St. John Ambulance

St John Ambulance North West Region

Quality Report

Crossley Road,
Heaton Chapel
Stockport
SK4 5BF
Tel: 0844 770 4800
Website: www.sja.org.uk

Date of inspection visit: 13 to 14 February, 28 February 2018
Date of publication: 20/09/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St John Ambulance North West Region is an independent ambulance service with a regional headquarters based in Stockport, Manchester and has ambulance operations bases at Liverpool, Chester and Chorley.

The main service provided by this ambulance service was emergency and urgent care services. Where our findings on emergency and urgent care services 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 the announced part of the inspection on 13 and 14 February 2018 along with one unannounced visit to the service on 28 February 2018.

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

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

Services we do not rate

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

We found the following issues that the service provider needs to improve:

- There were systems for the management of confidential patient sensitive information, however, there was no formalised or routine system of tracking that the information had been either sent or received which meant there was a risk of unauthorised persons being able to access sensitive information.
- Patient records were not consistently completed.
- Medicines were not locked away in ambulances. The process in place for checking medication pouches meant that only stock levels of medicines that had been administered were checked on a daily basis.
- Staff that we spoke with did not have a good understanding of patients' mental capacity and consent and records reviewed reflected this.

However:

- There were high levels of compliance with mandatory training.
- 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. All staff had received level one and two safeguarding training.
- Shifts were adequately staffed with the right staff skill mix on board ambulances.
- The service had suitable premises and staff looked after them well.
- There was good multidisciplinary working between ambulance crews and other NHS staff when treating patients.
- Staff we saw on the inspection were caring and treated people with dignity and respect at all times.
- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.

Summary of findings

- The service worked with local commissioners, such as the NHS ambulance trusts, to provide services that met the needs of local people.

Ellen Armistead

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		St John Ambulance North West Region is part of St John Ambulance, a national first aid charity St John Ambulance provides national services which include patient transport services, emergency services, events first aid and first aid training. The North West Service is based in Stockport Greater Manchester. The service in Greater Manchester provides all the above services Ambulance Operations are managed by a Sector Manager who is linked to a national chain of support. The service has two registered managers, one for Ambulance Operations and one for Event First Aid Services.
Patient transport services (PTS)		Patient transport services were a smaller 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.

St John Ambulance North West Region

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS)

Detailed findings

Contents

Background to St John Ambulance North West Region

St. John Ambulance is a registered first aid charity and it operates St. John Ambulance North West Region, as one of its regional centres.

St John Ambulance provides ambulance services across England and Wales providing a number of services which include first aid at events, emergency and non-emergency patient transport services and first aid training.

The main objective of St. John Ambulance is the relief of sickness and the protection and preservation of public health. The organisation works with both volunteers and employed staff to provide services.

St John Ambulance North West Region provides support to one NHS ambulance trust and three NHS acute hospital trusts in Greater Manchester. This included transport for patients from hospital to home, between NHS acute hospital sites and to hospitals for appointments.

The provider is registered with the Care Quality Commission (CQC) to provide treatment for disease, disorder and injury and transport services, triage and medical advice provided remotely.

They provide an events support service and if requested by the organiser will convey patients to hospital from the event, using appropriately trained staff.

The service had been inspected in 2014 and was compliant with the regulations at that time.

We completed an announced inspection in the North West region head office on 13 and 14 February 2018 and also visited the Chester and Chorley stations on the same dates. We did an unannounced inspection in the North West region head office on 28 February 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and three other CQC inspectors. The inspection team was also supported by three specialist advisers. The inspection was overseen by Nicholas Smith, Head of Hospital Inspection (North West).

Detailed findings

How we carried out this inspection

St John Ambulance North West Region is an independent ambulance service with a regional headquarters based in Stockport, Manchester and Ambulance Operations base at Liverpool, Chester and Chorley.

The main service provided by this ambulance service in terms of activity was emergency and urgent care services. Where our findings on emergency and urgent care services 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.

During the inspection, we visited Stockport, Chorley and Chester bases. We spoke with 20 staff including; emergency and patient transport drivers and management. We spoke with three patients and one relative. We also received four 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 87 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

There had been no never events reported by the organisation.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

In the reporting period January 2017 to September 2017 there were 15,820 emergency and urgent care patient journeys undertaken.

In the reporting period January 2017 and December 2017, the service carried out 7,716 patient transfers.

Services accredited by a national body:

- The provider is accredited against ISO 9001 quality management system. The system is a tool which is designed to help organisations ensure that they meet the needs of customers and other stakeholders. It also directs organisations in meeting statutory and regulatory requirements related to its services.

Facts and data about St John Ambulance North West Region

In the reporting period January 2017 to September 2017 there were 15,820 emergency and urgent care patient journeys undertaken.

In the reporting period January 2017 and December 2017, the service carried out 7,716 patient transfers.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

St John Ambulance North West Region is an independent ambulance service with a regional headquarters based in Stockport, Manchester and Ambulance Operations base at Liverpool, Chester and Chorley.

The main service provided by this ambulance service in terms of activity was emergency and urgent care services. Where our findings on emergency and urgent care services 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.

During the inspection, we visited Stockport, Chorley and Chester bases. We spoke with 20 staff including; emergency and patient transport drivers and management. We spoke with three patients and one relative. We also received four 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 87 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

There had been no never events reported by the organisation.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

In the reporting period January 2017 to September 2017 there were 15,820 emergency and urgent care patient journeys undertaken.

In the reporting period January 2017 and December 2017, the service carried out 7,716 patient transfers.

Services accredited by a national body:

- The provider is accredited against ISO 9001 quality management system. The system is a tool which is designed to help organisations ensure that they meet the needs of customers and other stakeholders. It also directs organisations in meeting statutory and regulatory requirements related to its services.

Emergency and urgent care services

Summary of findings

Services we do not rate

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

We found the following issues that the service provider needs to improve:

- There were systems for the management of confidential patient sensitive information, however, there was no formalised or routine system of tracking that the information had been either sent or received which meant there was a risk of unauthorised persons being able to access sensitive information.
- Patient records were not consistently completed.
- Staff were unaware of a formal process in place to check specific equipment within the response bags.
- Medicines were not locked away in ambulances. The process in place for checking medication pouches meant that only stock levels of medicines that had been administered were checked on a daily basis.
- Staff that we spoke with did not have a good understanding of patients' mental capacity and consent and records reviewed reflected this.

However:

- There were high levels of compliance with mandatory training.
- 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. All staff had received level one and two safeguarding training.
- Shifts were adequately staffed with the right staff skill mix on board ambulances.
- The service had suitable premises and staff looked after them well.
- There was good multidisciplinary working between ambulance crews and other NHS staff when treating patients.
- Staff we saw on the inspection were caring and treated people with dignity and respect at all times.
- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.
- The service worked with local commissioners, such as the NHS ambulance trusts, to provide services that met the needs of local people.

Emergency and urgent care services

Are emergency and urgent care services safe?

The main service provided by this ambulance service was emergency and urgent care.

Where our findings on patient transport services also apply to emergency and urgent care, we do not repeat the information but cross-refer to the emergency and urgent care section.

Incidents

- The provider had an incident management framework policy and incident reporting procedure. Staff had access to incident report forms for both incidents involving vehicles and those involving patients or staff members. Both the policy and the procedure had last been reviewed in 2015 and were due to be reviewed again in July 2018.The procedure covered immediate management of incidents, how to report an incident and the timescale required and initial action requirements, based on the impact of the incident. All incidents were required to be reported within 48 hours. In the case of incidents with an impact rating of moderate or above, they were required to be reported immediately to a senior manager. An on-call senior manager was available to speak to out-of-hours.
- The provider had recently rolled out a new electronic web-based incident reporting system that could be accessed from any mobile device. We were told this would improve the process of incident reporting by crew and communication with Managers, Staff were still reporting incidents on paper incident report forms as well as using the electronic system until the full role out of the new electronic system. At the time of our inspection, staff that we spoke to told us that they had not been trained on the electronic reporting system. However, managers provided evidence that training is being rolled out to staff. The new system had been developed with an in-built duty of candour element. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain "notifiable safety incidents" and provide reasonable support to that person.
- Incident reports were sent to the Ambulance Operations Assurance Team for initial actions. The Ambulance Operations Assurance team is a national assurance team which was developed by St John Ambulance to maintain quality standards across all services on a national basis. Managers told us they were contacted by the team to advise on follow-up actions required, for example, a full investigation. We requested copies of six investigation reports, lessons learned, recommendations and action plans following incidents. However, we did not receive these. We were therefore not assured that incidents were effectively investigated or followed up with action plans and recommendations. The information provided only gave a very brief overview of the outcome of each incident and there was no evidence showing the process that the provider had followed in response to the incidents.
- We saw from the incident report log that many incidents did not appear to have been reported within 48 hours, as per the Incident Reporting Policy. In 56 out of 88 incidents (63.6%) reported on the log for urgent and emergency and patient transport services, the report had not been made within 48 hours. The provider was unable to provide incident data relating specifically to urgent and emergency care, for example, where a staff member was potentially put at risk whilst working alone on an ambulance, the incident was not reported for seven days.
- Between January 2017 and December 2017 there were 32 incidents reported relating to the whole service. The incidents varied from medication incidents, staff sickness and vehicle damage. We were unable to identify if these were reported within the expected timelines as data provided only showed the date of the incident and not when it was reported.
- Senior managers told us learning from incidents took place with individual staff in one-to-ones and in quarterly team meetings. Senior managers told us that any learning from incidents that needed to be disseminated nationally, throughout the organisation, was discussed at the National Operations Meeting so that managers received the same message to cascade to staff. However, we did not see evidence that any incidents were discussed at the team or operational meetings from the minutes that the service provided.

- Key learning from incidents was also sent out nationally as a "Take Five" message. We observed "Take Five" posters were displayed in ambulance stations and contained key learning and messages for staff to read whilst in the building.
- The service had reported no never events. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic 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.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain "notifiable safety incidents" and provide reasonable support to that person. The provider had a Duty of Candour Policy in place and a Being Open Procedure.Ambulance crews received training on duty of candour and being open, as part of the continuing professional development day with data showing 97% of all staff had attended.

Mandatory training

- Mandatory training included safeguarding, medicines management, infection prevention and control, information governance and conflict management. Training was delivered face-to-face and through online training modules. Employed and volunteer staff completed the same training.
- Managers told us that staff had allocated time to complete mandatory training.
- All staff working on the ambulances were required to complete two separate continuing professional development days per year. One day was theory based, for example information about dementia, and the other was practical for example moving and handling. In addition, staff were required to complete online training modules, for example information governance.
- Data provided showed all modules had been achieved above the provider target of 80 % across both emergency and patient transport services, apart from PREVENT training which was 70%. PREVENT training focusses on raising awareness of safeguarding vulnerable people from being radicalised.
- Staff received conflict management training every three years which included how to manage conflict situations and de-escalation techniques. Data provided showed all staff had completed the training.

Safeguarding

- The provider had a national safeguarding team (based in London) who supported regional safeguarding champions to support and advise staff at a local level.
- St John Ambulance North West Region had two regional safeguarding managers in post who were trained at level three. Staff at all levels in the region had good access to safeguarding advice and support. St John Ambulance North West Region had access to level four safeguarding leads who worked in a national safeguarding directorate. The directorate had oversight of the activities of the regional leads across England.
- Staff had access to a safeguarding policy which had been implemented in 2016 and was due for review in 2019. The policy defined what abuse is, types of abuse and actions to take in recognising and escalating concerns. The policy stated that staff were only required to undertake an introduction to safeguarding module one, on joining the organisation This is not in line with their own guidance that states that training in level two children's safeguarding is required for all non-clinical and clinical staff who have any contact with children, young people and/or parents or carers. The provider has informed us that the policy will be changed to reflect the present requirement for staff to undertake safeguarding level two when the policy is reviewed in 2019.
- The provider had recognised that there was a risk that staff were not adequately trained to recognise all forms of abuse and had introduced level two training for all staff. This was a comprehensive training course. Safeguarding training for both adults and children level one and two was mandatory for all staff at the time of our inspection. Data provided showed all staff were trained to level one and two in adults and children's safeguarding.

- Staff we spoke with understood their responsibilities and demonstrated how they would report safeguarding concerns. They gave us examples of safeguarding concerns they had escalated in a timely manner.
- Staff reported safeguarding issues on a "cause for concern" form which was sent via email to the national safeguarding team who were responsible for onward referral to other organisations, such as local authorities. During our inspection we observed safeguarding forms on ambulances were accessible to staff to use. However, if staff identified any concerns that required immediate action and review they escalated these to the safeguarding team via phone at that time.
- Ambulance crews working on behalf of an NHS ambulance trust reported safeguarding concerns directly to the safeguarding team for that trust. These concerns were also passed on to local managers. Managers and staff could also feed these concerns into a national framework. The service and the national team worked with trusts to minimise concerns and if necessary flagged concerns to local safeguarding teams. The service also flagged these concerns to the CQC through statutory notifications.
- Staff were required to complete a workbook about all aspects of adult and child safeguarding. The training included sections on female genital mutilation and modern slavery.
- Ambulance staff were provided with 'safeguarding pocket cards' which included a flow chart for reporting concerns along with contact numbers. Staff also had support and guidance from the providers safeguarding team at all times and an on-call manager.

Cleanliness, infection control and hygiene

- The provider had an infection, prevention and control policy that was available to all staff via the provider's intranet page. The staff we spoke with were aware of their responsibilities related to infection, prevention and control.
- Ambulance operation staff were expected to complete modules on infection, prevention and control that included effective handwashing, management of waste and of contact with bodily fluids and sharps. Staff knowledge and skills were assessed during their annual revalidation. Data provided showed that 97% of all patient transport and emergency ambulance operations staff had completed the training.
- Staff had access to personal protective equipment at each ambulance station and on all ambulances including disposable clinical gloves. Hand gel dispensers were available in the front cab of all nine ambulances we viewed. However, we observed only one ambulance of the nine, had hand gel in the area where patients were transported. The provider told us that staff carried hand gel attached to their person and therefore did not need gel to be carried in the back of ambulance.
- All vehicles had decontamination wipes to use between patients and we observed these were available to use on the ambulances except on one vehicle at the Chorley station. We observed a large supply of single use linen readily available for staff to use.
- Except for Chorley, ambulances stations were visibly clean and free from clutter. In Chorley station we observed ripped seats, exposed seat mechanism and litter in two ambulances. This was raised at the time of inspection. Management in the service took immediate action to resolve the issue on the day after our concerns were raised. The ambulances were taken out of service and repaired.
- Ambulance staff were given allocated time at the beginning of their shift to clean their vehicle and completed daily task sheets which were kept on the ambulance for a week with any outstanding tasks performed on Sunday. However, data provided showed that it wasn't clear what tasks had been completed with many of the days, including Sunday, not signed for on the three cleaning task sheets we viewed.
- An external provider was contracted to deep clean all vehicles. We were told this had recently decreased from every six weeks to twelve weeks although vehicles could be deep cleaned at other times if required, for example after a high-risk event. A swab of each vehicle was taken before and after each deep clean to measure the number of bacteria present. We saw evidence of vehicle deep clean reports, monthly audits and swab testing for bacterial pre- and post-cleaning which assured the provider of effective cleaning.

- Staff told us where possible clinical waste was disposed of in an orange bag at the hospital immediately after use. When this was not possible it was disposed of at the station at the end of each shift. At each station clinical waste and sharps bins were stored in clearly identifiable lockable bins which were emptied regularly by a private contractor. During our inspection we observed clinical waste disposed of within designated bins and sharps bins were closed.
- Staff were provided with four uniforms and were responsible for washing them. During our inspection we observed staff uniforms were visibly clean and staff were observed to be bare below the elbow. Wrist watches were not worn by staff, the service provided all staff with a fob watch which attached to their tunic.
- Cleaning equipment in ambulance stations was seen to be colour coded and clearly marked as to the area that it was to be used for cleaning. For example, red colour code was only to be used in toilets and showers, green for kitchen areas and yellow for ambulance interiors only. In the Chorley station, disposable, one use mop heads were in use for cleaning ambulance interiors. Sluices were tidy and well signed.

Clinical Quality Dashboard or equivalent

- At the time of the inspection the service did not have a formal, clinical dashboard in place to monitor safety. The organisation was part-way through the implementation of an electronic system. This was designed to manage incidents and risks, audits, including the International Standards Organisation (ISO) requirements and other performance monitoring tools such as outcomes dashboards. ISO 9001 quality management system is a tool which is designed to help organisations ensure that they meet the needs of customers and other stakeholders. It also directs organisations in meeting statutory and regulatory requirements related to its services

Environment and equipment

- We found the ambulance stations, 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 were told the garages were well lit at night. There was CCTV in operation across all garages.
- We observed at the Chorley station, that checklists were in place for the station manager to carry out checks of the building, environment and equipment. There were daily checklists that covered fire exit and fire extinguisher access, hazards and cleanliness of the kitchen, management and crew rooms. A weekly checklist included a fire alarm test, check of medical gases, check of the showers (for prevention of legionella), medicines book and insurance certificates for vehicles.Once a month there was a fire alarm test plus evacuation drill, a stock check of the crew store, a review of the medicine pouches and a stock check of the main store. Checklists had been completed at the Chorley station until the first week in February but did not appear to have been completed since then.
- We requested similar checklists for the Chester, Stockport and Liverpool stations but these were not sent to us. However, the service provided walk-around audits for the Liverpool, Chester and Stockport stations from January 2018.The audits looked at whether the building was welcoming, whether it appeared safe, whether there was a supportive environment and whether it was well organised. Significant findings from the audit at the Liverpool station were that patient record form boxes needed fitting in the garage, additional collection of clinical waste was required and the car park area was untidy with rubbish. An action plan had been put in place to rectify the issues found.
- The Stockport station audit found that vehicles had not been placed on charge, there were items of panelling that needed to be disposed of stored around the back of the building and the medicines cabinet was exposed to cold temperatures in the main garage area. Action plans were put in place to rectify the issues, for example, the medicines cabinet was moved to the linen store room and daily temperature checks introduced.
- We observed fire evacuation procedures clearly visible within the station. However, we did not see one at Chester: this was raised at inspection to the team leader. We saw data at Chorley which showed regular testing of the fire alarm.
- At each station we visited, staff had access to a kitchen area, rest room and bathroom and toilet facilities. However, we observed equipment such as the microwave within the kitchen area at the Chorley base had not been serviced within the expected expiry date.

- Staff were expected to perform journey, vehicle and cleanliness checks. This included checks for damage, tyre condition and mileage along with specific information for example any driving incidents. We viewed three records and observed that all were completed fully.
- Stock including equipment and consumables such as dressings was stored neatly in dedicated store rooms with equipment. We observed an ample supply of stock available to staff during our inspection.

  Equipment was available to staff to use including hazardous chemical suits and helmets.

  Vehicles were equipped to support staff in carrying out basic observations of adult patients during transport to monitor for signs of deterioration in the patient's health. For example, staff could carry out blood sugar monitoring and monitor oxygen saturation levels and monitor the heart where required. Staff had paediatric life support equipment including airways, masks and oxygen mask. Vehicles were reviewed regularly and where crewed by higher clinical qualification staff e.g. paramedic or doctor, additional equipment was provided to meet the skill set and to meet the potential needs of patients likely to be encountered.
- We were told specially adapted harnesses were available for children below 19kg to travel securely in ambulances. Staff told us they would encourage the parent or guardian to bring the child's car seat with them or car seats were also available at Chorley and Stockport station but this meant that staff would have to return to pick it up. The provider Fleet Management Policy states that when transporting a child under the age of 12 or less than 1.35 metres in height, appropriate car seats, restraints or booster seats must be used in order to comply with legislation.
- All the vehicles had working doors and no visible issues to the outside. All vehicles had emergency equipment, including a defibrillator, oxygen and suction machines. The equipment in all the vehicles we viewed had been checked and we found that all equipment was in order and had stickers showing the next checking date. All equipment had been safety tested and appropriately calibrated, where necessary.
- All gases on board the vehicles we checked were not empty, were in date and were stored securely. At Chorley station we observed one vehicle with no fire extinguisher inside and another vehicle with a fire extinguisher not secure with the pin removed which meant there was a risk of injury to staff or members of the public. We told managers of any issues with equipment we found on the ambulances during our inspection and the provider took appropriate action to rectify these.
- The Fleet team were responsible for maintenance, Ministry of Transport test (MOT) and tax of the vehicles. Staff reported any defects of vehicles or equipment on a dedicated form which was sent to the national fleet team for review and action. Vehicles were collected for repair or Ministry of Transport test and we were told they were usually returned within one day following a test.
- Each ambulance had a response bag which contained equipment and consumables which could be taken to the patient. A senior manager confirmed there was no formal process or checklist but staff told us they checked the contents of the response bag daily. Staff told us that they knew what should be in the bag and when checking to make sure that it is all there, they additionally check that all the equipment was in date. We could not be assured that the contents of the response bag were being checked daily and that all staff knew what should be in the response bag as there was no audit trail to demonstrate this. This meant that there was a risk that equipment was not available to staff if missing equipment was not identified and replaced.
- During 2017 we found nine incidents that had been reported at events where equipment was found to be missing or out of date for example no medical kit bag or intravenous access equipment. Of the nine incidents one was identified whilst treating a patient who was transferred to hospital. During the same period there were two incidents reported relating to missing equipment across urgent care services.
- There had been no never events reported by the organisation. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Medicines

- The service had a medicines management policy available to all staff. The purpose of this policy and supporting procedures was to ensure that medicines used were suitable for purpose, met internal and external safety standards, were procured, stored, prescribed, dispensed supplied, administered and disposed of safely and effectively. The policy was supported by a procedure for storing and recording medicines; a local operational procedure for medicines management and an approved medicines list, outlining the medicines that were able to be used by paramedics, ambulance technicians, certified advanced life support providers, emergency transport attendants or medical technicians as well as nurses, patient transport attendants and first aiders. The documents were available to staff on the provider's intranet.
- Medicines management training was part of mandatory training. Data provided showed that 98% of staff had completed the training within the last 12 months which was above the provider's target of 80%.
- The service had recently introduced a new system for storing medicines. Medicine packs were stored in the stock rooms in locked cupboards. The packs were colour coded so that staff at different levels of training could easily identify which packs they could use.
- There was also a colour-coded tag to indicate when a pack had been opened, and when it had been used and required replenishing. Staff told us they would check stock levels and complete the log book in the pouch only for medicines administered; this meant there was a risk that other medicines stock levels in the pouch were not checked on a regular basis to ensure that none were missing. Packs which needed renewing were placed in a secure drop box, picked up by a member of staff responsible for reconciling stock and sent back to a depot in the north east where the packs were created. We reviewed one pouch and observed that although medications administered had been documented, staff had not signed to indicate the stock level had been checked and this was not in line with agreed processes.
- The pouches contained over the counter medication and these were stored loosely within the grab bag on the ambulance and were not locked away. This meant that medicines were accessible to staff but also meant that they were accessible to members of the public. Whilst these were not controlled medicines it did not adhere to the provider's medicines management policy which stated that all medicines on vehicles should be stored in separate locked cupboards.
- During 2017 we observed there were seven incidents reported relating to medication across urgent care services and five across the events team these included missing or expired medication.
- We observed details relating to an incident where unauthorised medication was administered by a member of staff. We did not receive a copy of the investigation as requested. However, on the inspection we were able to determine that this incident had been resolved by a formal investigation and disciplinary process.
- Medicines which were no longer required or had expired were stored in a locked box within the garages. The medication was then collected and disposed of by a St Johns employee from the medicines management team who restocked-tagged or disposed of medicines that had expired medicines.
- Data received following an audit of 12 medication pouches on 24 and 25 January 2018 showed medication and records within four pouches were correct, with two of those not previously opened or used. The remaining eight pouches did not have completed, or had incorrect documentation on the medication record. For example, six pouches did not have the end of shifts check completed. We also saw one pouch was taken out of use due to medication reaching its minimum stock level. Some actions taken were documented against each pouch audited and was focussed on educating specific crew. However, it was not clear who was responsible to educate staff or the expected timeline for this action. We did not see any plan in place to share with all crews or actions taken to monitor compliance. Medical gases were stored in a specifically designated brick room inside the Chorley garage. In Stockport and Chester medical gases were stored within a designated cupboard within the garage area. During our inspection we observed at Chester an ambulance parked directly next to the cupboard which posed a risk of damage or explosion. We raised this at the time and the vehicle was removed to another area of the garage. However, this meant that it was difficult for staff to move cylinders to and from the vehicles as access was restricted. The

British Compressed Gases Association Code of Practice for the storage of compressed gases states that vehicles should be parked a minimum of one metre away from stored oxygen and a vehicle exhaust should be a minimum of three metres away to avoid the risk of heat from the vehicle causing an explosion. The vehicle was not parked in accordance with the code of practice.

- In the Stockport garage vehicles were prevented from entering the space in front of the medical gas cabinets by use of a physical barrier and that vehicles were more than one metre from the cabinets and vehicle exhausts were more than three metres away from the cabinets, in accordance with the British Compressed Gases Association Code of Practice for the storage of compressed gases.
- Medical gases were provided by an external provider who also collected empty cylinders and supplied the metal storage cabinets where these were in use. We expressed concern to the provider about the use of metal cabinets in which to store medical gases as the British Compressed Gases Association Code of Practice for the storage of compressed gases states that the Fire and Rescue Service do not like to encounter gas cylinders in cabinets at all due to the significantly increased fire load and the need to see the cylinders when applying cooling water from a distance in the event of a fire. Whilst we acknowledged that the cabinets were supplied by the external provider and were for the purposes of storing gas cylinders, we signposted the provider to the Fire and Rescue Service for advice as to the appropriateness of storing the medical gases in these cabinets.
- Following our inspection, the provider carried out a risk assessment at each location to ensure the safe storage of medical gases. Following the risk assessment action was then taken to reduce the risk potential.
- Staff we spoke to were aware of a patient safety alert that had been issued in January 2018 by NHS Improvement on failing to obtain and continue flow from oxygen cylinders. The provider had ensured that all staff were operating oxygen cylinders correctly in a timely way.

Records

- The service used standardised, patient report forms for patient transfers and these were completed in real time as part of their contracts with other providers.
- Patient record forms consisted of patient's medical history, current medication, allergies and observations, care and treatment given. We reviewed 87 records and found a number of issues with regards to completion of the forms. For example, 70 forms did not have a signature from the receiving department or health care professional to identify that they had taken over care of the patient. We raised this at the time of inspection and the service sent a reminder to staff regarding the completion of the patient record via the "Take 5" poster. The provider carried out an audit of the records that we had reviewed on inspection. We requested a copy of the outcomes of the audit but did not receive this. On our unannounced visit, two weeks later we reviewed another 10 records, which had been completed the previous day and noted that there was no improvement to the standard of the records.
- During shifts, the patient records were stored in an envelope and at the end of the shift they were taken to the station and stored in a locked cabinet. However, at Chorley the cabinet was accessible with envelopes that could easily be removed without unlocking the cabinet. We were told the records were collected daily and taken either to the post office or Stockport ambulance station. However, during our inspection we observed that they had not been collected for a few days at both Chester and Chorley stations. The provider responded to our concerns by installing a new secure cabinet and sent out a "Take 5" poster.
- There was no clear process for staff to follow in transporting the records to the Stockport station and staff told us they would take them in their cars. We observed that on one occasion an incident recorded showed that patient records had been left in a staff member's car overnight. At the time of our inspection, all patient record forms at Stockport were sent to a scanning centre via post in a sealed envelope. However, the records were not sent by recorded or tracked delivery and there was no record regarding how many were sent and received at any given time. There was a risk that if any records were lost in transit at any point, this would not be identified.

- This was raised at inspection and senior managers told us that the way in which patient record forms were sent to the scanning centre was part of a national policy. The forms were sent in batches with a "batch header form" that identified the region and base or event to which they related. However, there was no indication on the batch header form as to how many forms were in the batch so the third-party company who were responsible for scanning the forms had no way of identifying whether all the forms had been received. Scanned forms were identified by batch number but there was no-one in St John Ambulance North West Region who could check whether all the sent forms had been scanned, if there were missing forms, or to which patients they may relate. Managers told us that they had, on occasions found scanned forms that had been incorrectly labelled by the scanning company. Records provided by the provider showed that, in 2017 there were two incidents reported regarding patient records being found in public areas at events and two incidents from urgent care where records had not been stored in a secure environment. In the factual accuracy return the provider has stated that they have introduced a new system to manage confidential patient information. The system includes a secure posting method, reduced patient information on patient record forms and a new audit system which covers the sending and receiving of documents.
- Following scanning, patient records were available to view electronically online. Patient information fields that had been written on the forms were transcribed into text at the scanning company to enable a search facility.
- Specific information, such as, do not attempt cardiopulmonary resuscitation orders were included as part of the patient records that included the patient record form. Staff understood the need to review and hand over any patient information, including hospital notes, when a patient was transferred to a new provider.
- Crews completed a daily log sheet with all patients seen documented and the start and end times of each job recorded.

Assessing and responding to patient risk

- Crews working on behalf of the local NHS ambulance trust had access to an escalation policy on board the vehicle. Staff were to follow this when a patient deteriorated and we observed incidents were this had been done. We observed that crews contacted the NHS ambulance trust for clinical advice and advice on whether to escalate or de-escalate a patient.
- Ambulance crews who completed observations carried a pocket reference book that described action to be taken if the observations were outside of an expected range.
- If a patient was at risk of or suffering from sepsis we were told the crews contacted the control room at the NHS ambulance trust so that they could go through their sepsis pathway with them. The NHS ambulance trust then decided as to whether a crew with a paramedic on board was required on scene and whether the treatment was time critical. Managers told us that crews sometimes attended patients who had been referred by GPs to be transported to hospital. Sometimes crews found that the patient had deteriorated since the referral was made so they would immediately escalate the patient onto the sepsis pathway.
- We reviewed a contract in place with a local NHS ambulance trust which stated that staff were not to interpret observations and staff were not to accept a journey where the clinical interpretation of observations is required (for example, over and above recording of observations during the care episode). We observed that crew carried out regular observations during the episode of care and these were noted on the patient record form.
- Data provided showed that all calls were triaged by the NHS ambulance trust.
- During our inspection we observed one crew being called out to a patient who had not been triaged and in one record, a patient whose observations meant the patient was at risk of deterioration. Although the observation had been recorded we could not see any immediate action taken to address the risk to the patient. Therefore, we were not assured that the service was adhering to the exclusion criteria in the contract.
- On receiving a call from the local NHS ambulance trust, staff were provided with any known specific information for example any potential risks or needs of the patient.

- Staff could request police back-up and told us that they would escalate the situation to the NHS ambulance trust if they encountered a violent or aggressive patient. However, managers told us that St John Ambulance North West Region crews were not regularly sent to patients who were known to be violent or aggressive.
- Dynamic risk assessments for private ambulance transfers were performed by the service via a questionnaire which was completed prior to the job being accepted. This included environmental hazards and the patient's weight. The service performed risk assessments at the location prior to jobs that were perceived as a high risk and if the patient's safety could not be maintained throughout the transfer the service would not be provided.

Staffing

- Data provided showed that, in December 2017 there were 54 staff working across four sites in the St John North West Region, there were:
  - two emergency care assistants;
  - ten casual, one fixed term contract and 26 permanent emergency transport attendants
  - six lead crew;
  - two service delivery coordinators;
  - four station managers; and
  - three station team leaders working in urgent and emergency care services.
- We found that levels of staff sickness and staff turnover had been monitored. Senior managers told us in the last 12 months there had been changes in contracts with external clients. Fixed contracts with staff had been terminated and staff had left to further their career, which had impacted on the turnover rate which was 58%.However, the service had enough remaining staff to cover current contractual obligations.
- Shift staffing and skill mix was arranged by the Service Delivery Team, based at the Stockport headquarters. Staff were colour coded on spreadsheets according to their skill sets and the team ensured that the correct people were assigned to each shift to give the appropriate skill mix on each emergency ambulance.
- Many crew members worked across patient transport services, urgent and emergency services and event services.
- Shift patterns at the bases varied but staff generally worked a shift from 10am to 8pm, 12pm to 10pm or 1pm to 11pm.
- Bank and agency staff were not used in the area served by the provider on urgent and emergency care vehicles but were used on patient transport. Casual staff were used regularly and we were told that their use was recorded and monitored. The provider was committed to giving regular work to casual staff to ensure that staff maintained their competencies and avoided the need to re-train. Some casual staff had substantive roles elsewhere and only liked to work during their holidays. Casual staff were allocated to specific stations. If casual staff had not worked for some time they would have to re-train. All staff were required to undertake mandatory training and continuous professional development days.
- Staff did not take part in handovers when starting their shifts. If there were any issues or hazards that needed to be passed on to another crew the details were given to the on-call manager before ending their shift to ensure that any pertinent information was given to other crews.
- A report on sickness absence showed that in the last twelve months, sickness rates were within acceptable levels at 4.6% with 838 days of work lost due to sickness.

Anticipated resource and capacity risks

- Anticipated risks were considered prior to attendance at an event. An event risk assessment was completed for each event by the event manager. The risk assessment included details of potential hazards, to whom they may cause harm, existing control measures and additional measures required. Staffing and skill mix levels were calculated in liaison with the event provider and other agencies such as the Police, Fire and Rescue Service and NHS Ambulance Trust.
- The Service Delivery Team was responsible for planning anticipated resources and capacity and managing foreseeable risks.
- Managers told us that there were generally backup crews available at short notice to respond to increased demand. Similarly, reserves were built in across the sites

to avoid unfilled shifts if staff were unable to work at short notice. Casual staff or staff on overtime were used as there were financial penalties for unfilled shifts from the NHS ambulance trust. However, managers told us that if shifts could not be filled with staff of the right skill mix then the shift would be declined

Response to major incidents

- The provider had a national policy for emergency preparedness, resilience, and response. This was due to be reviewed in March 2017. The policy included guidance for responding, supporting and assisting other services, including the NHS, in the event of a major incident. The policy had not been updated despite two major incident reviews involving a fire at Liverpool Echo Arena and the terrorist attack at Manchester Arena
- Team leaders and ambulance staff explained to us how they felt proud that they had supported the emergency services in responding to two recent major incidents
- St John Ambulance North West Region did not have a local agreement with and were not invited to participate in table-top exercises with local NHS providers and the local authority to walk through major incident scenarios or major incident simulations. This meant there was a risk that staff may not feel prepared in responding to a major incident.
- A senior manager told us they had provided a debrief immediately following one major incident at an event and ensured all staff had a welfare check within 24 hours. The following week staff were signposted to counselling services if this was required. We were told lessons learnt were identified following this major incident and changes in processes were being reviewed.
- The service had local business continuity plans which could operate in the event of an unexpected disruption to the service, including loss of premises, for example due to fire or flooding. The business continuity plan was due to be reviewed in March 2017. Senior managers told us this was being reviewed at the time of our inspection.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Managers told us and we saw that policies were based on national guidelines.These included the National Institute for Health and Care Excellence and the Joint Royal Colleges Ambulance Liaison Committee national service frameworks, national strategies, national patient safety alerts and other guidelines applicable to the service.
- Policies for staff were available on the provider intranet system.Staff told us that they were aware of the policies and procedures and were able to access them.
- Staff had access to a Clinical Procedures Manual that was available to access from mobile devices.This was based on national guidelines. The manual covered general guidance, such as consent, patient assessment, transfer of care, duty of candour, safeguarding and manual handling.There was a section on medical conditions that staff may encounter and what to do in the event of each.A section on procedures covered items such as aseptic cleaning techniques, basic adult life support, taking blood pressure, cardiopulmonary resuscitation techniques for adults, children and infants and medical gas safety.There was a section on equipment that covered the use of all the equipment that may be found on an ambulance or in response bags.The final section covered procedures that may be carried out only by healthcare professionals.
- In November 2016, the national organisation received a certificate of approval from the International Organisation of Standardisation (ISO) 9001:2008 for quality management system, which included design, development of training courses in health and safety related topics.

Assessment and planning of care

- The service was contracted to an NHS ambulance service provider to transport patients to hospital and between sites; this included transporting patients who were above a certain weight which required specialist equipment.
- At the time of the inspection the service did not use a recognised pain score and there was no consistency in pain scores undertaken and recorded on the patient record forms at the time of inspection. For example, in 27 out of 57 records reviewed, no pain scores were recorded although six of the records showed analgesia had been administered. We were therefore not assured

patients pain was assessed. The patient record form documented pain scores were to be recorded from zero to three. However, we also observed scores documented from zero to 10 with instances of crossing through the zero to three on the form. It was not clear if a score of three was severe or moderate pain because staff were using more than one pain scale with three or ten being the severest pain level. During our inspection we did observe staff assess and manage patients' pain appropriately. As part of the factual accuracy submission the provider has informed us that they have reviewed the way it manages pain score. The provider introduced in June 2018 a new patient record form and this now includes the nought to ten scale used in local NHS ambulance trusts.

- An audit of patient records provided after our inspection showed that in patients presenting with a fracture, pain relief was considered in 88% of the patients. However, it was unclear as to whether a pain score had been recorded on the record or analgesia had been administered.In patients presenting with a headache, the audit did not measure whether pain was assessed or analgesia administered. The date of the audit was not documented and no action plans were provided to show actions taken in response to the audit. As part of the factual accuracy submission the provider has informed us that the audit tool was modified to include a focus on pain score recording.
- If crews considered that the best course of action was to see and treat the patient without transporting them to hospital, as initially planned, they would seek advice and approval from the NHS ambulance provider in order to do this and a clinical decision would be made by a paramedic. We observed that this had been done on one of the patient records that we reviewed.
- During our inspection we observed ambulance staff discussing needs with the patient prior to transfer. Discussions were also held with healthcare staff and documentation was checked regarding specific instructions. For example, do not attempt cardiopulmonary resuscitation status or if the patient was living with dementia. On arrival to the receiving hospital or place we observed the crews gave a well-informed clinical handover of the patient and ensured all relevant documentation was handed over.
- We observed crew attending to a patient; contact a senior paramedic at the NHS ambulance trust to ensure that the patient's condition meant that it was safe for them to transport the patient to hospital or whether a clinical crew was required.The crew received appropriate authorisation and instructions on treatment during transport.
- We observed patients that had sustained a fall, were given a full assessment before further decisions were made on the appropriate course of action.
- For event first aid, staff told us they would take the patient to the nearest accident and emergency department, should it not be possible to care for them at the event

Response times and patient outcomes

- The provider told us they did not monitor response times and patient outcomes as it was not a requirement of their contract with the NHS ambulance trust. However daily log call sheets were completed by ambulance staff and monitored by the NHS ambulance provider who escalated any exceeded timescales they identified.
- Managers told us that, although they did not monitor patient outcomes, they did receive feedback on patient outcomes for any cardiac arrests that staff had dealt with or had involvement in.
- We observed some activities were monitored by the service as part of their internal key performance indicators. This included the number of patient journeys completed, the number of cancelled or declined shifts and numbers of vehicles out of operation. This data was regularly reviewed by management staff to identify areas for action, such as staff recruitment or fleet management systems.
- Ambulance crews took patients to the nearest appropriate hospital for their treatment as directed by the NHS ambulance provider or the healthcare professional who had requested the hospital admission or transfer. Staff told us if a patient request an alternative hospital, the ambulance crew would refer back to the provider for advice.

Competent staff

- All new staff, staff who have been transferred from another location along with staff returning from a long period of absence were required to complete the 'welcome induction programme'. We were told each member of staff completed an induction checklist, provided with a learner handbook and a passport which described specific training attended. The line manager and an assigned buddy supported the member of staff throughout the six-month probationary period.
- Staff who were new to an ambulance station received a local induction before commencing their first shift.
- Events staff had the opportunity to develop and progress within the service from first aider to advanced first aider and on to emergency care technician through additional training.
- Training requirements were role or task dependant and staff were assessed through a revalidation programme to ensure they were competent. If staff did not complete the revalidation programme, or any other required training elements, this resulted in individuals becoming non-operational.
- Volunteers were required to meet the same standards of training as employed staff.
- Drivers were issued with a driving permit which showed the category of vehicle each driver was permitted to drive. Driver details including medical status, driving qualifications and driving infringements were recorded in the St John Ambulance National Driver and Fleet register.
- All staff completed an ambulance clinical competency assessment each year. This covered areas such as basic life support and holistic care. The clinical competency assessment was aligned with staff member's appraisal. We requested the compliance rates for the clinical competency assessment and this was shown to be 97% for the urgent and emergency care staff in the North West.
- On road assessments were undertaken at least quarterly by station managers or team leaders.
- Managers told us that the ambulance operations team identified any training needs by reviewing incidents and complaints. Staff told us they could raise any training requirements through 'the forum 'via representatives who requested and shared ideas with management. Further training in mental health had been requested and we were told by a team leader this was being looked at.
- There were no staff with professional registrations.However, staff were periodically required to provide a renewed disclosure and barring service check.This was managed by human resources who sent an email to the staff member six months before the existing certificate was due to expire. Staff were not allowed to work a shift if their certificate had expired.
- 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). Appraisals were carried out on a yearly basis and included an interim review at six months. Data provided showed all staff had received their appraisal within in the last year. Competencies had been written for ambulance staff that they needed to demonstrate to meet the St John Ambulance values.

Coordination with other providers

- There were arrangements in place for escalating issues with the sub-contracting NHS Ambulance Trust. Staff gave examples of how they raised incidents and safeguarding concerns directly to the NHS ambulance trust through direct telephone contact numbers and we also observed this in the records we reviewed.
- Staff told us clinical advice could be obtained from NHS Ambulance trust and if required they could request a paramedic to attend and treat a patient, as well as to pre-alert the nearest hospital that an emergency care patient was imminently arriving.We observed this in the patient records we reviewed.

Multidisciplinary working

- We observed good multidisciplinary team working between crews and other NHS staff when treating patients. We saw good co-ordinated care and transfer arrangements when handing the care over to NHS staff.

- We observed that crews liaised with the patient's GP via the NHS ambulance provider.Staff would wait with a patient until a GP visit had been arranged if this was the most appropriate course of action.During our inspection we observed examples of involving the multidisciplinary team in assessing, planning and delivering people's care and treatment. We observed one crew that worked with the patient's GP and a senior paramedic to obtain the best outcome for the patient during a call out.
- When a patient was transported to hospital, the middle copy of the patient report form was used to provide a handover of the patient to hospital staff.

Access to information

- The service was reliant on the information provided by the patient or carer or GP to enable them to effectively assess and manage their care. This was documented on the patient report form.
- Staff had pocket reference guides to access relevant information. They could telephone the duty manager or the operations centre of the local NHS ambulance service for advice if required.
- Some of the vehicles had a satellite navigation system which was updated centrally. Older vehicles did not have a system that could be updated. As part of the factual accuracy submission the provider has informed us that all vehicles have received upgraded satellite navigation systems.
- Patient safety alerts were monitored by the national team and cascaded to all staff either via a 'take five' poster or on an instruction note; we observed this during our inspection.Staff were able to tell us about recent patient safety alerts shared with them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 87 records and observed in 12 records the patient was recorded in a tick box as having no capacity but also consent had been given. We were therefore not assured what process the ambulance crew had followed to decide that the patient did not have capacity and there was no record of decisions made in the patient's best interest. Staff we spoke to showed us a pocket guide around determining patient's capacity and making best interest decisions. However, in the 12 records there was no evidence staff had followed the process. We told managers about our observations around indicating that patients without capacity had given consent during our inspection and they began an audit of the records that we had examined.
- Staff told us if they had concerns regarding a patient's capacity to consent they would discuss with family for advice on the patient's wishes as per the policy. However, we did not see this documented in the records we reviewed.
- 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.
- Where a patient had capacity, staff demonstrated a good understanding of explaining treatment and gaining the consent of the patient to treat them. We observed staff explaining treatment and procedures and providing patients with the opportunity to ask questions before gaining consent.
- Records showed that 97% of staff in urgent and emergency care in the North West had received training on the Mental Capacity Act and consent at the time of our inspection.
- The Legal Aspects of Clinical Care Policy, dated March 2017, stated that a minimum of 10 care episodes should be audited every quarter to measure the effectiveness of clinical care provided, including consent, respect and recording.We requested a copy of the last clinical care episode audit and action plan but data provided did not include data or assurances around consent obtained or actions arising from the audit.
- Staff had received training on Gillick competency and Fraser guidelines as part of level two safeguarding training.Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to those under 16 without parental consent.Since then they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.Staff were taught that they were able to seek consent from a young person under 16 as long

as they had sought to involve an adult with parental responsibility, that they had assessed that the young person had sufficient maturity to understand the nature, purpose and likely outcome of what was proposed and that they had assessed that what was proposed was in the child's best interest.This information was also contained in the provider's Clinical Procedures Manual that was available to all staff online.

- The provider did not routinely provide transport services to individuals being detained in accordance with the Mental Health Acts (1983 and 2007) unless contracted to do so. However, if this service was required as part of the contract the ambulance crew would work with and obtain guidance from healthcare professionals and the police.

Are emergency and urgent care services caring?

At present we do not rate independent ambulance services. However, during our inspection we noted the following for caring;

Compassionate care

- We saw that staff demonstrated a genuine desire to help people in need and we observed that staff were very polite, caring and respectful when dealing with patients.
- Staff introduced themselves to patients and carers and explained who they were before undertaking any assessment or care.
- We saw that staff ensured that patients were treated with dignity and respect at all times.
- We observed that staff demonstrated a caring and respectful attitude to relatives and carers who were with the patient.
- Ambulances all had pull-down blinds that were used to promote dignity when patients were being treated inside.
- We saw that the Fire Service had commended two St John Ambulance North West Region crew who had attended a road traffic accident and demonstrated care and compassion whilst staying with the patient.
- We received four patient comment cards from people who had been treated and transported by ambulance crews. All four comment cards were very positive about the staff and care patients had received.One card said that "both ambulance staff were exceptionally good, kind, cheerful and polite.They made me feel better."A relative of a patient living with dementia said that they could not praise the staffs' attitude and professionalism enough.Another patient said, "The staff were brilliant and very caring and treated me with respect."

Understanding and involvement of patients and those close to them

- We observed that the crew discussed with the patients their pain and gave an explanation of what they were doing.
- Staff gained consent from the patient to carry out treatment and transfer the patient to hospital.
- We observed that crews had gained a history of the patient's condition and discussed a good outcome with the patient and whether they needed to speak to their GP.
- Staff were seen to give patients their full attention and to answer questions in an open an honest way, allowing patients to ask whatever questions they wanted to.
- We observed that crews continued to talk to and explain to the patient what was happening whilst monitoring them during transit to the hospital.
- We observed during one care episode that the crew discussed the patient's "do not attempt cardio-pulmonary resuscitation" document with care home staff and explained that they would be taking it with the patient to the hospital.

Emotional support

- Staff took the time to provide emotional support to patients, family members and care home staff.
- 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.

Supporting people to manage their own health

- We observed that staff supported patients to manage their own care and wellbeing and maximise their independence. For example, we observed that staff advised a patient who declined to go to hospital who to contact if their condition deteriorated.

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

Service planning and delivery to meet the needs of local people

- The provider had a contract with an NHS ambulance trust to provide ambulance and patient transport services. There were options to extend the contract to March 2021.The provider had to plan and review staffing levels around contracts in place.
- The provider had weekly contractual shifts from the NHS ambulance trust but was also able to bid for additional shifts that were released as they became available from the trust. The shifts were made available via a third-party company and anyone on the ambulance provider framework could bid to undertake the shifts.
- The provider had worked with the NHS ambulance trust to improve the service. For example, they had proposed that blood glucose monitoring tests could be carried out by ambulance crews. The trust therefore trained the St John Ambulance North West Region staff and the provider bought the necessary equipment. The provider had also carried out more advanced blue light training as requested by the NHS ambulance trust and had carried out an audit against the training standards.
- We were told major events were planned in advance and the event manager worked closely with other professionals and post event briefings were held with the organisers to review the service provision at these events. This included whether they had met people's needs and areas for improvement at future events, staff gave us examples of when this had happened.
- Over the last year, the provider had provided staff at around 3500 events but only 91 of these involved staff providing regulated activities. In general, this meant that ambulances on site could be used as emergency ambulances to transport patients off site to an accident and emergency department if required. Many of the events were staffed by volunteer first aiders where no regulated activity was carried out.
- Records provided from the organisation show that from January to December 2017, there were a total of 35 shifts declined by the provider that could not be filled with appropriate staff. These were all in August and September 2017.
- Managers told us that, in the event of increased demand or shortage of crews or vehicles, that vehicles and crews could be brought in from other bases. There were spare resilience vehicles that could be used at short notice. The regional fleet manager reported to the national fleet manager and had access to vehicles from other regions if necessary.

Meeting people's individual needs

- The service provided training for staff to deal with patients with specific needs, including dementia and mental health. For example, 96% of staff had completed specific training in dementia awareness as part of their continuing professional development and staff told us there was additional training available on line.
- A telephone interpreting services was available to staff on each vehicle for patients whose first language may not be English. This service was available at all times and could be accessed immediately. Staff we spoke to were familiar and knew how to access the service.
- Staff had access to communication aids, such as picture charts, to support non-verbal communication on all vehicles. However, we did not see any resources available for those patients who had visual impairments.
- Staff gave us examples of when they had considered patient's requirements and preferences and made practical adjustments, to meet individual needs prior to transporting patients.
- Staff involved in transporting patients who required bariatric equipment had received specific training on the specialist equipment and adapted vehicles. Bariatric patients are those that are very overweight and require additional or modified equipment to accommodate them.

- Staff had undergone end of life care training as part of their continuous professional development to meet the needs of patients nearing the end of their life.

Access and flow

- The service was provided at different times and included shifts during the day and the night, and over the weekend. Ambulances that were equipped to deal with bariatric patients were available and additional vehicles were accessible at each location to ensure that the service could continue in the event of vehicle breakdown. Patients were allocated and referred to the service by the NHS ambulance trusts.
- The service recorded relevant timings for ambulances including dispatch times, arrival at the scene, left scene time and arrival at hospital. This was all recorded on the patient report form. Whilst we did not see evidence that his data was being audited by the service. It was being monitored through contracts with NHS trusts.
- The NHS ambulance trust had access to the St John Ambulance satellite navigation system so could track where the vehicles were and routes taken to allocated jobs.The St John Ambulance crews could communicate any delays directly to the NHS ambulance trust control room.
- Data provided as part of a national dashboard showed, between January and September 2017, 15,820 urgent care patients were transported across the North-West region. It was difficult to benchmark the service against other areas as different services were provided across the locations.

Learning from complaints and concerns

- There was a management of patient complaints and patient feedback framework policy (2015) which had been due to be reviewed in 2016. The policy explained the complaints process and staff role and responsibilities with the regional director having overall responsibility in ensuring complaints were responded to within agreed timeframes and keeping the complainant updated of any delays. The ambulance operations assurance team took the lead on investigating formal complaints. If the complaint involved a sub-contracting organisation such as the NHS ambulance trust there was a process for the joint investigation and learning.
- The organisation's website also had information on how to raise concerns, complaints or compliments. However, we did not observe any information on the ambulance vehicles. Staff had access to feedback forms which patients could complete and they also had small cards they gave out to patients with contact details if they wished to provide feedback. Staff at the Chorley station told us they had run out of the cards and that these had not been replaced despite requesting further stock.
- The service kept a compliments, concerns and complaints log and we observed the ambulance service had received two formal complaints within the last 12 months. One complaint had been finalised and closed within the timescales set out in the patient complaints policy. The other had not been responded to within the required timescales.
- Senior managers told us that the events service had not received any complaints within the last 12 months.
- We did not see complaints discussed at the station team or senior team meetings in the minutes we reviewed. However, data provided stated complaints were shared to staff across the service by the 'take 5' memo. Staff we spoke to were aware that there were few complaints raised but gave us examples of ones they were aware of.

Are emergency and urgent care services well-led?

At present we do not rate independent ambulance services. However, during our inspection we noted the following for well-led;

Leadership of service

- We found good leadership structures in St John Ambulance North West Region. The management team of St John Ambulance North West Region comprised of two managers, a Sector Manager responsible for the core ambulance service and an Operations Manager for events. The two managers were supported by a station managers, event managers, co-ordinators, and station team leaders. The two managers were supported by other regional managers and this fed into national

directors and national directorates. Whilst the two managers had different portfolios it was clear that they supported each other and when needed supported each other's crews

- Staff and management were open and honest and acknowledged that the service had faced a period of change and uncertainty which had been difficult. There had been a review and reorganisation of structures within St John Ambulance and the national service had transformed into four "super regions". Whilst this was the case, we found that staff felt that St John Ambulance was a supportive organisation with a proud tradition which they wanted to maintain. A number of staff told us that they had started their careers at St John Ambulance as volunteers and had become managers and senior clinicians over a period of time.
- Senior managers told us that the executive leaders had the skills and knowledge to do the job well.Managers felt that standards had risen and told us that the organisation had become more professional and business like. We were told that the director was fully focussed on ambulance operations.
- Local team managers we talked to told us that the senior manager's leaders had the skills and knowledge to do the job well.
- We found that managers and staff felt supported at each layer of the organisation and that 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 place to resolve problems and some could undertake shifts on the road if required.
- Senior managers told us that they spoke to station managers daily to get feedback on anything they needed to be aware of. The two Sector managers would often physically attend stations on an everyday basis particularly when managers were off.
- Managers had undertaken a team leader development course where they learnt skills in mentoring.
- Managers and staff interacted well during our inspection and were positive and responsive to each other.

Vision and strategy for this this core service

- The provider had a vision that stated, "Everyone who needs it should receive first aid from those around them.No one should suffer for the lack of trained first aiders." The provider also had a mission which was to, "provide an effective and efficient charitable first aid service to local communities; to provide training and products to satisfy first aid and related health and safety needs for all of society and, to encourage personal development for people of all ages, through training and by volunteering within our organisation."
- The service had a five year strategy from 2016 to 2020.There were three main strategic goals.These were firstly, "delivering first aid."Developing a vibrant network of active first aiders to deliver more first aid.Secondly, "equipping the public."So that more people have the motivation, skills, confidence and access to equipment to deliver first aid to those around them. Thirdly, "campaigning and leadership." To make more people aware of the importance of first aid and empower more of them to take positive action.
- To compliment the new strategy, St John Ambulance North West Region had also been through a period of reorganisation.The reorganisation consolidated some regional services into bigger hubs, and also standardised some governance structures into national departments. An example of this was a new model of senior management where regional management structures were reviewed and made fit for purpose.
- The regional managers had recently undertaken a review of their own job roles and now had management responsibility for bigger regional areas where some services had been amalgamated or integrated. Management spoke positively about change in the organisation and felt that it made St John Ambulance ready for the challenges it faced in the future. The managers told us that 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 told us that there were no local strategies for the urgent and emergency operations service but that all staff had received a copy of the St John Ambulance five year national strategy.

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

- We identified one major risk to patient confidentiality during our inspection. Patient report forms, which included patient identifiable sensitive information, were being posted through the postal system. There was no formal process for tracking forms how many forms had been sent or any system to track how many had arrived at an external scanning and archiving facility. This risk had been identified in two previous inspections of regional St John Ambulance services; the last was carried out in October 2017. We found no evidence that the service had added any mitigating features to manage this risk at the time of time of our inspection of the North-West region. As part of factual accuracy, St John have provided evidence that this issue had been addressed since our inspection.
- Recorded risks on the risk register at the time of our inspection reflected the national challenges and we felt that this was important. Managers told us that the development of an ambulance operations risk register was in progress and this mirrored a risk register that had been developed for first aid operations. However, we found that the lack of a local risk register at the time of inspection impacted on governance structures significantly. Local issues could seem minor when compared to national risk and be lost in the conversation between managers and staff.
- We also found that the service needed to improve how it reflected on incidents and how it made improvements in patient and staff safety. At present the incident log does not reflect a clear picture of how things changed after an incident was reported. Again, we understand that the service has plans to introduce new electronic systems to improve incident reporting and track patient safety but these had not been fully implemented at the time of our inspection and must be seen as a priority.
- A quality dashboard for ambulance operations, with number of incidents, complaints and safeguarding referrals had been created on a national level and this was provided at regional level for comparison and monthly trend analysis however, we would have liked to see local managers having local data to improve the experience of local patients.
- Whist the above impacted on our view of risk and governance structures St John Ambulance North West Region had some positive governance structures and had developed a staffing structure which supported governance processes. An example of this was its national safeguarding team, which had produced a national structure which fed into associated local structures which were in turn supported by policy and procedures.
- 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. However, we saw that some policies were out of date and had not been reviewed by the stated date, for example, the management of patient complaints and patient feedback framework policy that was due to have been reviewed and updated in 2016.
- Governance meetings although undermined by the lack of a local risk register and a quality incident reporting system were held locally and regionally. National governance meetings fed into regional meetings and vice versa.
- St John Ambulance North West Region managers had a regional business action tracker which logged significant actions with individuals and completion dates.
- The national service had undergone restructuring in 2016 and a new quality and standards directorate had recently commenced.The service told us this national directorate was focussed on consolidating and strengthening the activities of the health and safety, clinical and audit and assurance functions under one directorate. Managers told us this would provide a stronger governance framework and eliminate previous local differences.
- . The register was linked to the new incident reporting framework.

- Managers told us that they would review local risks that were specific to each location when the service risk register had been fully developed.

Culture within the service

- The managers in St John Ambulance North West Region told us that there was a culture where staff felt able to raise concerns.The staff supported the view that concerns could be shared and addressed organisationally without individual blame.
- St John Ambulance North West Region managers informed us that they supported 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.
- Staff safety and well-being was being supported by the organisation. We found a culture of nurturing staff and volunteers. The provider had subscribed to a "Head space" application for all employees to access that provided meditation and mindfulness techniques to staff to reduce stress and aid better sleep.
- Managers made contact with staff that were off sick on to check on their welfare and arrange 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 via face to face appointments.

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

- Staff took part in employee forums that were run by managers and human resources managers.The meetings had an agenda, such as health and safety and business updates. These meetings also included a team "voice box" where staff could discuss anything and suggest improvements.
- We were given a number of examples of things that had been introduced or changed following suggestions made at the employee forum, such as improved lighting at the Stockport base in the car park and the purchase of a fridge freezer for one of the ambulance bases.
- Some staff acted as representatives on a national employee forum. Performance development reviews were introduced to staff at an employee forum and feedback was gathered from staff.
- The provider sought feedback from patients and the public. There were cards available in ambulances, although we found gaps and at events to advise the public on how to provide feedback or to make a complaint.
- The business development team attended events with a stall to promote and advertise the work of St John Ambulance.

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

- Managers told us that business continuity and sustainability was challenging because of contract stability and that offering longer contracts to staff on fixed term contracts was frustrating because this depended on the commissioned contracts in place.
- We found that national decision by St John Ambulance on moving towards local risk and incident reporting structures would be positive in enabling local managers to assess the performance of St John Ambulance North West Region
- The structure of the ambulance operations service had been changed and strengthened. Team leaders were paid at an increased band and had taken on additional responsibilities.
- The managers told us that they were proud of the bariatric vehicles' staff who provided a vital service to the region and who were trained in the specialised bariatric equipment.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

See Emergency and Urgent Care section for information.

Summary of findings

The main service provided by this ambulance service was emergency and urgent care.

Where our findings on patient transport services also apply to emergency and urgent care, we do not repeat the information but cross-refer to the emergency and urgent care section.

Patient transport services (PTS)

Are patient transport services safe?

The main service provided by this ambulance service was emergency and urgent care.

Where our findings on patient transport services also apply to emergency and urgent care, we do not repeat the information but cross-refer to the emergency and urgent care section.

See patient transport services section for main findings.

Are patient transport services effective?

Coordination with other providers

- In PTS we saw examples of where care had been co-ordinated with health professionals in other settings. This included care homes, hospitals and health professionals providing patient escorts. We observed handovers at hospitals and St John Ambulance North West Region staff had extremely good interaction with the receiving establishments. On our ambulance journey we saw all paperwork was checked prior to leaving to ensure this was fully and correctly completed.

Are patient transport services caring?

See Emergency and Urgent Care section for main findings.

Are patient transport services responsive to people's needs?

See Emergency and Urgent Care section for main findings.

Are patient transport services well-led?

See Emergency and Urgent Care section for main findings.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that there is an audit trail of all patient records being transported to minimise the risk of data being lost or unauthorised access.
- The provider must ensure that incidents, lessons learnt and actions are presented clearly.
- The provider must take appropriate actions to consistently monitor the quality of services, including the audit and monitoring of patient outcomes and audit of patient records.
- The provider must ensure that all ambulances are stocked with everything that they need and there is evidence that this has been checked, including medicines in pouches and equipment within response bags.
- The provider must consider providing staff with clear pathways to follow when treating a patient, including ensuring that staff are appropriately trained in obtaining consent and acting in accordance with the Mental Capacity Act 2005 where patients lack mental capacity.

Action the hospital SHOULD take to improve

- The provider should ensure that a local risk register is developed rather than a national register.
- The organisation's website should show information on how to raise concerns, complaints or compliments and ensure systems and processes are in place to allow patients access to information about making complaints.
- The provider should ensure that gas cylinders are stored appropriately and safely and take advice if required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to establish and operate systems and processes to monitor and improve services: **How the provider did not meet the regulation** There was no adequate system in place to maintain records securely always and prevent the loss of data or unauthorised access. Incident investigations, lessons learnt and action plans arising were not presented clearly. There was no system in place to consistently monitor the quality of services, including the monitoring of patient outcomes and audit of patient records. This is a breach of Regulation 17 17(2)(a)(b) and (c)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have sufficient safe and proper systems in place to ensure that ambulances were stocked with equipment and medicines required. This is a breach of Regulation 12 Health and Social Care Act 2008 (regulated Activities) Regulations 2014 (Part 3) (As amended) parts 12(2)(a)(b)(c)(f) and (g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The provider did not have systems in place to ensure that people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided, especially where persons may lack mental capacity to make an informed decision.

This is a breach of Regulation 11 Health and Social Care Act 2008 (regulated Activities) Regulations 2014 (Part 3) (As amended) parts 11(1)(2)(3)(4) and (5)