emergency and urgent care services

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- There was a system in place to demonstrate that policies had been developed, reviewed, and updated to reflect current practice.
- Systems were in place for staff to seek patient's consent, and assess capacity to agree to treatment when required.
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- British Red Cross (North East) had a multi-lingual phrasebook on each ambulance as well as access to the NHS language line.
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Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

• There were no never events reported in this service from October 2016 to October 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.

• Staff were aware of how to report incidents. The policy set out the accountability, responsibility and reporting arrangements for all staff in relation to incidents.

• Incidents were reported using an electronic incident reporting system, which was available to all staff.

• There had been 291 incidents reported from October 2016 to October 2017. Incidents related to driving and vehicles; facilities and security; fraud and theft; health and safety; information governance; and practice and clinical issues. Of the 291 incidents reported, 62 were clinical incidents. There were no serious incidents reported.

• During interviews with staff we heard examples of incidents, investigation processes, actions taken and how lessons learned were shared with crew members.

• The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering a written apology. Staff had an awareness of the requirements of duty of candour and gave an example of when they would apply duty of candour.

Clinical Quality Dashboard or equivalent

• The service used a quality dashboard. It reviewed its incidents and complaints through the electronic reporting system and gave feedback to staff through a staff portal site, one to one meetings and weekly briefing.

Mandatory training

• The British Red Cross (North East) plan and delivery staff training locally. Staff training records were held electronically and alerted staff when updates were required.

• We reviewed eight staff training records and found all staff had completed initial mandatory training which included induction, fire safety, first aid at work, moving and handling, protecting vulnerable adults and children level 2, duty of candour, infection prevention and control, and Mental Capacity Act training.

• Basic Life Support training and Resuscitation refresher training were undertaken on an annual basis with most other training refreshed three yearly. All staff were up to date with their training.

Safeguarding

• The service had systems, processes, and practices in place to keep patients and staff safe from avoidable harm.

• The service had a safeguarding policy for vulnerable adults and children in place. It contained relevant guidance for staff to recognise and report any potential safeguarding concerns and reflected national guidance.

• The service had a safeguarding adults officer (SAO) who was responsible for supporting and overseeing the British Red Cross (North East) response to a safeguarding adults concern. The SAO liaised with the line manager and informed the staff/volunteer about the next course of action. The SAO also advised staff about other sources of support available to the individual. The SAO was responsible for ensuring that appropriate referral and signposting occurred and the concern was reported externally as required.

• During our inspection, safeguarding adults and children level two training had been provided for all staff. The safeguarding adults officers held level three training.

• Staff we spoke with were aware of the process for reporting any safeguarding concerns and were able to describe events, which may trigger a referral. The service made 136 safeguarding referrals from October 2016 to October 2017 in accordance with the safeguarding policy.

• All staff and volunteers used the electronic reporting system to report safeguarding adult concerns internally after speaking with a safeguarding adults officer.

Cleanliness, infection control and hygiene

• The service had systems in place to maintain cleanliness of vehicles and equipment.

Emergency and urgent care services

• There was an up-to-date infection prevention and control (IPC) policy, and this was available electronically and all staff had access.

• We saw staff using hand-sanitising cleanser to clean their hands. The service undertook monthly hand hygiene audits with outcomes between 93% and 100%. The IPC lead monitors all hygiene audits.

• Vehicle audit varied between 75% at the lowest and 100%.

• We observed that hand sanitising gel dispensers were fitted in each of the vehicles we inspected and that each container had been replenished.

• Personal protective equipment (PPE), such as disposable gloves in a range of sizes, was available for staff to ensure their safety and reduce the risk of cross contamination. PPE was stocked on all vehicles, with additional supplies stored in an equipment storage cupboard in the office area.

• During our inspection, we observed good compliance with uniforms being worn in a clinical setting, including operational staff adhering to the 'arms bare below the elbows' principle for infection control purposes.

• The vehicles' base areas we visited were visibly clean, tidy and free from clutter.

• We inspected five emergency ambulance vehicles during our inspection. All vehicles were visibly clean inside and contained IPC equipment and PPE.

• Crews were made aware of specific infection and hygiene risks associated with individual patients but also took universal precautions for everyone.

• The service provided appropriate waste disposal systems, which included domestic waste, clinical waste and sharps bins. The appropriate containers were observed to be in place during inspection.

Environment and equipment

• British Red Cross (North East) premises were situated within an urban residential area. The service included an office area, staff room, training areas, storage rooms and kitchen area. The outdoor area included a locked ambulance parking area, a garage and gas storage units. The building was shared with other British Red Cross services.

• We were advised that areas of the premises were no longer fit for purpose and an application was being made to renovate the building. Areas unfit for purpose were closed and sealed.

• The service had a robust system in place to ensure the safety and maintenance of equipment.

• The service was compliant with Ministry of Transport (MOT) testing and servicing of the vehicles. We reviewed the vehicle monitoring log which was comprehensive and tracked when each vehicle was next due for servicing, tax and MOT. All vehicles had appropriate service, MOT, and insurance arrangements in place. There were a sufficient number of vehicles available to replace any vehicles taken out of service for repair.

• Each of the five vehicles we inspected had appropriate equipment that included first aid equipment, PPE, blankets and suction equipment.

• We checked a range of equipment in each vehicle including masks, suction equipment, carry chairs, and stretchers. Equipment appeared clean and was neatly stored meaning it could be accessed quickly when required.

• Each garage had a restock point for crews to access, which was re-filled on a twice-weekly basis.

• Each ambulance had a fire extinguisher secured appropriately in the vehicles. We found fire extinguishers were clearly marked with the next service test date and all were within date.

• Daily checks before a shift started included checks of vehicle roadworthiness. We saw the vehicle checks sheet were completed for the vehicles we inspected. An external service provided the vehicle deep clean on a 12 weekly basis. Swab tests were undertaken for hygiene standards.

• The operations staff were responsible for cleaning the vehicles at the end of a shift and a logbook stored within each vehicle indicated when this had been done.

• Ambulance keys were held securely within the ambulance station.

• All vehicles assigned to the NHS contract had built in booster seats on the rear facing attendants chair. These seats folded down into a booster seat as and when required.

• Crews were able to transfer patients with mental health needs if required.

Medicines

• The operations lead and registered managers took responsibility for the safe provision and management of medicines. There was an effective system in place to manage medicines. Medicines were store in a locked cupboard in the crew room within the station.

• Medicines audits were predominantly scoring 100% with two occasions when outcomes dipped to 92%.

• Stock checks were undertaken weekly and gas deliveries were received the day after they were ordered.

• Each garage had a medicines restock point for crews to access, which was re-filled on a weekly basis.

• The service did not use controlled drugs (which are medicines that require an extra level of safekeeping and handling). However, there were controlled drugs held in a locked safe on site, which were used by the British Red Cross event first aid team based at the same location.

• There is a controlled drugs safe on every ambulance should a paramedic be working on the ambulance or transporting with the Red Cross crew.

• Stock checks, administration records and audits were in place to ensure safe storage of gases. Gases were stored appropriately in cages and rotated when new stock arrived. We saw cylinders were stored in a room with the appropriate ventilation. The British Compressed Gases Association recommends a well-ventilated storage structure for medical gases.

• We saw that staff maintained a record of the name of and amount of medicines given, the batch numbers, expiry date and patient details, alongside the date of administration.

• We reviewed the medicines management policy, which was in date and fit for purpose. The policy was stored electronically and all staff had access.

• Medicines bags were provided and stocked by the Red Cross and were checked in and out of the ambulance at the beginning and end of shift.

Records

• Ambulance crews used patient report forms (PRFs) which were a record of patient care, transfer times, as well as pick up and drop off times. We looked at six patient record forms and saw that they were accurate, complete, legible, and up to date. The service audited the completion of the patient report forms, which meant any issues with record keeping could be identified or actioned.

• We saw evidence of PRF audits being completed on a monthly basis.

• The service had an appropriate system in place for the confidential storage of records in line with the Joint Royal Colleges Ambulance Liaison Committee guidance. All PRFs were scanned and stored securely by the Red Cross. PRFs were then placed in secure bags and given to the local commissioning NHS ambulance service.

• British Red Cross (North East) provided a staff 'online portal', which was used to keep staff informed of policies and procedures, staff meetings and staff rotas, for example operational staff could access the portal from their mobile phones via an app.

Assessing and responding to patient risk

• Staff were aware of their responsibility to assess and respond to patient risk. For example, we saw ambulance crews record patient observations and treatments during transfers and shared this information with staff on arrival at the destination.

• If patients deteriorated during transportation, the crew were able to provide emergency support as needed and would either call emergency services for back up if a paramedic was required, or transfer to the nearest acute hospital.

• Staff were informed of active 'do not attempt cardiopulmonary resuscitation' orders (DNACPR) prior to completing the planned transfer. On any occasion where DNACPR had not been discussed prior to transfer, patients would be resuscitated in line with the British Red Cross (North East) policy.

• The crews followed care bundles that linked to The National Institute for Health and Care Excellence (NICE) guidelines for example for asthma, major trauma, and diabetes.

• There was a sepsis pathway in place for staff to follow and adhere to. When training/refreshers were undertaken the service obtained the most up to date information from the sepsis trust.

• The computer system in the vehicle was used to pass information between the emergency control centre and the crew. When the crew decided to transport a patient to hospital, they selected the required hospital on a list and the computer provided them with directions through the integrated satellite navigation system.

Staffing

• Staffing levels and skill mix were planned and reviewed to ensure that people were safe from avoidable harm and received safe care and treatment. Crews were predominantly made up of a mix of ambulance crew and ambulance technicians.. The service did not employ paramedics.

• The service had 36.5 WTE members of staff. The managers were responsible for the safe staffing of all activities. Some staff worked on an ad-hoc basis, supporting substantive staff for transfers or activities as scheduled. The service did not use bank or agency staff but use staff who work casual hours.

• During the inspection, we reviewed the lone working policy that was in date and appropriate. The policy was available electronically, and was uploaded to the online staff portal, which meant it could be accessed by staff at any time. Staff kept in touch with the office during patient journeys by mobile phone.

• Staff rotas were generated and uploaded onto an online programme which all staff had access to via an app on their mobile phone or computer. The programme showed the rota pattern and shifts which required cover. Staff were required to have 11 hours downtime between shifts with a maximum of four shifts in a row. We saw rotas which demonstrated the appropriate downtime between shifts.

Anticipated resource and capacity risks

• Senior managers did not feel there was resource or capacity risks at the time of inspection.

• The services has an ongoing recruitment strategy to ensure appropriate staffing levels are maintained and uplifted when new work is awarded.

• The British Red Cross (North East) continues to provide services to the local NHS ambulance trust under a framework agreement.

• The service had protocols in place to manage changes in demand, seasonal weather, loss of facilities or infrastructure and disruption to staffing levels.

Response to major incidents

• The British Red Cross (North East) responded to major incidents under instruction of the commissioning NHS Ambulance Trust.

• Local and national business continuity arrangements were in place. Should a major incident occur at the Newcastle office, staff were able to continuing operations from the Stockton office with minimal delay or disruption.

• Training for major incidents took place. A mock run incident took place in December 2017 and was run nationally. Table top exercises were undertaken based on the British Red Cross (North East) business continuity plan. One scenario was around a fire at the main operating base.

• The British Red Cross does not respond directly to CBRN incidents. The ambulance crews would support a response as directed by the local NHS ambulance trust. The British Red Cross Emergency Response service often support a response by implementing rest centres and providing psychosocial support and recovery systems.

Are emergency and urgent care services effective?

Evidence-based care and treatment

• All staff employed by the provider had pre-employment checks, references and training/skills assessment records to ensure that they were competent, experienced and suitable for their role.

• Staff had access to evidence based policies and procedures on the electronic recording system.

• People's needs were assessed and delivered in line with evidence-based, guidance, standards and best practice. The services followed the National Institute for Health and Care Excellence (NICE) quality standards and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) as evidence bases for care.

• British Red Cross (North East) completed vehicle check audits, hand hygiene audits, clinical waste, health and safety, medicines and patient record audits with a minimum of four each per month.

• We found that quality assurance was monitored through monthly audit and crew assessment days.

• The management team operate a system of important memos and updates to be sent to all staff members via email. All staff must accept receipt and understanding of these.

• Staff followed care bundles for specific conditions when assessing a patient need.

Assessment and planning of care

• Staff identified patients by confirming their details to ensure they had the right details and were going to the correct destination.

• The service ensured that patients go to the most appropriate hospital for treatment by instruction from the commissioning ambulance trust. However, crew were aware of the need to divert patients who require trauma care, maternity, paediatric or other specialist units.

• Where appropriate, staff 'see and treat' rather than convey patients to hospital. All information was documented on the PRF and a handover provided to the appropriate community service.

• Patients' hydration needs were considered and there were some arrangements such as bottled water in the vehicles, which could be given to the patient if required.

Response times and patient outcomes

• All response times and outcomes were recorded by the commissioning NHS ambulance trust and meetings were held six monthly to discuss performance.

• All response times were taken and collated directly by the local NHS ambulance trust as the information was not required by the Red Cross. If required the service could request audits of response times for discussion in meetings with the commissioner when reviewing performance.

• The service did collate detailed performance information relating to the number of responses, type of response and treatment of patient.

• Patient Record Forms (PRFs) were audited to ensure the correct care path bundles were used.

• There was participation in relevant local and national audits, benchmarking within the British Red Cross, and peer review within the service.

Competent staff

• Staff had the appropriate qualifications and experience for their role within the service at the time of inspection.

• There was an induction programme in place and we saw evidence that all staff had received this.

• The registered managers were qualified to provide clinical supervision, which were on a one to one basis.

• The registered managers were also a qualified trainer and undertook annual assessments of competence.

• Additional training was available to staff which enhanced their professional development.

• We found that all staff including volunteers and ad hoc staff undertook a Foundation Training Programme (FTP) which included subjects such as: learning the service and services; safeguarding; supporting people emotionally; manual handling; professional boundaries; confidentiality; principles and values; basic first aid; emergency response; as well as empathy and sympathy. Following this, staff commenced their medical training and Pearson's Ambulance Crew Award examination.

• Volunteers working within the service were required to complete one shift per month to ensure skills remain up to date.

• All staff had a period of being supernumerary on shift, post induction.

• We saw that all staff with driving responsibilities had completed the necessary blue light driver training and fitness to work checks were in date.

• We were advised that all tutors were quality monitored on a two yearly basis to ensure competence.

• We saw evidence that all substantive staff had received annual appraisals.

• We saw evidence of competencies in administration of medical gases.

Coordination with other providers

• When staff transferred patients to hospital, they provided a formal handover to staff at the hospital.

• Ongoing relationships were maintained with the local NHS Ambulance Trust. Information was shared through a third party compliance document on a quarterly basis.

• There were no current links with the local Clinical Commissioning Groups (CCG).

Emergency and urgent care services

Multi-disciplinary working

• We observed patient handovers at the Emergency Department. These were found to be appropriate, comprehensive and prompt.

• The British Red Cross (North East) frequently made referrals internally and externally for patient support. For example, referring for mobility aids, safeguarding concerns, and crisis team input. We saw evidence of a crisis team referral being made for a patient thought to be mentally unwell.

• We saw staff see and treat patients. Information from staff attendance and treatment was shared with the patients' doctor when necessary.

• Staff advised that there was a strong team working ethos within the organisation.

Access to information

• All responses are managed by the local NHS ambulance trust. Crews are dispatched directly from the emergency control centre. Most vehicles have mobile data systems installed which displays all the relevant information. Other vehicles use pagers which display the same information in a smaller format. All vehicles carry radios provided by the trust.

• The service's 'do not attempt cardiopulmonary resuscitation' (DNACPR) policy stated that ambulance clinicians must check for DNACPR paperwork as soon as possible after arrival at the patient's location and ensure that it is currently valid and signed by the responsible clinician in charge of the patient's care.

• Crews carried radios and were able to receive updated information.

• Access to policies and procedures was available via the online portal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

• The Mental Capacity Act 2005 (MCA), consent, and Deprivation of Liberty Safeguards (DoLS) were included in the mandatory training package. All staff had completed the training.

• The service had an up-to-date policy on consent. This included definitions and guidance on assessing capacity. Staff understood consent, decision-making requirements and guidance.

• We saw evidence of staff assessing capacity and documenting the outcome on the PRF, this included best interest decisions.

• All staff had completed training on restraint and de-escalation techniques. For restraint to be required and legal it must take control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, end or significantly reduce the danger to a person and others and contain or limit a person's freedom for no longer than is necessary. The appropriate use of restraints policy and quick guide was accessible for all staff.

Are emergency and urgent care services caring?

Compassionate care

• We were able to observe an emergency response for four patients. Staff maintained patients' privacy and dignity, by using clean blankets to cover them and ensuring they closed the vehicle door before moving or repositioning patients. We saw that each vehicle had a supply of extra linen to support patient dignity when transporting patients.

• Staff were experienced at meeting patient's individual needs and positive feedback was received by the service.

• During our observation, we found staff were kind and compassionate towards patients.

Understanding and involvement of patients and those close to them

• We saw an example of a patient and carer being involved in the delivery of care. A carer was requested to travel in the ambulance with a patient as he had been trained in the use of the patient's heart equipment.

• Staff were able to explain how they supported families and provided advice when necessary. We witnessed families being supported during delivery of patient care.

Emotional support

• All staff we spoke with demonstrated a consideration for the emotional wellbeing of patients and their relatives.

• Staff were understanding and sympathetic towards patient needs, adapting as required.

• We observed staff take the time to reassure and support both patients and their relatives.

Emergency and urgent care services

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

Service planning and delivery to meet the needs of local people

• Service delivery was based on contracts held with an NHS ambulance service. The service employed staff with different qualifications and backgrounds to meet the needs of people in their locality and wider community who required emergency and urgent care.

• The service was provided seven days per week, on a 12 hr shift basis. There was no night shift coverage to allow staff the appropriate breaks between shifts. Staff said they had no issues with working extended hours if required.

• The service provided training, which covered various ways of communicating with people with sensory impairment.

• All vehicles were accessible to patients with a physical disability.

• The Red Cross was not required to collate response time data under the contract agreement with the trust. Information on response times was available and provided by the commissioner on request. Any issues with response times were raised in progress review meetings with the trust.

Meeting people's individual needs

• All vehicles had a child booster seat built into the rear facing airway seat. This folded down out of the seat to provide a booster seat and harness.

• The contract operated did not have any requirement for bariatric services, however, the Red Cross had invested heavily in bariatric services and had upgraded two ambulances to be fully bariatric capable with bariatric trolleys. A full training package had been developed and was being rolled out to staff.

• To support bariatric services the service developed a set of operating procedures and risk assessments to ensure this area of work was delivered safely and effectively.

• Each ambulance carried a communications book which had a number of medical questions written in various languages with some basic responses. The ambulances also have on them a phone with which staff can ring language line.

• During the week the crews also had access to the refugee support team who between them spoke approximately 20 languages.

• Crew carried communications learning card which assisted with language barriers.

Learning from complaints and concerns

• The service had received 39 complaints from October 2016 to October 2017.

• The service had a complaints policy in place, which stated that complaint resolution should be possible within 1-2 working days for the majority of minor complaints and negative comments requiring a response. A maximum of 20 working days was allowed for the completion of a complaints investigation and a response to be provided. We looked at two complaints, the associated investigations, outcomes and actions. We found them to be detailed, comprehensive and timely.

• If the complaint came from the commissioning NHS Ambulance Trust, the British Red Cross (North East) followed the trusts policy and timelines.

• The service manager was identified as having responsibility for recording, reporting and sharing information from complaints, compliments and comments on a local, regional and national level. In addition to this, the policy highlighted an open culture which encouraged the capturing and sharing of all feedback

• There was evidence of learning shared with staff on the weekly briefing letter. One to one meetings took place if a learning event was required for one member of staff. If the concern affected the wider team, training would be provided.

• Most complaints had not been upheld and had related to the crews driving. These had not been upheld as the CCTV in the vehicle exposed any areas of bad driving. Telematics on the vehicles highlighted if a driver was speeding or braking too hard. Telematics is a method of monitoring a vehicle. By combining a GPS system with on-board diagnostics it is possible to record and map exactly where a vehicle is and how fast it's traveling, and cross reference that with how the vehicle is behaving internally.

• Each vehicle carried complaint / compliment feedback forms which patients were encouraged to complete, where appropriate.

• There was one occasion where Duty of Candour was applied following a patient complaint.

Are emergency and urgent care services well-led?

Vision and strategy for this this core service

• The 2015-2019 corporate strategy was called 'Refusing to ignore people in crisis'. The British Red Cross (North East) state that putting people in crisis at the heart of everything they do, will guide their work for the next five years. The services aimed to listen and respond to the changing needs of those they help. Progress towards achieving the strategy was reviewed at the operation leads meetings.

• The services values were underpinned by seven fundamental principles. The values of the service were to be compassionate; courageous; inclusive and dynamic. Their fundamental standards were humanity; impartiality; neutrality; independence; voluntary service; unity; and universality.

• The provider had a statement of purpose giving clear details about the service and its vision and values.

• Ambulance staff and managers displayed the service values when talking about their work, strategy and motivations.

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

• British Red Cross (North East) had a detailed risk register in place that showed short, medium and long-term actions. The register was up-to-date and reviewed regularly.

• The ambulance pulse check audit April 2017 highlighted that the service approach to quality assurance was firmly evidenced and reflected in its information governance system. The audit outcome for governance was 72% out of a possible 100%. The audit outcome was recorded on the risk register with actions to increase performance.

• We requested the minutes of team meetings and found that there was a high attendance, information was shared with the team; and concerns, training, vehicle problems, systems and processes were discussed at length. The service held staff meetings on a monthly basis.

• Policies and procedures were all in date and were accessible on the service's computer system, and staff had access. However, there was no assurance process in place to ensure staff had read them.

• Risk assessments had been carried out where appropriate, including in relation to fire and building safety.

• National ambulance operations lead meetings were held and brought together all operation leads, business partners, governance teams and health and safety teams to feedback on governance, figures, trends and themes.

• The service had systems in place to manage effective staff recruitment processes. For example, we reviewed eight substantive staff files and found evidence that staff details had been appropriately checked. Staff files showed evidence of satisfactory references being requested and reviewed.

• The service undertook Disclosure and Barring Check (DBS) checks on both substantive and ad hoc staff in their employment.

Leadership and culture within the service

• The service had a CQC registered managers in post, with responsibility for the daily running of the service, provision of staff. The managers were fully aware of the Care Quality Commission registration requirements.

• The operational lead had oversight of all operations in the north of England. Responsibilities included monitoring the contract with the local NHS ambulance trust and procuring new contracts. In addition to this, the role included supporting the service manager fulfil their role and ensuring the British Red Cross (North East) provided a good and safe service.

• The culture of the service was positive and team-based. It was apparent that staff wanted to provide a good quality service. Staff told us they felt well supported and the British Red Cross (North East) was a good place to work.

• The service had implemented new policies and procedures since the restructure in 2016 and staff told us they saw the change as positive journey to improve patient care.

• Management felt that crew morale dipped following the restructure of the service. However, we saw that managers were visible and approachable with an open door policy.

Emergency and urgent care services

• The British Red Cross (North East) collect Workforce Race Equality Standard (WRES) data which was published annually. The data was not shared with the Care Quality Commission at the time of the report publication.

Public and staff engagement

• The national staff survey was undertaken every two years. Response for the region was low. As a result, management were working with crews to encourage participation.

• A wellbeing survey was completed at the end of 2017. However, response was low so the wellbeing survey was incorporated into the one to one supervision sessions. Wellbeing champions were crated as a method of improving survey participation through a peer approach rather than a manager approach.

• The service was restricted with its public engagement due to the work being undertaken on behalf of the local NHS ambulance trust. However, friends and family feedback from each patient contact was gathered. This information was gained by the individual scanning barcodes on ambulances or on paper forms.

• Service user feedback was used to gage information on the service provision and to share good feedback with crews. Feedback was also used to make changes to the way the service is delivered.

• The British Red Cross (North East) provided a psychosocial practitioner who assisted staff with any personal difficulties or those requiring emotional support. The service was confidential.

• Wellbeing champions were implemented to encourage staff to engage with the organisation about their health and wellbeing including their professional development.

Innovation, improvement and sustainability

• The British Red Cross (North East) provided a psychosocial practitioner who assisted staff with any personal difficulties or those requiring emotional support. The service was confidential.

• Wellbeing champions were implemented to encourage staff to engage with the organisation about their health and wellbeing including their professional development.

Outstanding practice and areas for improvement

Outstanding practice

• The British Red Cross (North East) provided a psychosocial practitioner who assisted staff with any personal difficulties or those requiring emotional support. The service was confidential.

• Wellbeing champions were implemented to encourage staff to engage with the organisation about their health and wellbeing including their professional development.