St John Ambulance West Midlands Region

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	
Are services responsive?	Good
Are services well-led?	Good

Overall summary

St John Ambulance, West Midlands Region is operated by St John Ambulance. This inspection and report covered the West Midlands region only. The main service provided by this ambulance service is emergency and urgent care. The service also provides a patient transport service for the local NHS trust. Where our findings on emergency and urgent care, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the emergency and urgent care section.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 21 and 22 November 2019.

Summary of findings

During our inspection we rated the service using our five key lines of enquiry. We looked at if the service was safe, effective, caring, responsive and well led. We were unable to rate caring for the emergency and urgent care service as we did not see any regulated activities being carried out.

The St John Ambulance service has both paid staff and volunteers working within the service. Throughout the report when staff are referred to it means both staff and volunteers.

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.

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.

We rated it as **Good** overall.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good 	St John Ambulance is a national charity that is split into four regions. This service sits in the West Midlands region and provides first aid cover for events and transfer from site to another provider. Urgent and emergency services were the main activity. The service carried out 203 emergency and urgent service patient journeys from November 2018 to November 2019. Where arrangements were the same across both urgent and emergency services and patient transport services, we have reported findings in the urgent and emergency services section. Staffing, equipment, vehicles and most processes were the same for both the urgent and emergency services and the patient transport t services. We have rated this service good overall.
Patient transport services	Good 	Patient transport services were a small proportion of activity. The main service was urgent and emergency services. Where arrangements were the same, we have reported findings in the urgent and emergency services section. The patient transport service was contracted by local NHS trusts, including an acute trust and a hospice. Between November 2018 and November 2019, there had been 17,798 patient transport journeys.

Summary of findings

Contents

Good

St John Ambulance, West Midlands Region

Services we looked at

Emergency and urgent care; Patient transport services;

Summary of this inspection

Background to St John Ambulance West Midlands Region

St John Ambulance West Midlands Region is operated by St John Ambulance. The service opened in 1999. The service opened with one manager and one ambulance crew. It is an independent ambulance service in West Midlands. The service primarily serves the communities of the West Midlands.

The service has had a registered manager in post since November 2016.

The service was first registered on 21 October 2012. St John Ambulance West Midlands Region is part of St John Ambulance, which is a national charity providing first aid and other ambulance services. St John Ambulance became a separate legal entity and subsidiary of The Priory of England and the Islands of the Order of St John in 1999. St John Ambulance primarily provides first aid across the country and services include emergency and urgent care, non-emergency patient transport, and first aid and ambulance provision for events. St John Ambulance West Midlands Region provide first aid cover for events and patient transport services (PTS) to take patients to and from hospital on behalf of a local NHS ambulance trust. The provision of first aid at events is not in the Care Quality Commissions (CQC) scope of regulation. Although if a patient needs to be transferred to another provider from an event for continuing care needs then the treatment and care given to the patient during transport is subject to CQC regulation. The Care Quality Commission also has responsibility to regulate patient transport services. The service is staffed by a range of people including trained paramedics, ambulance technicians and ambulance care assistants.

The aim of the organisation is to offer first aid to those who need it and to ensure communities are provided with first aid trained staff. St John Ambulance West Midlands Region is registered to provide the following regulated activities:

• Transport services, triage and medical advice provided remotely.

• Treatment of disease, disorder or injury.

The service has two registered managers one for each of the core services.

The current registered manager for transport services, triage and medical advice provided remotely has been in post since October 2019.

The current registered manager for treatment of disease, disorder or injury has been in post since 2018.

The management strategy and leadership model of the service is the same for both the emergency and urgent care service and the patient transport service although each have their own dedicated manager. Some staff deliver both the emergency and urgent care service and the patient transport service. Where our findings on emergency and urgent care service, for example, management arrangements, also apply to the patient transport service we have not repeated the information but cross-referred to the emergency and urgent care services service core service.

We inspected this service in 2017 but at that time did not have the power to rate the service provided.

At the last inspection the service was given the following actions:

We told the provider they should:

- Review the safeguarding awareness training programme to ensure that it meets all national recommendations as set out within the intercollegiate document.
- Ensure that audit results reported through the national yearly audit programme are used at a regional level to support and secure local service improvements.

Summary of this inspection

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and two specialist advisors with expertise in urgent and emergency care and patient transport services within ambulance services. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about St John Ambulance West Midlands Region

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the West Bromwich Ambulance Station , and a satellite station in Coventry. We inspected eight ambulances at the two locations visited. We spoke with 13 staff including; registered paramedics, emergency care attendants, the operations coordinator, the fleet manager, and the registered managers. We were not able to speak with any patients on the day regarding the emergency and urgent care service because we were not able to observe any care within our scope of regulation during the inspection. However, we did speak to four patients who were being transported by the patient transport service. We also reviewed patient feedback provided to SJA.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once previously in March 2017.

Activity (November 2018 to November 2019)

In the reporting period there were a total of 17,798 patient transport journeys carried out. A total of 203 patients were conveyed to alternative care from event medical cover under urgent and emergency care conditions.

Track record on safety

- No never events.
- No clinical incidents resulting in harm, low harm, moderate harm, death or severe harm.
- No serious injuries.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	N/A	Good	Good	Good
Patient transport services	Good	Good	N/A	Good	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Good

Emergency and urgent care

Safe	Good
Effective	Good
Caring	
Responsive	Good
Well-led	Good

Information about the service

The service provided emergency care at events and transferred 203 patients from events to another acute care provider for ongoing care in the period from November 2018 to November 2019.

The service risk assesses all events to ensure appropriate staff and volunteers are available with the correct skill mix in place to provide safe cover. The service is staffed by both volunteers and employees, the employees work in both the emergency and urgent care service and patient transport service.

Summary of findings

We found the following areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Good

Emergency and urgent care

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

- Not all policies were up to date due to restructuring, however the Executive Leadership Team/Policy owners had reviewed the policies, confirmed that they were still valid and agreed a one year extension.
- The provider did not report data at local level to ensure transparency and openness.

Are emergency and urgent care services safe?

Good

We had not previously rated this service. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received training when they started working with the service. Update training then took place at unit meetings and staff were reassessed annually. All operational staff were up to date with their mandatory training. Staff who had not competed the mandatory training were made non-operational and were not deployed until they were fully compliant.

The mandatory training was comprehensive and met the needs of patients and staff. The service required all staff to complete training in essential subjects. These included safeguarding, conflict resolution, general data protection requirements (GDPR), materials management, equality inclusion and diversity (EID), infection prevention and control (IPC), basic life support (BLS) and driver training.

Sepsis recognition and management was part of mandatory training for all staff, as part of their compulsory personal development (CPD).

Managers monitored mandatory training and alerted staff when they needed to update it. For example, staff were sent electronic alerts to remind them when their training was due.

Staff we spoke with confirmed managers gave them protected time to complete mandatory training. A tracking system used amber and red flags to highlight when training was about to expire and if it had expired. Managers recognised that many of their staff would have received training in many of the mandatory training topics from their main employer or from other providers. In these cases, the provider recognised and accepted evidence of this.

Managers regularly volunteered at events alongside staff. This gave them the opportunity to assure themselves staff understood and followed St John's policies and procedures.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff received effective training in safeguarding safety systems, processes and practices. They completed safeguarding training as part of their induction to St John Ambulance and updates on mandatory training. Although, staff were trained to level two which was a level below that advised in the intercollegiate document 'Safeguarding Children and Young people: Roles and Competencies for Healthcare Staff', published by the Royal College of Nursing in January 2019, the level of training was proportionate to the type of service, the service being delivered, and the staff employed. Most paramedics had posts with the NHS and were therefore already trained to level 3. Managers said that the service had an action plan in place to deliver level three training to all paramedics in the service.

Under the children and neonate's (PTS) contract 3042 children were conveyed between November 2018 and November 2019. SJA staff did not provide clinical care. The NHS staff delivered clinical care directly. These staff were all trained to level 3 or above. SJA staff were responsible only for driving the vehicle transporting the children.

The service had arrangements to safeguard adults and children from abuse and neglect that reflected relevant legislation and local requirements. There were up-to-date provider wide safeguarding policies and procedures in place which were accessible to staff through the trust's intranet site.

Staff had a clear understanding about what constituted abuse and the need to report this. The service's policies and procedures for safeguarding had information about safeguarding and abuse. This included information about female genital mutilation (FGM), preventing radicalisation and child sexual exploitation.

Staff clearly understood their responsibilities in line with the safeguarding policies and procedures, including working in partnership with other agencies. For example, staff told us they would contact the police if they believed there was immediate danger. Senior members of the safeguarding team attended the multi-agency safeguarding hub (MASH). This was the single point of contact for all safeguarding concerns regarding children and young people in the area.

The systems in place within the service were structured and robust to support staff and patients if safeguarding concerns were identified. The head of safeguarding was trained to level four for both adults and children and all five members of the national safeguarding team were trained to level three. Their safeguarding competencies were maintained through four continued professional development (CPD) sessions a year. This was facilitated by the national safeguarding advisor. This person was also the named safeguarding lead for local GP surgeries commissioned by three clinical commissioning groups (CCGs) in their day to day role.

The national team oversaw all safeguarding concerns and attended MASH meetings. Many of the volunteers were doctors, nurses and paramedics in their every day jobs and came with a wealth of safeguarding knowledge and experience.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff reported safeguarding issues on a "cause for concern" form which was sent by email to the national safeguarding team who were responsible for onward referral to other organisations, such as local authorities. Safeguarding information and forms were accessible to staff on vehicles and all staff carried a comprehensive safeguarding pocket card with advice, guidance, telephone numbers, policy statements and reporting concerns flowchart.

If staff identified any concerns that required immediate action and review they escalated these to the safeguarding team by phone at that time.

All staff told us they received information about safeguarding updates and changes, feedback and learning from referrals in monthly newsletters, emails and at weekly training meetings.

The service promoted safety in recruitment practices. All new recruits were subject to an enhanced disclosure and barring service check (DBS) and required two references before they could work clinically. The service also required the DBS updated every three years for staff in post.

The regulatory assurance manager carried out assurance visits. As part of the visit they presented staff members with safeguarding scenarios to ensure they understood the safeguarding process and could identify a safeguarding concern.

We reviewed the most recent quality report (September 2019). Four safeguarding referrals had been made to social services in the month of August and these were all concerning 'neglect'. This showed staff understood how to take appropriate action when they had safeguarding concerns.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. For example, patient seating was designed to facilitate easy cleaning. The environment and all equipment were visibly clean.

All staff completed infection prevention and control training when they started with the service and this was included in their annual mandatory assessment.

All the vehicles we checked were clean and well maintained. Cleaning records were up to date and demonstrated that the vehicles were regularly cleaned.

An external provider was contracted to deep clean the vehicles on a 12-week cycle. There was clear guidance for what was cleaned and how this was carried out.

Crews followed an escalation process when vehicles got contaminated. The external organisation provided an extra clean if this was required. The external provider carried out swabbing of the vehicles before and after cleaning to make sure the cleaning was satisfactory.

Managers completed audits of pre and post swabs to assure themselves that decontamination was effective. We saw evidence confirming this process was effective.

St John Ambulance managers met with the external provider every three months to monitor the effectiveness of the service and deal with any problems or concerns. We saw evidence of this such as meeting minutes.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff were provided with personal protective equipment, such as gloves, aprons and eye shields. These were stored on all vehicles.

Colour coding of cleaning materials and equipment and disposable one-use mop heads ensured they were not used in multiple areas, therefore reducing the risk of cross-infection. For example, red colour code was only to be used in toilets and showers.

Cleaning area at the hub were well laid out and properly equipped

The provider had recently launched a national five-year plan regarding infection prevention and control along with monitoring tools to audit implementation. The plan included training for staff, audit plans, recruitment and development.

Infection prevention and control (IPC) leads within the region carried out spot checks at events to ensure compliance with IPC.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The ambulance stations we visited, including the garages and equipment storage areas, were clean and well laid out. They were spacious, tidy and fit for purpose. The stations were accessible by a locked door and keys to all vehicles were kept within a locked cupboard.

We checked a cross section of vehicles and found staff complied with cleanliness, infection control and hygiene, environment and equipment policies and procedures.

The provider focused on avoiding repairs and asset failure through preventive and predictive methods. The

service operated a robust planned preventative maintenance (PPM) scheme. Every vehicle, dependant on type, underwent a safety inspection against a time-based schedule. Ambulances were safety inspected every 13 weeks and serviced in line with manufacturers recommendations. All other fleet were safety inspected every 26 weeks and serviced in line with manufacturers recommendations.

Over the previous two years St John Ambulance had invested in purchasing a fleet management system and a fleet telematics system. The fleet management software system allowed full sight of all associated aspects of every vehicle from legal compliance, expenditure of whole life costs through to carbon dioxide (CO2) emissions. Direct fuel use could be imported from fuel card invoices, tyre use and all associated costs. It also had live mileages imported from the telematics system. The system was installed to ambulances and treatment centres and it allowed managers to track any vehicle's live location, replay journeys and monitor driver behaviour. It offered driver identification input, so managers knew who was driving a vehicle at any time in the event of any incident, such as a fixed penalty notice or accident. The system was used to plan all planned maintenance and logged all unplanned maintenance. There was a mobile app that was downloadable onto a smart device that all St John Ambulance staff with a St John Ambulance email address could access to carry out daily vehicle checks, report defects and check the legal compliance of any vehicle on the system.

The National Fleet Office at Union Park managed all the pre-planned work, booking vehicles into the garages for servicing, inspection and MOT. The administrators planned equipment servicing, fire extinguisher checks, tail lift and winch compliancy maintenance, updated the fleet management system and dealt with all invoicing and audit checking of work carried out.

Staff told us defects of vehicles and equipment were attended to promptly. We saw evidence of this on the fleet management system.

A process to declare a vehicle off road had been put in place which involved the driver and fleet co-ordinator making the decision together. If the issue was a safety issue such as an issue with brakes, then the vehicle was immediately removed from use.

Staff stored vehicle keys securely when they were not in use. Keys were stored in a safe. Staff members had personal pegs which released the keys in the safe. This meant managers could always identify who had what vehicle.

The service had enough suitable equipment to help them to safely care for patients. Staff ensured all required equipment was on the vehicle by completing a daily check list. This detailed all the equipment that should be on the vehicle and recorded that staff had checked the equipment was in working order. Staff confirmed that faulty equipment was replaced quickly and was available when required.

The provider ensured they conveyed children safely in their vehicles. They had adjustable harness straps.

The arrangements for managing waste and clinical specimens kept people safe. This included classification, segregation, storage, labelling, handling, treatment and disposal of waste. Staff disposed of clinical waste safely. Vehicles had waste disposal bins.

All staff had access to a Control of Substances Hazardous to Health (COSHH) procedure. COSHH regulations 2002 is the law that requires employers to control substances that are hazardous to health. Staff complied with these regulations. For example, all COSHH products were locked away securely.

Staff followed a systematic approach to the acquisition, deployment, maintenance (preventative maintenance and performance assurance), repair and disposal of medical devices. Single use medical devices, such as hypodermic syringes and needles, were used only once and then discarded. Single patient use medical devices such as nebuliser masks and linen were used on one patient only and then discarded.

A national equipment manager advised what equipment to introduce to the service and methods for trialling equipment

The service had enough suitable equipment to help them to safely care for patients. All the equipment we checked was within its service date. When equipment was faulty staff tagged them with a red tag and placed it on a dedicated shelf in the store room.

A servicing plan was in place for annual servicing. The medical gas tracker was up to date. This meant managers were able to keep track of all the cylinders they had.

The store room for ambulance operations was clean and tidy and managers completed monthly stock checks.

Lead crews monitored and audited vehicles monthly. We reviewed a selection of these. Any learning points were cascaded through a variety of channels such as the staff intranet.

Managers completed building and vehicle audits monthly and identified action plans to improve the service as a result.

The staff using the vehicle had responsibility for ensuring vehicles were suitably prepared (including stocking, cleaning and disinfection) for use at the start of each shift. However, the service was planning to introduce "make ready" solutions. The provider hoped this would offer benefits in terms of morale, vehicle utilisation, vehicle condition, infection control compliance, accountability and be an enabler for a smaller fleet becoming more effective.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

All ambulance operations staff had access to a current pocket guide of the Joint Royal Colleges Ambulance Liaison Committee protocols and also had access to clinical procedures on the SJA staff intranet.

Staff completed comprehensive risk assessments for patients and they developed risk management plans in line with national guidance and managed risks appropriately. For example, staff used the FAST test (the FAST test is used to identify a person having a stroke and stands for facial drooping, arm weakness, speech difficulties and time to call emergency services.) and the AVPU scale (the AVPU scale is used to measure a person's level of consciousness and stands for alert, verbal, pain, unresponsive).

The provider had appropriate equipment to manage an emergency, for example, staff had access to a defibrillator for use in the event of a cardiac arrest. All defibrillators were self-testing and if any issues were identified staff were alerted to these through a default sign. They were serviced every 12 months.

Staff were aware of the national guidelines for cardiac arrest and stroke and took steps to ensure local centres for specialist services were identified before completing an event. This meant patients were transported to the most relevant acute health care provider in a timely manner.

Staff told us they could always easily contact an on-call manager 24 hours a day, seven days a week if they needed to escalate a risk or seek advice or help.

The service ensured assessments were completed prior to transferring a patient to an emergency department (ED), which ensured there were no unnecessary transfers. Patients being discharged from the service were given advice on the next steps, for example, visiting their GP or pharmacy if problems persisted.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately Staff were clear regarding escalation processes for managing a deteriorating patient. The procedure for escalation depended on the level of the problem but varied from seeking advice from managers or facilitating immediate admission to the acute department at the trust. Staff monitored patients for signs of deterioration. To assist with the identification of a deteriorating patient, staff used the National Early Warning Score (NEWS2) for adults. Staff very rarely transported children under emergency and urgent care conditions from events to acute settings. However, if need be they used an adapted early warning score tool called the PEWS (paediatric early warning score).

All staff completed the minimum level of basic life support and paediatric basic life support. Some clinical staff were trained in intermediate and advanced life support. Staff said they would liaise with police and local mental health services when caring for disturbed or violent patients.

Staff shared key information to keep patients safe when handing over their care to others.

Staff completed a patient record form and gave a copy to the facility where the patient was being transferred to.

Staff had access to the national policy for emergency preparedness, resilience and response.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not have a set number of staff as their baseline due to demand for services outstripping the service's ability to supply at the time of inspection.

The service used an assessment tool to determine staffing levels (numbers and skill mix) for each event, dependant on the type and size of the event and whether the contract included conveying patients from the event to acute hospital settings. The event dates and staffing requirements were detailed on the electronic system. The head of event operations confirmed the service only accepted work they knew they had the staff to safely provide cover. Event cover staff was a mix of emergency care assistants, ambulance technicians paramedics and first aiders. .

Managers did not use external bank and agency staff. In the event of an unfilled shift or sickness, the service first tried to fill with volunteers and then went to its internal casual bank which comprised of St John Ambulance's own staff. The casual bank was paid work and both contracted staff and volunteers could be registered.

Staff based at the Coventry and Union Park ambulance stations consisted of one station manager. They were responsible for the operational management of all ambulance related activity in the designated ambulance station(s)/location(s) ensuring full delivery on agreed contracts and framework agreements while taking ownership of maintaining clinical standards and management of the team locally in line with St John Ambulance policies and procedures and CQC standards.

The coordinator was responsible for coordination of the regional ambulance control / administration centre, ensuring the running of the service was safe, effective, efficient, economical and done so in a compliant manner. They maintained a crew rota and despatched ambulance crews to fulfil customer requirements.

Four lead crew staff members for general and KIDS/NTS (neonates) supported the station manager in the delivery of a quality crew service to patients and customers in line with the organisation's standards. These were ambulance crew roles with added responsibilities.

There were 42 ambulance crew emergency care assistants and 11 ambulance crew patient transport attendants. This number included casual members of staff who worked on an ad hoc basis. Ambulance crew were responsible for the provision of high quality and effective clinical care to the community, responding to a wide range of situations including medical emergencies, inter-hospital transfers, urgent hospital admissions, routine journeys and other allocated operational activities. They drove a range of vehicles, under both emergency and non-emergency conditions as required.

The ambulance operations coordinator ensured all ambulance services administration duties were performed within set targets and provided support through set processes to front line crew and managers.

Managers monitored sickness. From 1 November 2018 to 31 October 2019, the percentage of days lost was 2.6%. Managers said this was a low figure. A sickness policy was in place and managers followed a sickness management plan to assist in the management of both short term and long-term sickness.

Managers shared they had a major challenge in recruiting enough people quickly enough to meet the increasing demands of the customers. Recruitment of volunteers for events was a national challenge for the organisation. However, managers said this did not impact on services offered. For example, they carried out an assessment of first-aid needs to determine what level and amount of staff to provide at events. If they could not provide what was needed to ensure patient safety, they would not accept the contract.

The provider monitored turnover rates. At the time of inspection, there was a 23% rate. The provider was aware of the high turnover rates, had recorded this on the risk register and had produced action plans to address this area.

Records

Staff recorded notes on a patient log and updated them with details of their care. Records were clear, up to date, stored securely and easily available to all staff providing care.

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. We reviewed five patient records.

Staff completed patient report forms when providing treatment to patients. There was one form with two sections, one section for first aid and one which provided space for advanced interventions and treatments This meant healthcare professionals were able to complete accurate records of the care and treatment they provided, while allowing first aid to be recorded on a simpler form. These forms were shared with the acute hospitals and used to handover care and treatment.

Staff stored completed patient record forms (PRF) securely in a folder at events, which was kept by the event lead. At the end of the event, the completed forms were posted to a secure electronic data storage facility where they were scanned and then destroyed.

Documents containing confidential or personal data such as staff files and patient records were stored in lockable units and were not left on desks overnight or in view of visitors.

Regular quality audits of records were undertaken, and changes made where necessary to ensure safety of patients. We saw that monthly audits of the completion of the PRF's were undertaken and reported in the monthly assurance and quality report with findings and actions required. For example, in the most recent September 2019 quality report it was reported that 109 forms were audited, and this showed 73% compliance nationally. Audits results, and action plans were shared with staff through a variety of communication channels such as the newsletter and intranet. Managers completed all clinical audits every month. This ensured managers had systems in place to confirm that improvements had been effective.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The provider did not hold a controlled drug licence and did not hold stocks of controlled drugs. However, they supported paramedics with the legal process and approval system to order and hold their own controlled drugs in accordance with home office regulations. Controlled drugs are prescribed medicines used to treat severe pain, induce anaesthesia or treat drug dependence. However, some people abuse them by taking them when there is no clinical reason to do so or divert them for other purposes. For these reasons, there are legislative controls around their use.

Paramedics administered controlled drugs following clinical assessments to sick or injured persons who needed immediate treatment. This was in line with National Institute for Health and Care Excellence (NICE) guidelines and legislation such as "The Human Medicines Regulations 2012" and controlled drugs regulations.

The service used systems and processes to safely record medicine. Staff knew which medicines they could administer dependent on their role and scope of practice. This was outlined in the up to date medicines management policy. Staff who were not registered healthcare professionals, such as first aiders, only administered medicines which did not require a prescription, or those which are listed in schedule 19 of the Human Medicines Regulations 2012 as medicines that may be administered by anyone for saving a life in an emergency.

The service had a safe system for the ordering and receipt of medications. Medications were issued to the appropriate staff and monitored centrally at the supplies service for expiry date and stock level. A paramedic's supply of drugs was issued to them personally and delivered by registered post; a signature was required on receipt and each delivery had a unique number to allow it to be tracked.

Paramedics had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance, which provided them with clear instructions about the administration of medicine.

Staff effectively managed the stock control of medical gases. For example, there were two separate cages, one

for full medical gases cylinders and one for empty. This was in line with industry guidance. Medical gasses were stored safely in a locked container in the vehicle compound.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The incident management framework was a key component of St John Ambulance's governance and risk management framework. The aim of all components of the framework was the reduction of unsafe or unsatisfactory practice, analysis of risk and the sharing of lessons learnt and best practice nationally.

This document set out organisation-wide procedures that applied to all St John ambulance staff (volunteers, employees and contractors). It was produced in conjunction with the St John Ambulance incident management framework policy.

All staff had a responsibility to report any incidents or near misses they became aware of. The incident reporting procedure provided personnel with clear information on how to report incidents and near misses.

Managers ensured staff understood their responsibilities to raise and record concerns, safety incidents and near misses. The provider ensured staff understood how to report them internally and externally where appropriate. All permanent and temporary employees of the provider received training and education on the incident reporting procedure as part of their induction.

There were effective arrangements to report, review and investigate safety incidents. Staff reported incidents and near misses through an electronic system. Staff we spoke to during the inspection were aware of the procedure and could describe how they would report an incident. Staff also told us that they were encouraged to report incidents as they arose.

However, although it was the providers policy that incidents must be reported within 24 hours of their occurrence, in September 2019 only 47% of incidents were reported within 24 hours of their occurrence in the ambulance operations service area, nationally. This was reported in the newsletter with a reminder for staff to complete incidents reports in a timely manner.

There were no never events since the provider registered with the Care Quality Commission. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Staff we spoke with said managers listened to their concerns and took them seriously. For example, vehicle defects formed a high proportion of incidents reported. Staff told us these were generally fixed in a timely manner.

Effective arrangements were in place to respond to relevant external safety alerts. The clinical directorate was responsible for identifying any relevant alerts; such as those issued by manufacturers or the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA is an executive agency of the Department of Health and Social Care in the United Kingdom which is responsible for ensuring that medicines and medical devices work and are acceptably safe. The head of clinical operations, or their nominated healthcare professional within the directorate, reviewed all such alerts and assessed their relevance to all St John Ambulance activities including event cover and patient transport services. The head of clinical services, or their nominated healthcare professional within the directorate, processed alerts daily Monday to Friday. They were required to report completion of any such actions to the clinical directorate. Staff told us managers shared these through a variety of channels such as the newsletters, emails and the intranet. We saw evidence of this.

Duty of candour formed part of the initial training packages. No serious incidents had been reported in the previous 12 months and therefore no duty of candour had been applied.

Good

Emergency and urgent care

Managers told us the content of their training and continued professional development days was designed in response to incident themes. For example, the provider responded to a trend identified in their incident management framework of manual handling incidents across all their service areas by way of reinforcing appropriate practice through their annual refresher training and re-assessment.

Managers held regular 'Lessons Learned in Regulated Activity Sessions'. The aim of the sessions was to provide a governance framework within regulated activity to ensure the risks and outcomes from incidents, complaints and audits were reviewed and recommendations/action plans developed to close the learning loop. We saw incidents recorded, immediate control measures, contributory factors, recommendations and root causes identified.

The service produced a monthly 'take 5' to share learning from incident and complaint themes. This was a short bulletin asking staff to take five minutes to read and consider learning points. For example, we saw 'take 5' regarding hand hygiene and glove use. Reminders included "Do you know what the principles of 'bare below the elbow' are?" and "Do you know when to clean your hands as per the '5 moments for hand hygiene'?"

Incidents were categorised into areas such as clinical care, medication and equipment. This meant managers could identify themes of incidents reported.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Good

We had not previously rated this service. We rated it as **good**.

Evidence-based care and treatment

Although not all policies were up to date, they were based on up to date national guidance and best practice. Managers checked to make sure staff followed guidance.

The provider considered evidence-based practice, regulatory requirements and up to date guidelines published by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). These were embedded in the company's policies and procedures.

The provider published A Scope of Practice in April 2019. This described the procedures, actions, and processes their healthcare practitioners were permitted to undertake in keeping with the terms of their professional license. Health care professionals were working to JRCALC guidelines. Staff had access to a clinical procedure manual and all events had a lead who was usually consultant level. They monitored and supported other event staff with clinical practice and ensured they were working to best practice. The provider was in the process of introducing care bundles which would allow for further monitoring, promotion and evidence of standards of clinical care.

Managers identified there was not one person with overall responsibility for and oversight of policies which meant the system was fragmented and not all policies were up to date. To address this, St John Ambulance were in the process of appointing a dedicated policies manager. The organisation were also committed to the development of a policy management framework and policy IT system.

Staff provided care and treatment based on national guidance. We saw evidence of this.

The organisation received a certificate of approval from the International Organisation of Standardisation (ISO) 9001:2015 for quality management system, which included design and development of training courses in health and safety related topics.

Pain relief

Staff assessed and monitored patients to see if they were in pain and gave pain relief in a timely way. The service had a suitable assessment tool.

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

A range of staff were employed who had differing skills and competencies in the management of pain from administering over the counter medicines to controlled drugs.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

Due to the small numbers of patients conveyed to acute hospitals, the provider did not participate in any national audits. However, staff told us they conveyed patients to an acute hospital immediately if the patient's condition required this. The managers said they had received no complaints from patients about response times.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers completed audits to ensure the patient report form (PRF) provided a medico legal record of assessments, observations, treatment and actions undertaken by its staff. This gave the provider assurance that the clinician's duty of care had been fully met. The September 2019 patient report form audit results showed that staff could record second observations more frequently and pain scores more diligently. This was shared with staff through the newsletter. Managers said the introduction of the new electronic reporting form would address this as only one set of initial pain scores needed to be recorded on these. Managers said the second recording of pain scores was not clinically needed.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service ensured all its staff were best able to perform the basic tasks of their roles safely and competently and provided them with information on the structures and processes of their working environment. All staff received an induction to St John Ambulance in line with the induction policy.

All new starters were assigned a 'buddy'. They acted as a first point of contact for any questions and generally provided a warm welcome and support.

We saw staff worked within the scope of their qualifications, competence, skills and experience, ensuring this was within the policies and procedures of the provider. Managers completed a clinical performance review of staff every three months. This assured managers staff were always adhering to safe clinical practice and following the guidelines of their professional bodies.

Some ambulance crew required a category C1 driving license (a category C1 driving licence is required to drive any vehicle weighing between 3,500kg and 7,500kg). The service ensured these were valid and in date using the fleet management system.

Appraisals were carried out on a yearly basis and included an interim review at six months. Staff said they found these to be supportive and meaningful.

Appraisals and competencies were based on the St John Ambulance values. These values were known as the HEART values. The acronym stood for: humanity (treating others with compassion and respect); excellence (pride in doing an excellent job); accountability (delivering what we promise); responsiveness (continuously learning and improving) and teamwork (working together effectively). Data provided showed all managers, team leaders and lead crew and 86% of ambulance crew had received their appraisal within the last year. The target was 85%. As of 31 December, 100% of staff were compliant with heir appraisal process. Competencies had been written for ambulance staff that they needed to demonstrate to meet the St John Ambulance values.

Staff at all levels said they were supported with their continued professional development (CPD). For example, the head of ambulance operations recently completed a gold multi agency gold incident commander course.

The service offered two mandatory CPD days for staff and one for volunteers. However, managers said from next

year (2020) the service would be offering joint CPD days for both volunteers and staff. This would allow staff of different positions and levels to share skills and good practice.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked in collaboration with other services. This included working with local police services and mental health services when appropriate to provide the best treatment and support for patients.

Staff told us there were effective handovers between themselves and hospital staff when they took patients to other providers for any continuing care needs. Staff told us a copy of the patient record form (PRF) was used as a handover document and left with the new service.

Health promotion

Staff gave patients practical support and advice to lead healthier lives

Staff supported patients to manage their own care and wellbeing and maximise their independence. For example, staff said they would advise a patient who declined to go to hospital who to contact if their condition deteriorated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

All staff had received training about the Mental Capacity Act 2005 when they started working in the service. This was included in the safeguarding training on induction with clear written guidance in the service's clinical legal handbook. Staff we spoke with showed awareness and understanding of the Mental Capacity Act 2005 code of practice and consent processes. For example, some staff said they would ask the patients some basic questions such as their date of birth and who the current prime minister is as tool to assess capacity. They said they would try to involve the patient's family and or carers. Staff said they would act in the patient's best interest where there were concerns in this area.

The patient report forms included tick boxes to record if the patient had mental capacity and whether consent was gained. For children there was also a box detailing the parent/responsible adult/next of kin. The member of ambulance crew was also required to sign the patient report form to confirm they had explained the treatment to the patient.

Staff would consider any do not attempt cardio pulmonary resuscitation (DNACPR) orders or advanced directives that patients had, if patients made them aware of them. A formal process was in place for staff to follow. This was taken from the Clinical Procedures Manual.

Staff recorded that consent was obtained to provide treatment unless the situation meant this was not possible. Staff also used the same form to record any issue surrounding Mental Capacity. The records we reviewed confirmed this.

Are emergency and urgent care services caring?

We were not able to give a rating about this key question in emergency and urgent care service. The service had little feedback from patients, and we were not able to observe any activity during the inspection.

Compassionate care

Staff spoke about patients with compassion and kindness, showing they respected their privacy and dignity, and took account of their individual needs. However, we did not see any care given to patients.

Staff shared examples of when they offered patients compassionate care. For example, they always offered patients blankets and extra pillows. Ambulances all had pull-down blinds that were used to promote dignity when patients were being treated inside.

We were unable to speak to patients directly as we did not see any patients transported under urgent and

emergency conditions from events. The provider did not record patient contact details in these circumstances therefore we were unable to contact any patients who had experienced this service.

Following our inspection, the provider supplied us with positive feedback from patients and other professionals. However, we did not have sufficient evidence from regulated activity to rate this key question. The evidence we did gather indicated that staff were caring compassionate.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff were aware of the need to support patients experiencing a mental health crisis. Frontline staff knew their responsibilities when transporting patients detained under the Mental Health Act.

We were unable to speak to patients directly as we did not see any patients transported under urgent and emergency conditions from events. The provider did not record patient contact details in these circumstances therefore we were unable to contact any patients who had experienced this service.

Staff showed an understanding of how to care for patients with different needs such as religious and cultural needs.

Following our inspection, the provider supplied us with positive feedback from patients and other professionals. However, we did not have sufficient evidence from regulated activity to rate this key question. The evidence we did gather indicated that staff were caring compassionate.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff said they routinely involved people who accessed their services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment. Staff said they would identify people's carers, advocates and representatives including family members and friends, and welcome and treat them as important partners in the delivery of their care. For example, staff would allow them to stay with the patient being treated.

We were unable to speak to patients directly as we did not see any patients transported under urgent and emergency conditions from events. The provider did not record patient contact details in these circumstances therefore we were unable to contact any patients who had experienced this service.

Following our inspection, the provider supplied us with positive feedback from patients and other professionals. However, we did not have sufficient evidence from regulated activity to rate this key question. The evidence we did gather indicated that staff were caring compassionate.

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

Good

We had not previously rated this service. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served

The registered manager ensured that the events team planned staff numbers and skill mix in response to the type and size of contracted events. They used a guide which was produced by The Events Industry Forum in consultation with the events industry. Its aim was to help those event organisers who were duty holders to manage health and safety, particularly at large-scale music and similar events. Staff provided key services seven days a week.

Meeting people's individual needs

Good

Emergency and urgent care

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff had aids to help them speak with patients who did not speak English as a first language. Staff always had access to a multilingual emergency phase book with prompts in 41 different languages and instruction on British Sign Language. Staff could contact a translator by phone if need be.

All ambulances within the service were adapted to transport patients with physical disability or mobility problems. All ambulances were fitted with a lift or a ramp.

Staff would call the NHS ambulance service if they needed to transfer patients with bariatric or wheelchair needs. This ensured these patients were transferred safely using specialised equipment.

For patients living with dementia and those with reduced mental capacity their support needs were assessed at point of accessing the services and recorded on the patient report form. Staff told us that relatives and carers would be able to stay to support through care given, if appropriate.

When staff identified serious mental health concerns such as suicidal thoughts, staff said they would call the local NHS ambulance service or if possible and depending on the contract with the event organisers convey the patients themselves to a location where the patient could receive more appropriate support. This would be the local NHS emergency department.

The service made sure that people with a disability or sensory loss were given information in a way they could understand. For example, arrangements were made to provide the correspondence in a format that could be clearly understood, these included large print, translation into another language or writing/speaking to a third party authorised by the patient. Staff had access to communication aids, such as picture charts, to support non-verbal communication on all vehicles. This was in line with the Accessible Information Standard (AIS) which was introduced by the government in 2016 to make sure people with a disability or sensory loss were given information in a way they could understand.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Between November 2018 and November 2019, 203 patients were conveyed under urgent and emergency care conditions.

The provider did not report on turnaround times at emergency departments. Staff would immediately transport patients to the acute setting if needed. Staff and managers did not share any concerns in this area and said no complaints had been made by patients or acute staff.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints, investigated them and shared lessons learned with all staff but not always within the service's own response target.

This feedback and complaint policy supported the process by which members of the public and customers could provide feedback about any areas of the service.

The document provided clear guidance on how to deal with feedback and complaints in terms of receiving, acknowledging, investigation, response, appeals and recording.

The procedure consisted of a formal three staged process. Stage one was local resolution, stage two was the regional review and stage three was the final review which the Chief Executive / Complaints and Feedback Manager oversaw.

Patients could make a complaint by telephone or in person. A written acknowledgement was provided within three working days of receipt of a complaint, unless the complaint could be answered, and a full reply could be sent within five working days.

A full written response was provided within 20 working days when the outcome of the investigation was known. Where this was not possible due to factors such as the complexity of the investigation a holding letter was provided within 20 working days. This explained the reason for not being able to provide a full response in the time frame and indicated when it was envisaged that this would be possible.

Good

Emergency and urgent care

A holding letter was sent at least every 20 working days in the event a response was not possible within the extended time frame.

Following on from a complaint and as part of St John Ambulance's commitment for continuous improvement, a review could be scheduled to look at the cause of the complaint and steps needed to minimise a reoccurrence.

Those involved in the investigation, and any other interested parties met to review the complete pathway of the complaint. They discussed what, if anything, could have been done to prevent or minimise the issue and any remedial actions required.

Any learnings/actions taken from the review were recorded and shared with the relevant units which included presenting to employees and volunteers.

All reports including minutes taken from any team meetings were uploaded onto the complaints log as a record of actions taken.

Each vehicle had patient feedback forms available on them for patients to complete. This included details of how to contact the office and make a complaint. Ambulances had information on the outside of the vehicle displaying the contact detail of the St John Ambulance Customer Services and a 'Q Code' which if scanned took people to the feedback page of the website. The feedback page explained how to complain along with timescales and processes in place if a patient was not happy with the response they received. There were also links to a patient experience survey, this was also available to complete anonymously.

Themes from complaints were captured in the quality report. Managers said due to the very low number of complaints received for the West Midlands region there were no themes identified.

There were 10 complaints made since January 2019 in relation to the West Midlands area.

Managers shared feedback from complaints with staff. All staff spoken to told us they received feedback from complaints by the service monthly newsletter, intranet updates and face to face at training sessions and the information was used as a learning point.

Are emergency and urgent care services well-led?

Good

We had not previously rated this service. We rated it as **good.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles

Local managers reported into the national leadership structure through an identified director who in turn reported directly to the chief operating officer. Leaders of the service had the skills and knowledge they needed. The registered manager of the service had eight years' experience within St John Ambulance with volunteer and operational management previously. Directors signed the fit and proper person checklist before starting work with the organisation.

Leaders demonstrated an understanding of the challenges to the quality and sustainability of the service. For example, the ongoing challenges to recruiting, and retention of volunteers. Leaders had put action points in place to address these challenges. They operated an on-going recruitment drive so they could maintain enough numbers of crews. They also tried to maximise the benefits of working for St John Ambulance, such as their wellbeing application and portal. The provider had a recruitment team who helped to focus their advertising in the most effective locations. They had reviewed their pay policy, which removed the classroom training rate so staff would be earning a better rate of pay from the outset. They were working closely with an external organisation so that they could be able to offer an externally recognised qualification, initially at Level 3. Leaders said the main challenges to recruiting and retention were largely due to staff moving to NHS Trusts and acknowledged this reflected well on the St John Ambulance standard of training and was a positive way for them to support the NHS.

Good

Emergency and urgent care

Two registered managers oversaw the two regulated activities provided. They focused on both between emergency and urgent care and patient transport services.

We found managers and staff felt supported at each layer of the organisation and leadership was accessible. Whilst responsibilities were clear there was a strong sense of togetherness in supporting each other and staff.

Many of the managers had been road crew and were able to guide staff effectively. Managers undertook continuous professional development and training alongside ambulance crews so were better placed to resolve problems and some could undertake shifts on the road if required.

St John Ambulance offered managers a suite of leadership courses covering processes and people management.

The station team leader line managed ambulance crews based at the assigned station(s) to ensure high standards of service delivery and overall performance. They ensured policies and procedures were implemented and adhered to by all crew on a day to day basis. The primary focus of this role was to manage ambulance crews, however there was a requirement for station team leaders to crew ambulance shifts when needed.

Managers and staff interacted well during our inspection and were positive and responsive to each other.

Vision and strategy

The service had developed a new vision for what it wanted to achieve.

The service had recently developed a new vision. This was 'By 2022 to be recognised as delivering the best volunteering experience and an outstanding provider of services evidenced by outstanding engagement and clinical outcomes comparable with the best achieved worldwide'. Staff and volunteers had been involved in its development. Staff were aware of the vision and said they has seen it on the intranet and staff display boards.

The strategy was aligned to local plans in the wider healthcare economy. The strategy included plans for the next ten years and described being at the heart of communities, helping to transform out of hospital care, having a positive impact on the people treated and supported, and the communities served.

The service was in the process of restructuring its management system. The managers told us the vison and restructure meant more efficient and effective service provision, as well as services providing a more consistent message to its crews around governance and standards.

Managers regularly worked alongside staff at events and carried out unannounced spot checks. This gave them the opportunity to ensure staff were displaying the provider's values in practice.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The culture was one of equality, team work, shared values and respect for standards, behaviours and performance. It was one where everyone's contribution was valued. The service led and developed paid and unpaid staff in the same way, whilst sensitive to contractual requirements and individual motivations.

Staff described St John Ambulance as a supportive organisation with a proud tradition which they wanted to maintain. Several staff members told us they had started their careers at St John Ambulance as volunteers and had become managers and senior clinicians over a period of time.

Leaders were visible and approachable. All staff we spoke to told us they would feel confident to discuss issues with any of the managers knowing that they would be taken seriously, and issues would be dealt with.

St John Ambulance promoted a culture that encouraged openness, honesty and candour at all levels within the organisation. The provider was committed to ensuring all staff were aware of their individual responsibilities in

relation to their duty of candour. Staff described an open, no blame culture. Duty of Candour was a standing item on the serious incident panel agenda, called within 48 hours of an incident.

The culture centred on the needs and experience of people who used their services. Staff provided tailored medical support depending on the type of event and client base. Managers said they would not provide a service to clients who were not willing to finance the medical cover needed to provide safe care.

There was a strong emphasis on the safety and well-being of staff. Staff could access support from managers any time. There was always a manger on duty. A manager provided us with examples of how they supported staff members.

Staff said managers carried out welfare checks on staff if they had faced a trauma or stressful incident. We were told that when staff had sustained a crash or accident in an ambulance they would be supported and given time to recover and be provided with additional support or training.

Managers contacted staff that were off sick to check on their welfare and arranged a phased return to work when they were ready to return. Absence management plans were put in place with supportive measures required to assist a staff member in returning to work following a period of prolonged absence.

Staff had access to counselling services if required and this could be done by telephone or through face to face appointments.

The service had a system in place to safeguarding the public interest and to promote a culture of public accountability and integrity. The service had a whistleblowing policy in place.

Staff were supported in speaking up and a positive culture of speaking up was promoted. Staff could access a Freedom to Speak Up Guardian. Freedom to Speak Up Guardians (FTSUGs) were appointed locally and were expected to fulfil the requirements of the National Guardian Office's job description for the role (the 'universal' job description).

There was CCTV in operation across the West Bromwich Ambulance Station, however staff expressed concerns around their personal safety at certain times such as when retuning a vehicle at the end of a shift on their own. Managers we spoke with were aware of this concern, however this was out of their control as the provider rented the hub from a private landlord. The health and safety team had completed a risk assessment and had put action plans in place to address the risk. Other mitigation included the existence of a lone worker policy.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A framework was established for which the service was accountable for continuously improving the quality of their services in place. Monthly governance meetings were held locally, which were then reported to the monthly executive leader team meeting. We saw minutes of the meetings and the content included discussion about, incidents, learning and any extra training requirements, complaints, service issues, risks and any up and coming changes or challenges.

The service had an assurance and quality team in place which was led by the head of assurance and quality and fed into the executive team.

The provider had embedded processes to assure themselves all staff had the appropriate competencies and skills to provide safe care and treatment. They had systems in place to ensure all staff had completed their required mandatory training and to ensure they were registered with their relevant professional body.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. The provider had systems to ensure staff worked within their competence. For example, they carried out thorough risk assessments of the events before allocating staff.

Policies and procedures were communicated to staff through the intranet and face to face meetings. When we asked staff, they understood the policies and procedures or knew who to seek advice from.

Not all policies were updated to their schedule due to restructuring, however the Executive Leadership Team/ Policy owners had reviewed the policies, confirmed that they were still valid and agreed a one year extension." We reviewed the Policy Review document from the Director of Strategy & Communications which confirmed this. St John Ambulance were in the process of appointing a dedicated policies manager. The organisation were also committed to the development of a policy management framework and policy IT system.

However, the provider acknowledged some policies were out of date and had appointed a policy manager to address this.

Management of risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events

The service had an assurance and quality team in place which was led by the head of assurance and quality, who worked closely with the medical director reporting to the people and organisation executive director.

The service had not received any liability claims in the previous 12 month reporting period.

Managers recorded all risks on the risk register. Risks mirrored what managers and staff told us and what we found on our inspection such as retention of staff. All risks had mitigating actions in place to address them and the risks were reviewed on a regular basis.

The service had a national policy for emergency preparedness, resilience and response, version six was awaiting final sign off by the executive team at the time of our inspection. This covered significant and major incidents. It includes business continuity information and standard operating procedures to be followed in the event of a major incident. Staff we spoke with were aware of the major incident plans.

The staff understood their role in major incidents and told us that they had worked with the police and fire brigade in a series of major incident simulations. These covered the most likely major incidents to arise. Managers told us there were plans to deliver more sessions in the future. Staff described these sessions to us as useful and feedback was positive.

Information management

Although the service collected reliable data and analysed it for each region and information systems in place were secure, the service did not collect data for local services, to allow understanding of performance and make decisions and improvements specific for the locality.

The provider demonstrated a holistic view and understanding of performance. We found the managers had oversight of all areas of the business and ensured they were fully compliant with regulations, guidelines and the law.

Quality and sustainability received enough coverage in the meeting minutes we reviewed.

There were clear and robust service performance measures such as monitoring training compliance which managers monitored and reviewed. Between them, they ensured the information used to monitor, manage and report in quality and performance was accurate, valid, reliable, timely and relevant. All the information we reviewed supported this.

Information technology systems were used effectively to improve upon patient care. For example, staff used an electronic incident reporting system to report incidents and mandatory training was monitored through an electronic system.

Although the service held large amounts of information and data about the service, nationally, data was collected for the West Midlands region which included South East, South West and the midlands areas, but not all this data was separated out for the West Midlands area specifically. This meant data such as PRF audits for the West Midlands area was not easily available to analyse performance to make decisions and improvements. This however did not have an impact on patient safety and decisions/ improvements were made and implemented across the service, based on national data.

Public and staff engagement

The service had a system in place to routinely collect and monitor information from patients on how the service was performing following treatment delivery. Leaders and staff engaged with staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff forums were established. This gave employees an opportunity to raise their employment related issues and a right to request the employer to consult, inform and communicate to them employment related issues, new practices and policies.

The service offered an online portal offering self-help and guided support. This included debt management, legal advice, work and career advice, critical incident support, immediate emotional support and session based emotional support.

Staff held a 'restart a heart' community engagement event and taught over 5,000 members of the public life saving skills. Quotes from the public about the event included "we had a gentleman attend the event, he was attending exactly one year after suffering a heart attack. Now he has learnt what to do if someone else suffers a similar medical emergency" and "two staff were very professional and explained and demonstrated everything really well, they were very helpful and made it clear"

The provider produced information leaflets called 'Looking out for volunteers welfare at events'. This included 'have the name and number of your supervisor' and 'have sun blocker available'.

St John Ambulance (SJA) had systems in place to recognise all staff contributions to their activities. The 'people recognition framework' provided a set of tools for managers and directors to use to recognise the contribution of their staff. This included immediate recognition tools such as heart postcard and team awards and employee of the year and long service awards.

Staff reported the provider communicated with them through a variety of communication channels including emails, and a range of newsletters and bulletins. For example, the SJA Brief shared top news stories, announcements policies and featured on the intranet every two weeks and the 'On the Road' newsletter kept staff up to date with key themes from across the function and wider organisation. We also saw examples of ad hoc communication such as the appraisal process review bulletins. This bulletin updated staff in changes to the process. The clinical lead wrote to staff members to inform them when they received positive feedback from members of the public or clients. Another bulletin thanked staff for their contribution to the service and informed them of what to expect on regulatory inspection days and questions they might be asked to prepare them for these

A staff survey was carried out in September 2019 to measure how well the provider was communicating with staff and how it could improve such as introducing a social media page.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The service was part of a bid with the peoples' post code lottery to introduce and trial electric vehicles. If they won, the bid this would be the first carbon neutral ambulance in the United Kingdom.

The service was planning to introduce a prototype vehicle to the area early next year. This vehicle was designed by staff and each vehicle would be suitable to use at events and for patient transport service journeys.

St John Ambulance were nominated for the 'The NHS In the Midlands: Excellence in Supply Awards' under the category Support Services Award. The nomination was made by a local NHS Trust. They also received several excellence awards from their children and neonatal patient transport and retrieval service.

Good

Patient transport services

Safe	Good
Effective	Good
Caring	
Responsive	Good
Well-led	Good

Information about the service

Patient transport services formed a small proportion of the organisation's activity. The main service is urgent and emergency services. Where arrangements were the same, we have reported findings in the urgent and emergency services section.

St John Ambulance (SJA) West Midlands region provides a neonatal and paediatric transport and retrieval service, a service providing 24-hour support, seven days a week services to transport sick neonates and children. This includes retrieval and repatriation. They provide specialist ambulances for this service. They deliver a dedicated patient transport service in Coventry specifically to transport patients from their home to one of five tissue viability clinics in Coventry and then home again after their appointment.

A new service they were providing was to residents of a local care home, on behalf of a local Council. This was a telecare response service. When telecare users activated their alarms the care home's call centre undertook an assessment and if the individual was a non-injury fall, they called the SJA crew who attended the property to pick the person up and make them comfortable, assess for any injuries and ensure they remained safe. This service did not fall under regulated activity; therefore, we did not inspect it.

Between November 2018 and November 2019, the total number of patients conveyed was 17,798.

The service was registered for:

• Transport services, triage and medical advice provided remotely.

• Treatment of disease, disorder or injury.

Staff did not only work for the patient transport service but also assisted with events and urgent and emergency care.

The service did not use one specific ambulance but any appropriate for transporting patients.

Good

Patient transport services

Summary of findings

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

- Not all PTS vehicles carried information on how to make a complaint. However, this was immediately resolved on the day of our inspection.
- Not all patient transfer crew adhered to the infection prevention control policy and procedures.
- Although the service collected reliable data and analysed it for each region. The service did not collect data for local services, to allow understanding of performance and make decisions and improvements specific for the locality.

Good

Patient transport services

Are patient transport services safe?

Good

We had not previously rated this service. We rated it as good:

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

For findings under this section please see the urgent and emergency care report.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

For findings under this section please see the urgent and emergency care report.

Under the children and neonate's contract 3042 children were conveyed between November 2018 and November 2019. SJA staff did not provide clinical care. The NHS staff delivered clinical care directly. These staff were all trained to level 3 or above. SJA staff were responsible only for driving the vehicle transporting the children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.

For full findings under this section please see the urgent and emergency care report

One crew we spoke with working on the patient transport contract that day demonstrated an understanding of infection prevention control (IPC) procedures. however, they did not always wipe down equipment in between patient contact or use hand gel in between patient contact. We raised this with management and they said they would speak with crew directly and remind them of their duties to comply with the IPC policy and procedures.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

For findings under this section please see the urgent and emergency care report.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration.

For full findings under this section please see the urgent and emergency care report.

We saw patient assessment ambulance pathways which all staff followed. Staff completed risk assessments for each patient on arrival and updated them when necessary using recognised tools.

Staff were not qualified to transport patients to hospital in the event of an emergency. If a patient's condition deteriorated staff would contact the local ambulance trust.

NHS KIDS/NTS staff used their own monitoring tools. SJA drivers under the KIDS/NTS contract did not provide any clinical care to children and were responsible to drive the vehicles transporting the children and neonatal babies. NHS staff who did provide the clinical care used their own monitoring tools to manage deteriorating patients.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

For findings under this section please see the urgent and emergency care report.

Records

Staff recorded notes on a patient log and updated them with details of their care. Records were clear, up to date, stored securely and easily available to all staff providing care.

For full findings under this section please see the urgent and emergency care report.

Good

Patient transport services

The PTS service staff did not complete patient report forms (PRF) in line with the urgent and emergency care services as they were not providing treatment. Staff recorded notes on a patient log and updated them with details of their care.

Patient details were phoned through by NHS clinical staff. Staff recorded these notes on a patient log and posted them in sealed envelopes to a mail address at the end of the day.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

For full findings under this section please see the urgent and emergency care report.

The service did not use any medicines or oxygen.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

For findings under this section please see the urgent and emergency care report.

Are patient transport services effective? (for example, treatment is effective)

Good

We had not previously rated this service. We rated it as **good.**

Evidence-based care and treatment

Although not all policies were up to date, they were based on up to date national guidance and best practice. Managers checked to make sure staff followed guidance.

For full findings under this section please see the urgent and emergency care report.

There was no comparison with other providers as St John Ambulance West Midlands area were sole providers of their patient transport services. They complied with contractual agreements.

The assurance and quality team carried out regular assurance checks across the organisation.

Nutrition and hydration

Staff stocked bottled water on the patient transport service vehicles.

Pain relief

Staff were not required to assess and monitor patients to see if they were in pain.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements

For full findings under this section please see the urgent and emergency care report.

Managers had oversight of whether staff were responding to calls in a timely manner. The provider monitored and recorded how many journeys took 15 minutes or longer to mobilise within the children's and neonates service. The provider investigated these further and took other factors into consideration when analysing the data.

The provider also monitored late finishes for this service. A late finish was classed as an hour over the time staff were meant to finish their shift. This meant managers ensured staff always had a minimum of an 11 hour break before starting their next shift. We reviewed late finishes from June to September 2019. For example, in July there were four late finishes, two of these the driver was swapped to reduce over run, however the other two were due to the team being at a distance which was too far to send a swap over or were returning from a long-distance transfer.

Managers monitored a number of areas for a contract with a NHS trust. For example, they monitored total journeys, ambulance hours and average journeys per day. For NHS acute and hospice transfers, they monitored the average

journey times and average cost per journey by location, response times, busiest hours and number of escorts used. This meant managers had oversight of the service and areas that needed improvement.

We reviewed the response times for September 2019. Seventy-three percent responded within the 15-minute target and 82% within the 30-minute target. Managers said reasons for these delays were generally due to external factors such as trust staff taking time to set up equipment for example.

Managers monitored response times for the discharge contract with the local NHS trust. The previous report showed staff complied with the 15-minute response times 73% of the time and 82% of the time they complied with the 30-minute response time.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

For full findings under this section please see the urgent and emergency care report.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

For findings under this section please see the urgent and emergency care report.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

For findings under this section please see the urgent and emergency care report.

Staff working on the neonatal and paediatric transport and retrieval service contract attended team meetings monthly with staff from the commissioning trust. Staff described a positive established supportive relationship with the trust staff.

Health promotion

Staff gave patients practical support and advice to lead healthier lives

For findings under this section please see the urgent and emergency care report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

For findings under this section please see the urgent and emergency care report.

Are patient transport services caring?

We had not previously rated Caring.

We were not able to give a rating about this key question in patient transport services. The service had little feedback from patients, and we observed a low number of staff and patient interaction during the inspection.

Compassionate care

Staff spoke about patients with compassion and kindness, showing they respected their privacy and dignity, and took account of their individual needs. However, we did not see any care given to patients.

We spoke with four patient transport journey patients and they all told us how they felt cared for and how 'amazing' the crew were. We observed crew ensuring patients received the care they needed. They were warm, empathic and compassionate in all their relationships.

Staff shared examples of how they provided compassionate care. For example, they used pillows to compact the affected area when transferring patient with pressure sores.

Following our inspection, the provider supplied us with positive feedback from patients and other professionals. However, we did not have sufficient evidence from regulated activity to rate this key question. The evidence we did gather indicated that staff were caring compassionate.

Good

Patient transport services

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs

Staff we spoke to were aware that transportation of patients may be stressful and described how they engaged with patients to ensure they remained calm during this period. This included providing extra blankets and engaging them in conversation throughout the journey to keep them calm.

Written feedback from patients included "outstanding support during a difficult transfer" and "In Response to your calm and understanding approach with parents on a difficult transfer".

Following our inspection, the provider supplied us with positive feedback from patients and other professionals. However, we did not have sufficient evidence from regulated activity to rate this key question. The evidence we did gather indicated that staff were caring compassionate.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

For full findings under this section please see the urgent and emergency care report.

Following our inspection, the provider supplied us with positive feedback from patients and other professionals. However, we did not have sufficient evidence from regulated activity to rate this key question. The evidence we did gather indicated that staff were caring compassionate.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

We had not previously rated this service We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

For full findings under this section please see the urgent and emergency care report.

Staff delivered a dedicated patient transport service in Coventry specifically to transport patients from their home to one of five tissue viability clinics in Coventry and then home again after their appointment. Managers had quarterly contract meetings

Staff provided a neonatal and paediatric transport and retrieval service, providing 24 hour, seven days a week services to transport sick neonates and children. This included retrieval and repatriation. They provided specialist ambulances for this service.

SJA also provided an ad hoc service for patients of a local hospice and a discharge service for a local NHS trust.

Managers worked closely with the commissioning providers to ensure their services met their patient's needs.

Staff provided patient transport services seven days a week.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

For full findings under this section please see the urgent and emergency care report.

Patient eligibility was pre-assessed by the commissioning providers; therefore, staff received all relevant information on the booking to meet their individual needs.

Good

Patient transport services

If staff transported individuals with learning disabilities (which was rare) they used a vehicle and staff most appropriate to their needs. For example, a double crewed vehicle or an accompanying escort.

Information about patients' physical disabilities was provided to staff by clinic staff and noted on the transport notes.

Staff relied on commissioners to ensure staff had the correct information and always followed do not attempt cardiopulmonary resuscitation (DNACPR) documents where they existed. This was covered during staff training courses.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

For full findings under this section please see the urgent and emergency care report.

The service did not record waiting times as patients were seen soon after being referred by the commissioned providers. Staff received a list of what time their patient's appointments were at the trust in advance. Staff prioritised picking up patients based in this information

Staff prioritised urgent transfers on their schedules on an ad-hoc basis. For example, staff said they always prioritised end of life care patients.

The total number of patients conveyed between November 2018 and November 2019 was 17,798.

Learning from complaints and concerns

Although it was not easy for people to give feedback and raise concerns about care received, the service treated concerns and complaints, investigated them and shared lessons learned with all staff.

For full findings under this section please see the urgent and emergency care report.

We found information on complaints were not stored on the patient transport service (PTS) vehicles we looked at. We raised this with the managers immediately and found they had stocked all PTS vehicles with these by the next morning. This showed managers were responsive to our feedback and improving the service.

Are patient transport services well-led?

Good

We had not previously rated this service We rated it as **good.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles

For findings under this section please see the urgent and emergency care report.

Vision and strategy

The service had developed a new vision for what it wanted to achieve.

For findings under this section please see the urgent and emergency care report.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

For findings under this section please see the urgent and emergency care report.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

For findings under this section please see the urgent and emergency care report.

Management of risks, issues and performance

Good

Patient transport services

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events

For findings under this section please see the urgent and emergency care report.

Information management

Although the service collected reliable data and analysed it for each region and information systems in place were secure, the service did not collect data for local services, to allow understanding of performance and make decisions and improvements specific for the locality.

For findings under this section please see the urgent and emergency care report.

Public and staff engagement

The service had a system in place to routinely collect and monitor information from patients on how the service was performing following treatment delivery. Leaders and staff engaged with staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

For findings under this section please see the urgent and emergency care report.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

For findings under this section please see the urgent and emergency care report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all policies are up to date (Regulation17(2)(f) Good governance)
- The provider should continue to ensure all PTS vehicles carry information on how to make a complaint.Regulation17(2)(f) Good governance)
- The provider should ensure all patient transfer crew adhere to the infection prevention control policy and procedures. Regulation12(2)(e) Safe care and treatment.
- The provider should consider reporting data at local level to ensure transparency and openness.(Regulation17(2)(f) Good governance)
- The provider should consider routine collection of patient feedback for the purposes of service improvement. (Regulation17(2)(f) Good governance)