British Red Cross Society

British Red Cross Abingdon

Quality Report

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services	

Summary of findings

Letter from the Chief Inspector of Hospitals

The British Red Cross is part of the International Red Cross and Red Crescent Movement, the world's largest independent humanitarian organisation. Within the UK, the Red Cross is split into three regions, within which are a number of areas. The British Red Cross Abingdon is part of the Thames Valley area.

The British Red Cross Abingdon provides an ambulance service in Oxfordshire and Berkshire through a contract with the local ambulance trust. There is also an events service that provides first aid support, at public events. The British Red Cross Abingdon has contracts with a number of organisations, which hold events in the local area. The Red Cross operates ambulances as a means by which the organisation can provide humanitarian support and assistance to those who need it in a crisis.

We inspected British Red Cross Abingdon on 4-5 November 2015. This was a pilot comprehensive inspection to test our new methodology for inspecting independent ambulance services. Therefore, we did not rate this service.

Our key findings were as follows:

Is the service safe?

- Staff did not always make sure they stored patient records securely after they completed them.
- Staff raised concerns around the lack of radios on vehicles. Staff relied on mobile phones to raise concerns and seek additional support.
- Staff knew how to report a safeguarding concern and completed safeguarding adults and children at risk training. However, staff were not always confident about what would be considered a safeguarding concern.
- Cupboards on some ambulances were not labelled which made it difficult to locate items in an emergency. There was no standard equipment list on the ambulance so staff could check all items were available. However, all ambulances were well stocked.
- Staff reported incidents and senior staff investigated these. The sharing of learning and action points took place locally and nationally.
- Staff completed their statutory and mandatory training.
- Staff followed infection prevention and control procedures. Vehicles in general were clean and tidy, with regular deep cleans taking place to reduce the risk of infection.
- The environment and equipment at the three locations visited and on the ambulances was well maintained. Vehicles had a current MOT, insurance and regular servicing took place.
- A new medicines management system was in the process of being introduced which would improve stock control, traceability and storage of medicines.
- There were effective systems to manage staffing requirements for contract and event first aid work, to ensure the appropriate number of skilled staff were on duty.
- Staff participated with other services in response training for major incidents.

Is the service effective?

- Staff provided care to patients in line with national guidance. Staff were able to seek additional clinical advice, if needed, whilst caring for patients.
- Staff completed relevant training for their role, and the majority of staff (85%) had received an appraisal in the last year.
- Ambulance staff raised concerns that the restrictions of the contract limited their scope of practice and did not utilise all their clinical skills. Staff assessed and provided pain relief for patients as needed.
- We saw good multidisciplinary team working between ambulance crews and other emergency teams.
- We saw patient consent was obtained before undertaking treatment or observations.

Summary of findings

- Staff did not demonstrate a clear understanding of the codes of practice for the Mental Capacity Act (2005) or Mental Health Act (1983).

Is the service caring?

- Staff provided compassionate care to patients and their families and maintained patients' privacy and dignity at all times.
- Nationally feedback from the Friends and Family Test was positive, with most patients extremely likely or likely to recommend the service.
- Staff explained the care and treatment they needed to provide in a way their patients could understand.
- Patients were encouraged to be partners in their care and involved in decisions about their care and treatment.

Is the service responsive?

- The service worked effectively with the contract ambulance trust and commissioners for event first aid work, to ensure they planned services to meet the needs of local people.
- Managers investigated complaints and provided a written response to the complainant. Managers considered learning from complaints, but it was not evident that this learning was shared with all staff, to improve services.
- Services were accessible to all and staff had training to support patients in vulnerable circumstances. However, language and communications guides, which were on the equipment lists , were not found on all vehicles, to support patients who had additional communication needs.

Is the service well-led?

- There was a local vision for the service, which reflected the national values of the organisation.
- Governance arrangements were being developed nationally and locally, with greater attention given to monitoring and reviewing the quality of the service, against a number of key outcomes. The contract provider monitored response times for ambulance crews and discussed performance at monthly meetings with the service.
- Staff told us leaders were competent, approachable and visible. Staff felt well supported by their immediate manager.
- Staff told us British Red Cross Abingdon was a friendly and caring place to work. However, staff raised concerns around their personal safety and welfare, due to there being no panic alarm on ambulances.
- The service encouraged feedback from patients and staff through the use of surveys.
- The service had identified ways to develop and sustain its services.

However, there were also areas of poor practice where the location needs to make improvements.

The location should:

- Ensure all patient records are stored securely at all times.
- All staff should receive training on duty of candour in order to understand the principles of this and their role.
- Review the effectiveness of the safeguarding adults and children at risk training so that staff are clear about what constitutes abuse and when to report a concern.
- Review the current communication channels and process for requesting support in an emergency, for example if the staff are attacked.
- Provide all staff with training on the mental capacity act and mental health act and ensure staff understand how to use the codes of practice appropriately when caring for patients.
- Ensure all vehicles contain the language and communication guides, to support patients with language difficulties and ensure safe care and treatment.
- Consider providing complaints information on all vehicles.
- Review the provision of equipment for the safe transportation of children.

Summary of findings

Professor Sir Mike Richards
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		This was a pilot inspection to test our new methodology for the inspection of independent ambulance services; therefore, no ratings were applied. Two information governance breaches around safe storage of patient records were identified during the inspection. Completed patient records were found in a first aid bag, which was ready for use, and on unsupervised open ambulances potentially putting patient confidentiality at risk. Staff had completed safeguarding training, but lacked confidence to identify potential safeguarding concerns. Staff raised concerns around being unable to escalate concerns promptly about deteriorating patients. Staff had to rely on the use of mobile phones to seek help, as there was no radio on the ambulance. There were sufficient numbers of suitably trained staff. Staff followed relevant procedures for reporting incidents and infection prevention and control. The environment and equipment were well maintained. Vehicles were well stocked. The provider had started to introduce a new system for medicines management, to improve the stock control, storage and traceability of medicines. Staff followed relevant national guidance to provide effective care for patients. Staff worked effectively with all healthcare professionals, involved in a patient's care, to ensure care was planned and co-ordinated to meet the patients' needs. Staff did not feel confident in the use of the codes of practice for the Mental Capacity Act (2005) and Mental Health Act (1983), when caring for patients and in relation to consent for treatment. Patients received compassionate care that respected their privacy and dignity. Patients were involved in decisions about their care. Staff were caring, understanding and supported patients emotionally. Staff provided care which was person centred. The needs of local people were considered when planning and monitoring services. Staff delivered care, which considered all the needs of the patient, not just

Summary of findings

their medical needs. However, language and communication guides were not available on all vehicles. Complaints were investigated and responded to, but learning was not widely shared with frontline staff.

The service had a local vision, which focused on the organisation strapline 'Refusing to ignore people in crisis'. There were governance arrangements in place to monitor quality and risk, but improvements were needed to ensure action plans and risks were reviewed. The service was active in seeking feedback from patients, volunteers and staff. Senior staff identified ways to ensure sustainability and development of the service. Staff spoke of a positive caring culture, with good leadership. Staff did however raise concerns around their personal safety, due to there being no panic alarm on ambulances.

British Red Cross Abingdon

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Detailed findings

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Background to British Red Cross Abingdon

The British Red Cross is part of the International Red Cross and Red Crescent Movement, the world's largest independent humanitarian organisation. Within the UK, the Red Cross is split into three regions and each region has a number of areas. The British Red Cross Abingdon is part of the Thames Valley area.

The British Red Cross Abingdon provides an ambulance service in Oxfordshire and Berkshire through a contract with the local ambulance trust. Through this contract, British Red Cross Abingdon is involved with the emergency transfer of patients to the accident and emergency department or the appropriate hospital department or ward. In addition, the service transfers patients between hospitals, if the patient needs to be admitted to a different ward for continuing care. There is also an events service, which provides first aid support, at public events. The British Red Cross Abingdon has contracts with a number of organisations, which hold events in the local area. The Red Cross operates ambulances as a means by which the organisation can provide humanitarian support and assistance to those who need it in a crisis.

The service provides cover seven days a week, for its contract work. There are five eight-hour shifts each weekday, which cover the period 8.30am until 11pm. Two shifts each from Reading and Slough, with one shift from Abingdon. At the weekend, there is one shift from Abingdon and one from Reading. Cover for event work is predominantly at weekends. The British Red Cross Abingdon has a mix of employed staff and volunteers.

We visited three locations Abingdon, Reading and Slough and accompanied staff on ambulances to observe care given to patients.

We inspected British Red Cross Abingdon on 4-5 November 2015. This was a pilot comprehensive inspection to test our new methodology for inspecting independent ambulance services. Therefore, we did not rate this service.

Our inspection team

Our inspection team was led by:

Inspection Manager: Lisa Cook, Care Quality Commission

The team of four included an inspection manager, an inspector and two specialists, an ambulance technician and an advanced paramedic.

Detailed findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting British Red Cross Abingdon, we reviewed a range of information we held about the location and asked other organisations to share what they knew. We carried out an announced visit on 4 and 5 November 2015.

During the inspection, we observed how people were being cared for and reviewed patient records of people who use services. We spoke with 14 staff including emergency care assistants, a team leader and service managers, including the senior service manager. We also spoke with the leads for safeguarding, complaints, quality and fleet management. We observed four interactions of care, by accompanying staff on an ambulance, when they responded to a call. This included the interactions between the ambulance crew and hospital staff or other emergency crews. We reviewed four patient records. We also looked at local and national policies which staff worked to and checked servicing records for a sample of ambulance vehicles and equipment on these vehicles. Random spot checks were carried out on six vehicles and at the three bases Reading, Abingdon and Slough to look at cleanliness, infection control practices and stock levels for equipment and supplies.

We would like to thank all staff and patients for sharing their views and experiences of the quality of care and treatment provided by British Red Cross Abingdon.

Facts and data about British Red Cross Abingdon

British Red Cross Abingdon key facts and figures

Safe

- 84 incidents (January 2015 to August 2015). Five accidents, 10 near misses and 67 other incidents.
- Currently 99.71% of our volunteers and staff have Safeguarding training. Up to 1st October 2015 Safeguarding was delivered as a two-part package, part 1 on Children & part 2 on Adults.

Effective

- The percentage of total staff receiving an appraisal

Ambulance Crew - Staff	76.9%
Ambulance Technician	50.0%
Ambulance Team leader	100.0%
Service Manager	100.0%
Senior Service Manager	100.0%

Caring

- Nationally, the majority of 'Friends and Family' test respondents would be 'extremely likely' or likely to recommend the British Red Cross event first aid and ambulance services (September 2015).

Responsive

- The provider works with a local ambulance trust to transport patients into hospital when requested by their GP or another clinician.
- In their event work they have grown the training framework to include technicians, along with further training & development of our staff and volunteers to deliver high quality care that avoids the need for hospital admission where clinically appropriate**.**

Well-led

- During 2016 the key priorities for Ambulance Operations within the Thames Valley are:
- To increase the cost recovery to 97% and achieve break even.

Detailed findings

- To maintain the current level of provision to the local ambulance trust.
- To achieve a 95% conversion of Emergency Driving Institute drivers to D2 or its equivalent.
- To enhance the commercial relationship with the local ambulance trust to enable long term planning for 2017.
- During 2016 the key priorities for Event First Aid Ambulance Operations within the Thames Valley are:
- Increase the number of qualified volunteer ambulance crew.
- Streamline the fleet of vehicles to ensure they are used to their best effect.
- Further enhance the offered continuation training to ambulance crews and prospective ambulance crews to provide development and growth within their volunteering roles.
- Encourage volunteers to attend events both locally and further afield where their skills can be utilised and expanded.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

British Red Cross Abingdon provides an emergency and urgent care service to patients across the Thames Valley area. This is through a contract with the local ambulance trust and by the provision of event first aid, for local and national events in the area.

Emergency and urgent care services were operated from three locations, Abingdon, Reading and Slough. The main office is at Abingdon, with a further office at Reading. The offices were used for all aspects of British Red Cross work, not just emergency and urgent care services. Vehicles used for contract work were kept at Abingdon or Reading. Two vehicles were kept at Slough for event first aid work, with a small rest room for crews to use, if they were in the area. The service had a mix of employed staff, for contract work and volunteers for event first aid.

During the inspection, we visited all three locations. We spoke with 14 staff including emergency care assistants, a team leader and service managers, including the senior service manager. We also spoke with the leads for safeguarding, complaints, quality and fleet management. We observed four interactions of care, by accompanying ambulance crews, when they responded to a call and reviewed four patient records. We also analysed data provided by the service both before and after the inspection.

Summary of findings

This was a pilot inspection to test our new methodology for the inspection of independent ambulance services; therefore, no ratings were applied.

Two information governance breaches around safe storage of patient records were identified during the inspection. Completed patient records were found in a first aid bag, which was ready for use, and on unsupervised open ambulances potentially putting patient confidentiality at risk.

Staff had completed safeguarding training, but lacked confidence to identify potential safeguarding concerns. Staff raised concerns around being unable to obtain support in a timely way when a patient's condition deteriorated. Staff had to rely on the use of mobile phones to seek help, as there was no radio on the ambulance. There were sufficient numbers of suitably trained staff. Staff followed relevant procedures for the reporting incidents and infection prevention and control.

The environment and equipment were well maintained. Vehicles were well stocked. Following audits completed in April 2015 the provider had started to introduce a new system for medicines management, to improve the stock control, storage and traceability of medicines.

Staff followed relevant national guidance to provide effective care for patients. Staff worked effectively with all health care professionals, involved in a patient's care, to ensure care was planned and co-ordinated to meet

Emergency and urgent care services

the patients' needs. Staff did not feel confident in the use of the codes of practice for the Mental Capacity Act (2005) and Mental Health Act (1983), when caring for patients and in relation to consent for treatment.

Patients received compassionate care that respected their privacy and dignity. Patients were involved in decisions about their care. Staff were caring, understanding and supported patients emotionally. Staff provided care, which was person centred.

The needs of local people were considered when planning and monitoring services. Staff delivered care, which considered all the needs of the patient, not just their medical needs. However, language and communication guides were not available on all vehicles. Complaints were investigated and responded to, but learning was not widely shared with frontline staff.

The service had a local vision, which focused on the organisation strapline 'Refusing to ignore people in crisis'. There were governance arrangements in place to monitor quality and risk, but improvements were needed to ensure action plans and risks were reviewed. The service was active in seeking feedback from patients, volunteers and staff. Senior staff identified ways to ensure sustainability and development of the service. Staff spoke of a positive caring culture, with good leadership. Staff did however raise concerns around their personal safety, due to there being no panic alarm on ambulances.

Are emergency and urgent care services safe?

Summary

By safe, we mean people are protected from abuse and avoidable harm.

Staff did not always make sure they stored records securely after they completed them. During the inspection we found six patient records in an event first aid kit bag, with the bag placed in the clean store, indicating it was ready for use. We also saw patient records on two ambulances, which were unlocked, with no staff on the vehicle. The provider had already started to address performance issues with relation to the records in the kit bag.

Staff knew how to report safeguarding concerns and completed safeguarding adults and children training. However, they did not always understand what would constitute a concern.

Staff raised concerns around the lack of radios on vehicles. They had to rely on mobile phones to raise concerns and seek additional support.

Staff felt confident when reporting incidents, which senior staff investigated. Learning and action points were shared locally and nationally. Staff did not receive feedback if they reported an incident to the contract provider. The service had plans to introduce a new process to improve this. Senior staff received training on Duty of Candour.

Staff completed their statutory and mandatory training. Driver training for emergency situations was being updated, to meet the new standard set by the ambulance contract provider.

Staff followed infection prevention and control procedures. Vehicles in general were clean and tidy, with regular deep cleans taking place to maintain hygiene standards. Staff had access to spare uniform and personal protective equipment, to reduce the risk of the spread of infection.

The environment and equipment at the three locations and on the ambulances was well maintained. Ambulances were well stocked, but cupboards on two vehicles were not labelled, which made it difficult to locate items in an

emergency. Ambulances did not carry a standard equipment list meaning staff could not check they had all the items. Most ambulances did not have specific equipment for transporting children.

The provider was introducing a new system for medicines management to ensure improvements in stock control, traceability and storage of medicines. There were no controlled drugs stored at the locations.

There were effective systems to manage staff levels/ numbers needed for contract and event first aid work.

Staff took part in joint response training for major incidents, with other services. Business continuity plans were in place, in the event of an emergency, but were out of date.

Incidents

- The service had a paper-based system in place for staff to report accidents, incidents and near misses (referred to as incidents for this report). All staff we spoke with were aware of their responsibility to report incidents and knew how to do this. Staff told us in general they received feedback when they reported an incident.
- There was a concern amongst staff that the contract provider did not provide feedback on incidents reported directly to them. In response to these concerns, the provider was introducing new paperwork for the reporting of incidents. There would be a formal reporting mechanism, which would include feedback.
- Incident data was collated locally. At a local level, the health and safety team was responsible for monitoring this information. The quality and outcome team was responsible for the reporting at a national level.
- The local incident spreadsheet did not indicate whether an incident resulted in low, moderate or severe harm. This meant it was not possible to see at a glance the level of impact of the incident on patients or staff.
- Senior staff and team leaders understood their responsibility to investigate incidents; they had received additional training to support them in this role. The incident spreadsheet, showed who had investigated the incident, action taken to prevent recurrence, any further investigations that took place and whether a risk assessment was reviewed or completed as a result of the incident.
- For November 2014 to July 2015 a total of 82 incidents were reported. There were five accidents 10 near misses and 67 other incidents, 38 of which were clinical incidents. The majority of these clinical incidents were staff being unable to drive under emergency conditions ('blue lights'), due to the restrictions in place under the contract. Senior staff were working with the provider to resolve this issue and all eligible staff were to complete additional driver training to enable them to drive under emergency conditions.
- Learning from incidents was shared with staff through email updates, bulletins on the intranet, face to face training and by a newsletter for volunteers.
- We saw that safety alerts were emailed to team leads from the contract provider, these were then shared with staff. Ambulance staff were required to sign to say they had read any safety alerts, to show they were aware of changes they needed to make to their practice.
- Senior staff gave an example of national learning because of a local incident, following the failure of a suction machine. This had resulted in a national review within the organisation, of the piece of equipment and a change in the testing procedure for the equipment.
- The Duty of Candour legislation requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Nationally the British Red Cross were in the process of applying the principles of Duty of Candour across all services. A new guidance document had been approved by the board and was to be introduced. Senior staff had relieved training of staff, as managers would have accountability to make an apology on behalf of the organisation. The serious incident procedure included the requirements of the duty of candour legislation.

Mandatory training

- Mandatory training for staff took place via face-to-face training, such as for basic life support and manual handling, which were updated annually. Some training was delivered via e-learning modules. Data showed 99% of staff had completed their manual handling training,

at the time of the inspection. The service did not provide specific information on which modules were considered part of staff mandatory training or the target compliance rate for mandatory training.

- Team leaders were able to review records to see the training staff had completed and training, which was due for renewal.
- The service had undertaken a recent review of the level of driver training needed by staff to enable them to drive under blue lights. This was in response to concerns raised by the ambulance provider whom the contract was held with, as their staff were required to have a different level of training. A rolling programme had been introduced for staff to complete the Institute of Health Care Development emergency driving training (D2). At the time of the inspection, 45% of ambulance staff had completed this training, with a target of 95% completion during 2016. Some staff needed to gain additional driving experience before it was appropriate for them to undertake the D2 course, due to the requirements that had to be met to start the course.

Safeguarding

- Safeguarding adults and children at risk training was one of the mandatory training subjects for staff. Staff we spoke with confirmed they had completed this training. As of September 2015, 99.7% of staff (Volunteers and employed) had completed safeguarding training.
- Staff we spoke with were aware of their responsibility to raise a safeguarding concern and knew how to do this. However, staff could not confidently describe the different types of abuse. A safeguarding concern arose during an observation of care. Staff did not initially raise this as a concern. This was discussed with the team leader and a referral made the next day. Ambulance crews were clear on the different process to follow, if they needed to raise a concern whilst undertaking contract work with the ambulance provider. Staff knew where to access the current policies and procedures, for safeguarding adults and children at risk, both for in-house and contract work.
- Staff of all grades told us they did not regularly receive feedback from the contract provider or the local authority about safeguarding concerns they had raised, to enable learning. The lead for safeguarding told us this information was provided if they contacted the service. The national safeguarding lead followed- up cases of significant concern.
- Senior staff had additional training to support them in their role as safeguarding officers and leads. There was an escalation process in place in the event of a staff member raising a serious concern, this included out of hours support, both locally and nationally. Changes to procedures were shared to frontline staff, through the local officers. We were told additional safeguarding training had been provided for staff in response to an increasing number of referrals around self-neglect.
- There were robust systems in place for safe storage and disposal of safeguarding records held locally, which followed national policy.

Cleanliness, infection control and hygiene

- A national infection control policy was in use, supported by a procedure for staff to follow, including information on hand hygiene.
- We visited three premises belonging to the service; all clinical areas at these locations were visibly clean and tidy. We also checked six ambulances, all were clean on initial observation, however on two ambulances, areas not obvious to the patient, such as around the suction machine, the machine for measuring oxygen levels and behind the seats were noted to be dirty and dusty. One ambulance was untidy, as it had not been cleaned at the end of the shift, as expected. This was not in line with the procedure on prevention and control of infection.
- All vehicles we checked had a record of the last deep clean, which was in date. A deep clean involved steam cleaning a vehicle to reduce the presence of certain bacteria. An external company completed this on a six weekly basis for vehicles used under contract and 12 weekly of those used for events. Set locations on the vehicle, were swabbed pre and post each deep clean, to confirm the clean had been effective and the results reported to the service. In the event of a significant contamination, the company provided a deep clean at short notice. Staff told us they responded promptly.
- Ambulance crews completed and signed daily vehicle check sheets to confirm the vehicle was clean at the end of the shift. Staff told us that each event first aid vehicle had a cleaning logbook kept in the vehicle. We checked two event first aid vehicles. One vehicle did not have a logbook, another had three books, and these had not been filled in by date order. There was no log kept on the vehicle to show when it was last used to cross-reference this with the cleaning record.

- Staff completed infection control training as part of their initial training. We observed one member of staff not cleaning their hands prior to putting on gloves. This did not follow the process stated in the procedure. For all other observations of care, staff followed best practice, to minimise the risk of the spread of infection between staff and patients.
- On all vehicles we checked, the hand sanitiser gel was available, but on some vehicles, it was not immediately visible, to encourage staff to maintain good hand hygiene practices.
- Personal protective equipment, such as gloves and aprons were provided for staff, both on vehicles and at premises, to protect staff from contact with infectious materials.
- We saw staff cleaning relevant areas and pieces of equipment on vehicles between patient contact. Spare linen was provided on vehicles and a system was in place at all hospitals for dirty linen to be exchanged for clean. For event first aid work, disposable linen was in use. Spills kits were provided on all vehicles, to minimise the hygiene risk until the vehicle could be cleaned. Disposable mop heads were used to clean vehicles at the end of a shift, to reduce the spread of infection.
- Containers for the disposal of clinical waste and shapes were in place on each vehicle. There were suitable facilities at all premises for the disposal of clinical waste, at the end of a shift.
- Staff were provided with sufficient uniform, which ensured they could change during a shift if necessary. Staff were responsible for cleaning their own uniform, unless it had been heavily contaminated, when it was disposed of as clinical waste.

Environment and equipment

- We checked six ambulances all were well stocked with single use items. We checked approximately thirty items and all were all within their expiry date and safe to use. The location of equipment and consumable items in cupboards was not the same on each vehicle, including vehicles of the same model. Also, on two vehicles the cupboards were not labelled. This meant that if a crew used a different vehicle there may be delays in accessing equipment and consumables in an emergency situation.
- There was no standard equipment list on each vehicle, therefore, it was not possible for staff to check and identify missing items. There was a potential for patient safety to be put at risk. The daily vehicle check required staff to check essential items the defibrillator, hand held and power suction machines, but no other items. We reviewed an audit, completed in September 2015 for one vehicle, this identified items that were out of date and needed replacing or where stocks were low. There was no minimum frequency for repeating this audit.
- We were told that the service had recently introduced vehicle champions, to encourage a high standard of quality to be maintained on vehicles, such as stocking of equipment and monitoring of cleanliness. All staff were responsible for maintaining stock on vehicles, by restocking when back at base, or during a shift if needed. Stock was clearly arranged at each location, with expiry dates visible were applicable. We were told that a stock check was completed every three months for items in the make ready cupboards, however, this was not written down to enable more detailed analysis of items used, for audit purposes.
- The organisation was introducing standardised kit bags, such as for burns and resuscitation, across all vehicles, which meant staff could access all the items they needed for an incident quickly. Within these bags was an expected kit list and a diagram on the layout of equipment within the bag. Team leaders and vehicles champions were responsible for maintaining these bags. A tagging system was used to indicate a bag was ready for use. We checked four bags, and found they were stocked correctly.
- An asset register for medical equipment was maintained. This included the item number, next service date and the frequency of service. We checked two items and the servicing information matched the sticker on the piece of equipment. The logistics of arranging servicing of both equipment and vehicles and ensuring enough vehicles for a safe service, were well managed. We were told external companies worked flexibly with the service to meet their need and where possible servicing was grouped to limit the time the vehicle was not in use.
- All vehicles had an up-to-date MOT, service and were insured. Keys were stored securely with only relevant staff having access but staff did not have to sign when they took or returned vehicle keys, to identify who had the keys in an emergency.

- We saw a vehicle log used in the crew room at Reading, to enable staff to see at a glance any major issues with vehicles and the action taken. One vehicle we checked had a 'not in service' sign in the front window, as the battery was flat and awaiting replacement.
- The service did not transport bariatric patients. We were told an appropriately equipped vehicle, from another service, would be requested if a bariatric patient was seen at an event and needed transport to hospital.
- There was limited provision on vehicles for the transportation of children. Only one vehicle we checked had a seat with an adjustable child restraint. Staff told us they would sit the child on the parent's lap or get them to lie with the child on the stretcher, if they had to transport a child. On one vehicle, we did not find a baby pulse oximeter or a paediatric blood cuff, to ensure appropriate observations could be carried out.
- Staff had training on the safe use of equipment and manual handling as part of their induction. Updates were provided by the service as needed. We saw staff following safe manual handling procedures when moving patients.
- One vehicle, which was new, did not have a mobile display terminal (MDT), but was in use. Staff had to rely on information about the patient and the location of the incident being called through to them on a mobile phone. The MDT was also used to programme the satellite navigation system, to enable the crew to respond quicker to the call. This piece of equipment was in place on the other ambulances.
- The service had completed a premises audit for Reading and Abingdon. An action plan had been produced and a number of actions completed with changes made to improve staff and visitor safety. For example, ensuring areas were clear from clutter, waste, completion, and display of Control of Substances Hazardous to Health (COSHH) assessments for the cleaning products used. However, some actions logged in March 2105 remained outstanding.

Medicines

- There was a clear system for the order receipt and safe storage of medicines. The keys to storage areas were stored securely. We checked the order, receipt and stock level for one medicine at Abingdon, which was correct.
- Medicines management audits had been completed for Reading and Abingdon, in March and April 2015 respectively, for both event first aid and contract work. Managers had addressed key actions, including providing new key cupboards to restrict, which staff had, access to the central medicines store and ambulance operations medicines.
- We checked seven items in the central store at Reading, these were all in date and stock levels matched those on the stock control sheet, providing assurance that medicines were being safely managed and distributed. However, there was no system in place at any location to record stock levels for items placed in the make ready cupboards, which all staff could access, or in kit bags on vehicles. It was not possible to trace where medicines had been issued to (vehicle or kit bag) and by whom. There were plans to introduce a new medication usage chart. We checked a sample of items across six ambulances, all were in date other than on two vehicles out of date glucose tablets were found. Medical gas cylinders were also checked and were in date and cylinders at least half-full. Staff checked levels at the start and end of the shift and restocked as needed. There was no system in place for recoding the exchange of gas cylinders. This was to be introduced and we saw the new procedure and transfer record sheet. At Reading, the stock levels in the central gas store had not been checked for a week, to ensure a sufficient supply. Medical gases were stored securely and safely at all locations.
- A coloured tagging system was used to show if a medicines bag was fully stocked and items in date. If staff used an item, but sufficient stock and items remained in date a different coloured tag was applied. There was no log sheet in the medicines bag to ensure traceability of medicines issued to patients. Three out of six bags we checked did not have a tag on them.
- Staff could administer different medications depending on their role. Staff were clear which medications they could issue. All vehicles contained the full range of medicines, in case a vehicle was used for event first aid work, rather than contract work. There was the potential for staff to be in a compromising situation, as they had training and access to additional medicines, but could not use them due to the restrictions of the contract.
- Medicines administered to patients were recorded on the patient report forms (PRF's). As part of the medicines audit a sample of PRF's were audited, to ensure correct documentation. Areas of concern were discussed with the staff member concerned or a general reminder sent to all staff by email.

- A log was kept of medicines that were disposed of, to ensure traceability and safe disposal.

Records

- Secure records storage was available at each office or station for staff to leave records on completion of their shift. The team leader was responsible for collecting and reviewing the records on the subsequent day. There was a secure storeroom for the archiving of records.
- There was a national policy on records management, which covered creation, storage, security and destruction of records.
- During the inspection, we found six completed patient report forms (PRF's) dated 18 September 2015, in an event first aid kit bag. These had not been removed at the end of the event, to ensure safe storage and access to records, as per the records management policy. In addition, the bag was in the clean store, identifying it had been checked by an event first aid coordinator and was ready for use. This checking process had not found the PRF's. The team leader took immediate action and made senior staff aware of this incident. Issues relating to staff compliance with this process were being addressed by the service.
- There was a risk of unauthorised access to confidential information as completed PRF's were left on unlocked and unattended ambulances, which was not in keeping with the records management policy. This stated that records were not to be left unattended in vehicles. While there was a level of accepted risk, to help manage the risk, staff moved records to a secure location at the base when they visited during their shift.
- All patient records were completed on carbonated forms. The original form was passed to staff at the receiving hospital, to ensure all staff delivering care for the patient could access the information. The second copy was kept by the organisation to ensure they had a record of care and were also used for auditing the standard of record keeping
- The service audited PRF's every three months. Four PRF's were reviewed for each crew. Feedback was given to staff on both the content of the PRF and the care they provided to patients. Some, but not all staff told us they had received feedback, to enable learning and improvement.
- The ambulance contract provider undertook a monthly external review of record quality for patients seen by the service. This information was shared with senior staff, who discussed any concerns with the member of staff concerned. Senior staff told us that the provider had asked for this process to be completed internally going forward and the findings shared at the monthly meeting.

Assessing and responding to patient risk

- Staff completed clinical observations on patients, as part of their care and treatment, to assess for early signs of deterioration.
- Ambulance crews worked as dual emergency care assistant (ECA) crews for the ambulance contract provider. This restricted the type of calls they were sent to. However, staff told us they were sometimes asked to attend as an initial response to a higher risk patient, with back up then provided. Staff told us they risk assessed, through discussion as a crew and with the team leader, before accepting the call.
- All the ambulance crews raised concerns around the lack of radios in vehicles. They told us this made it difficult to escalate concerns about deteriorating patients, seek support or raise concerns about their own safety. Staff used mobile phones, but reported they often could not get through in a timely manner to the relevant department. For example, a crew requested back up for a patient whose condition was deteriorating however, by the time they had received a call back, the crew had arrived at the hospital.
- Senior staff told us a national solution was being considered for the lack of radios, however, we were not given a timeframe for this. There was no assurance that the risk to patient and staff safety was being addressed promptly.
- Staff completed training as part of their induction to enable them to provide emotional support to patients with challenging behaviour and those experiencing a mental health crisis. A police officer accompanied any patients detained under the Mental Health Act (1983), as part of the agreement with the contract provider.

Staffing

- Team leaders and senior staff, regularly reviewed staffing levels and appropriate skill mix of staff to cover shifts through the contract with the local ambulance trust and event work.
- For event work, a workforce plan was devised based on the workload from the previous year and any comments from debrief sessions after events, about whether the

level of staffing was appropriate to meet the needs of the patients seen. Volunteers were asked which events they could commit to. Shortfalls were managed by asking volunteers to work additional sessions or seeking support from neighbouring British Red Cross teams. The service would sub-contract the work to another service, should they not be able to resource an event sufficiently.

- For work supporting the local ambulance service, an agreed number of ambulances were provided on each day of the week. An electronic rostering system was used to plan shifts. Shortfalls in cover were shown on this system and staff could request to work additional shifts. Shifts that were short staffed, were sometimes covered with paid staff from a neighbouring service or by casual workers, employed by British Red Cross. No agency staff were used.
- We were told that some shifts had to be cancelled if cover could not be found. Earlier this year this had been one to two shifts per month, but had recently increased to three to four a month. It was harder to find staff to cover shifts due to some vacancies remaining unfilled for a number of months. There were 2.5 whole time equivalent ambulance crew vacancies as of September 2015. There was an ongoing active recruitment campaign. Lack of available staff, identified as a risk in September, was on the local risk register. The contract did not stipulate a set number of sessions per month over a given time period, which made it difficult for senior staff to fully anticipate staffing requirements.
- We reviewed the rotas for the two days during our inspection. Actual staffing levels were as planned. We also saw that staff sickness had been recorded on the rota for a session in October and cover provided by another member of staff.
- Staff did not raise any concerns about access to time for rest and meal breaks. We saw crews taking their breaks.

Anticipated resource and capacity risks

- The service worked with the ambulance contract provider to ensure planned changes to staffing, affecting the number of vehicles that the service could operate, were communicated to them in good time. The service had reduced the number of vehicles from five to four during December, due to staff completing vehicle training. It was not possible with the current number of staff for the training to be completed and all shifts covered.
- Business continuity plans were in place for event first aid and contract work, to enable the service to plan for, manage and operate in the event of significant disruption to services. The current plans were out of date. However, senior staff told us they had been involved in updating the current versions, and the new versions were in a draft format.

Response to major incidents

- A member of staff told us and we saw on the rota, that staff had completed recent road traffic collision training with the fire service as part of the major incident training for staff.
- Ambulance crews were not routinely sent to major incidents as this was outside their scope of practice. However, there were occasions when crews would be dispatched to ensure enough resources were available for patients or they were the closest initial ambulance to the location of the incident.
- We were told that vehicles did not contain a triage pack, for the assessment and labelling of patients according to need, in the event of a major incident, due to the infrequency that they attended these events.
- Through the work with the local ambulance trust, the service was part of the local resilience forum, which provided a co-ordinated response in an emergency. A member of staff told us how the service had been involved in transporting patients during flooding in Oxford.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Summary

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Staff provided care to patients in line with national guidance. The service had procedures for staff to get additional clinical advice, if needed.

Emergency and urgent care services

Staff completed relevant training for their role, however, staff did not demonstrate a clear understanding of the Mental Capacity Act (2005) or Mental Health Act (1983). Staff knew the limitations of their knowledge and asked others for advice if needed.

The majority of staff had an appraisal in the last year. Ambulance staff raised concerns that the restrictions of the contract, limited their scope of practice and did not use all their clinical skills. Staff worried they could loose these skills. Time was allocated for staff training.

Staff assessed and provided pain relief for patients as needed. The contract restricted which pain relieving medications they could give to patients. Staff did not feel they could always manage patients' pain effectively due to these restrictions.

We saw good multidisciplinary team working between ambulance crews and other emergency teams. Information shared during patient handover was relevant and enabled continuing care of the patient.

Staff asked patients for consent before starting treatment or observations.

Evidence-based care and treatment

- Staff based care and treatment on national guidance from the British Red Cross. This guidance was included as part of the training programme for all staff, both paid and volunteer. A pocket reference guide was available for staff to use to ensure they provided patients with the most appropriate care. The national guidance was based on guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- The national clinical advisory group undertook reviews of current clinical guidance, including from JRCALC, to ensure staff provided evidence-based care that was current.
- Staff followed guidance and protocols of the ambulance provider, if patients were detained by the police under section 136 of the Mental Health Act and they needed to transport the patient to hospital.

Assessment and planning of care

- Staff adhered to relevant national and local guidance for their role, when assessing and planning care for patients.
- If staff needed clinical advice, they contacted the clinical support desk, based in the emergency operations centre for the ambulance provider. Staff told us the advice provided enabled them to support the patient further.
- Ambulance crews took patients to the nearest appropriate hospital for their treatment, as advised by the health care professional who had requested the hospital admission or transfer. For event first aid, the patient was taken to the nearest accident and emergency department, the agreement included conveying a patient, should it not be possible to care for them at the event.
- For event first aid crews there was no guidance or protocol to follow to identify which patients must be advised to attend hospital and those who did not need to attend, for example, after a patient had sustained a minor head injury. Patients were potentially at risk due to lack of a standardised operating procedure for staff to follow.
- All ambulance crews we spoke with had a limited understanding of the Mental Health Act and the associated code of practice. We were not assured that patient with a mental health problem would be identified correctly and supported appropriately.

Response times and patient outcomes

- The ambulance provider monitored response times for work undertaken as part of the contract and reported these to the service at monthly meetings.
- Data was recorded and compared to the provider for initial response time, on scene time and turnaround time once at the hospital. The provider acknowledged differences in the calls attended by the service, affected some of these results. In addition, turnaround times could not always be captured as patients were taken to departments, which did not have a handover screen. This meant the arrival time at the hospital could not be recorded.
- Ambulance crews again raised concerns around the scope of practice they worked to and the impact of this on response times and possible patient outcome. Staff gave an example where they had responded to a cardiac arrest patient under normal road speed. Staff had not been able to respond or convey patients under blue lights, due to the provider requesting a specific level of

driver training. Staff logged as an incident all calls they responded to where they unable to drive under emergency conditions due to the restrictions of the contract.

- The service had worked with the provider to address this and 45% of staff had now received the required driver training. Further training sessions were to be offered later this year. The system used by the provider enabled them to see which drivers had the relevant driving standard and allocate suitable calls to crews.
- The service did not routinely collect or monitor information on patient outcomes, such as the number of patients seen by the event first aid team, who were treated at the scene versus admitted to hospital.
- Patients seen as part of the contracted service were generally planned admissions to hospital, the collection of outcome data was therefore limited. There were also difficulties around access to data as the contract provider held this.
- Data was collected on the incidence of cardiac arrest as part of the audit requirements of the Sudden death and cardiac arrest in event first aid policy. The data for 2014 identified that for nine out of 26 patients, who suffered a cardiac arrest, there was a return to spontaneous circulation (patient had a pulse) before the patient left the care of the service.
- Staff did not raise any concerns about the relationship between the service and the different departments they took patients to.

Pain relief

- Staff were observed asking patient's about their level of pain. This was scored and recorded on the patient report form. Emergency care assistants (ECA's) managed the patient's pain within their scope of practice, defined by the framework in which they worked. . Staff told us they found this situation frustrating, as they could not fully manage the patient's needs.

Training with the British Red Cross covered a wider range of medicines, to give a greater range to help control pain. When undertaking emergency work staff requested back up from other emergency staff who could issue more effective pain relief or supported the patient the best they could, until they got the patient to hospital. This situation did not affect event first aid staff, who could work to their full scope of practice.

Competent staff

- There was a comprehensive induction process in place for all staff, employed and volunteers. This included modules on first aid and providing an emergency response to patients. A matrix system indicated which modules staff needed to complete depending on their role. Training programmes developed nationally were delivered locally for both staff and volunteers.
- New ambulance crew staff undertook a four-week induction programme. There was a competence based written and practical assessment. During this time, they worked with an experienced crewmember. Staff were issued with a preceptorship log, which had to be completed and signed by an experienced colleague, to demonstrate competencies such as infection control practices and clinical skills. We saw the completed preceptorship log for one member of staff.
- All staff were required to update some modules on an annual basis, such as basic life support, to demonstrate they were still competent to safely care and treat patients. Ambulance crew volunteers, were required to attend a minimum of 20 hours continuation training each year, this was included in their job description. Some elements had been to be renewed on a three yearly rolling basis.
- Discussions were taking place with an external training provider to offer a new nationally recognised technician training course. It was hoped this programme would be recognised by the local ambulance trust and enable staff to care and treat more complex patients.
- Staff had an annual appraisal. As of September 2015, three staff groups had achieved 100% completion. For ambulance crew staff 77% had received an appraisal and for ambulance technicians 50% had completed an appraisal.
- A team leader told us that it was difficult to complete six month reviews or hold regular three monthly reviews with staff because of the current staffing pressures. However, if there were areas of poor performance, these would be addressed through this process and a written log kept, we saw an example supporting this. Standards of driving were also monitored. This data was captured through the vehicle tracking system and could be accessed by senior staff. Staff were offered additional training were necessary. Team leaders and the service manager undertook clinical shifts, which enabled routine supervision of staff to take place.

- Ambulance staff told us that they completed some continuing professional development in their own time, due to current staffing pressures. However, the service did provider quarterly update training days, which we saw allocated to staff on the rota.
- There were no staff trained to paramedics level employed at this location, however event staff volunteers may be paramedics. These volunteers had to have been qualified for a year and hold a current registration with no restriction. They had to be insured and registered with British Red Cross to work with the events team. There was a yearly due diligence process to ensure they maintained their registration.

Coordination with other providers

- Ambulance staff worked to agreed care pathways under the agreement with the local ambulance trust, to ensure standardisation of care for patients across both services.
- Patients were taken to the most appropriate hospital department for continuation of their care. This had been determined by the health care professional requesting the ambulance. We observed that patients were not always taken to A&E, if another department was more suitable, such as the children's' ward.
- The service had agreed processes in place for working with the police. This included the transportation of a deceased patient and patients detained under the mental health act.
- Through the work with the contract provider the service was part of the local resilience forum, which provided a co-ordinated response in an emergency.

Multidisciplinary working

- We observed good multi-disciplinary team working between ambulance crews and other emergency staff when responding jointly to a call. The teams worked well together to coordinate the care for the patient and agree onward transfer arrangements to hospital.
- We also observed three handovers between ambulance crew and hospital staff, for patients who were transferred to another hospital for continuing care. Appropriate information was shared to ensure safe care of the patient during the journey. Staff once at the receiving hospital gave handover information clearly and brought any urgent concerns to the attention of staff, such as a patient needing a meal, due to a delay in their transfer.

Access to information

- Staff told us and we observed that if multiple services were involved in the care of a patient, one set of paperwork was completed and this stayed with the patient, to ensure safe care and treatment at all stages of their care. Forms were carbonated so individual services could keep a copy for their own records and audit purposes.
- Staff did not have access to 'special notes' about a patient such as pre-existing conditions, safety risks or advanced care decisions, unless the patient told them or the information was provided by the emergency operations centre who dispatched the crew to the call. Staff told us they would check for a care plan in a patients' home or if they collected a patient from a nursing home. For inter-hospital transfers this information was provided by staff during the handover.
- Staff did not raise any concerns around access to information on patient location and the reason for the calls they responded to

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff, in non-emergency situations, explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was recorded in the patients' records. For children, consent was sought from the parent or guardian.
- Staff we spoke with had a limited understanding of the Mental Capacity Act (MCA) (2005) particularly around the assessment of capacity and completing a best interest assessment. There was a Service users' informed consent to support, care and treatment procedure (2015) available for all staff via the intranet.
- Staff told us they had received little training on the MCA or the Mental Health Act (MHA) Code of Practice (1983). This was covered as part of the initial basic training and at continuing professional development sessions. No figures were available on the completion of this training. Staff told us that they did not use the learning from the training they had received that often, to feel confident with supporting these groups of patients.
- Ambulance staff did not currently restrain patients as part of their legal powers under the MCA or MHA. No

training had been provided on restraint, although this was under review, with a view to a change of policy on restraint. Police support was requested when a patient needed to be restrained.

Are emergency and urgent care services caring?

Summary

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We observed staff providing compassionate care to patients and their families. Staff anticipated and responded to patients' needs. Staff maintained patients' privacy and dignity at all times. Staff were kind and showed empathy to patients' they were caring for, particularly when upset or in pain

Nationally feedback from the Friends and Family test was positive, with most patients extremely likely or likely to recommend the service.

Staff explained the care and treatment they needed to provide appropriately for each patient so they understood. They encouraged patients to be partners in their care and always asked for consent before they gave care.

Staff completed training on supporting patients who were distressed, anxious or who had mental health condition, but they did not often care for these groups of patients, so lacked confidence.

Compassionate care

- Staff were respectful, friendly, kind and compassionate when providing treatment or care to patients. They spoke with patients in a gentle manner and offered reassurance, particularly if the patient was distressed or in pain.
- Staff were professional in their approach and spoke politely to patients and carers travelling with the patient. They were responsive to patients' needs, such as opening the window on the ambulance , to help keep a patient cool.
- Staff maintained patients' privacy and dignity. An emergency care assistant offered support to a nursing colleague, when a patient needed support to get changed and the other member of nursing staff was of the opposite gender.
- Emergency care assistants raised concerns around maintaining patients' privacy and dignity when transferring a patient from a wheelchair to a stretcher. The layout and space within the ambulances meant this sometimes had to be performed outside, in the hospital or care home. Staff did ensure that the patient was covered by use of a blanket or sheet.
- Friends and Family test data for event first aid and ambulance services was reported at national level. Response rates were acknowledged as being low, with a target response rate of 10% for each month. Date for September 2015 showed, that for both services, the majority of patients were either extremely likely or likely to recommend the service they were treated by. The response rate for event first aid was 6% and ambulance services 1%.

Understanding and involvement of patients and those close to them

- Staff gave clear explanations to patients about the care and treatment they could provide. Most patients transported by the ambulance service had been referred to hospital by another health care professional. The reason to admit to hospital had already been discussed with the patient or carer.
- All information provided to patients was verbal. There was no written information to support discussions, which had taken place. An emergency care assistant (ECA), was observed talking to a child. The ECA ensured they were at the child's level when talking to them, so the child felt involved and not intimidated. They explained things in a way that the child understood.
- Another patient was encouraged to walk to the ambulance. This was their preferred choice and it was safe for them to walk. Using a wheelchair, could have drawn attention to the patient and possibly increased the patient's anxiety.
- Crews asked permission to enter the patients' home, when they collected a patient from their home to take them to hospital.

Emotional support

Emergency and urgent care services

- We observed staff showing empathy to patients and to their carers. Discussions took place in a timely manner and at an appropriate stage during the journey to hospital.
- All staff were required to complete the British Red Cross psychosocial training programme, as part of their induction training, which enabled them to offer emotional support to grieving families or patients who were distressed anxious or confused.
- Staff were aware of the need to support patients experiencing a mental health crisis, but did not have regular experience of supporting this group of patients.
- The service did not normally transport deceased patients. Staff received training on looking after the deceased with care and dignity should they transport a deceased patient. Staff we spoke with were aware of the limitations of their experience and knew how to seek advice and support.
- Staff who encountered difficult or upsetting situations at work could speak confidentially with a member of staff from the psychosocial team.

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

Summary

By responsive, we mean that services are organised so that they meet people's needs.

The service worked effectively with the contract ambulance provider and commissioners for event first aid work to ensure they planned services to meet the needs of local people. The contract provider monitored response times for ambulance crews and discussed performance at monthly meetings with the service.

The location of the Reading office, on a busy road, sometimes made it difficult for ambulances to exit safely from the site and provide a prompt response in an emergency.

Services were accessible to all and staff had training to support patients in vulnerable circumstances. However, language and communications guides were not found on all vehicles, to support patients who had additional communication needs.

Managers investigated complaints and provided a written response to the complainant. Learning from complaints was considered by managers, but it was not evident that this learning was shared with all staff, to improve services.

Service planning and delivery to meet the needs of local people

- The service worked with the local ambulance trust, as part of the contract, to support them to meet patient demand for their service across the area they covered. British Red Cross Abingdon provided five ambulances across three different areas, from their bases in Abingdon and Reading. Some of these shifts were in areas were the contract provider found it difficult to recruit staff to, due to the high cost of living.
- There was fluctuation in demand from the provider, which made service planning difficult. This instability was identified as a risk on the local risk register, with monthly meetings taking place with the provider to establish current demand. Staff did not know what cover they would be expected to provide after the end of the year, which was causing concern and anxiety.
- The service had a number of contracts to provide event first aid, for local and national events within the area. Senior staff told us a post event briefing was held with the organisers to review the service provision at these events. This included whether people's needs were met and areas for improvement at future events, such as the number of staff needed to ensure a safe service.
- The Reading office was located on a residential street. There was no ambulance station, ambulances were parked in the car park, limiting parking space, and creating a possible security risk as the vehicles could be seen from the main road. To mitigate the risk, at night, the gates to the car park were closed, once the last vehicle had returned. All outside storage areas were locked to prevent unauthorised access to equipment and medical gases.
- The location also made exiting the car park difficult in an emergency. Cars were parked close to the entrance and on both sides of the road. Staff told us and we saw on the incident log, that parked cars had been damaged due to these difficulties. In addition, exit could be delayed due to having to wait for cars to pass, due to traffic going in one direction only due to the parked cars.
- We were told that the local council were considering how the situation could be improved, including markings on the road to limit car parking by the exit.

Staff told us that due to the instability of the work from the ambulance provider it was not considered viable at present to provide a more suitable building and location for the ambulances.

Meeting people's individual needs

- A phrase book of common questions and answers in a number of alternative languages had been developed, to aid communication with non-English speaking patients. A communications book was also in use. This contained pictures for common words and medical problems, such as level of pain, high temperature and part of the body affected, to support patients with language difficulties, complex needs, or those unable to communicate due to their medical condition.
- The service told us that these books should be on all vehicles. None of the three vehicles we checked had the language guide and only one had the communications book. A pile of the books was seen in the crew room at Reading.
- Complaints/comment cards could be provided in 11 different languages and large print, to ensure views could be captured from all service users.
- Contract work undertaken for the ambulance provider limited the range of calls that crews responded to and their involvement with people in vulnerable circumstances. All staff received training on supporting people experiencing a mental health crisis or responding to challenging situations. Where patients were detained by the police under section 136 of the Mental Health Act, staff would follow the guidance and procedures of the ambulance contract provider.

Access and flow

- Ambulance crews had travelling time built into their shift, if they were due to start their shift some distance from their base location. This ensured an efficient response could be provided to patients, when a call was received from the emergency operations centre.
- Response, on scene and turnaround times were all monitored by the contract provider. These figures were reported on at the monthly meeting between the service and the provider. Comparison was made to the contract ambulance provider response times and targets. However, direct comparison was difficult due to the difference in the number of calls responded to and the type of calls which the service were sent to by the provider. There was no assurance that similar data was being compared for both services.

Learning from complaints and concerns

- Patients, carers and members of the public could provide feedback via the British Red Cross website, by email, letter or telephone. The website provided information on the complaints process and the expected response times to acknowledge a complaint and provide a written response. These timeframes matched with information contained within the service's Complaints, compliments and comments policy and procedure, both of which were in date.
- A complaints/ comments card had been introduced and was to be available on all ambulances. We did not see these cards on the five ambulances we checked.
- Staff knew were to access the complaint policies and procedures on the intranet site. The information was also provided as 'quick guides' so less senior staff could access the part which was relevant to their role.
- A manager was nominated to oversee the investigation of each complaint, with a formal written response provided to the complainant, identifying the outcome and any actions taken.
- Senior staff told us that learning from complaints was shared at both a local and national level. Staff we spoke with could not provide examples of learning, which had taken place as a result of a complaint.
- At a national level, as a result of feedback from patients, a review was to take place on the use of opaque glass in ambulances. Patients found the restricted view difficult during the journey to hospital. Alternative forms of glass were to be considered, which still maintained privacy and dignity.
- During the last two years there had been 25 comments received, across all services in the Thames Valley area. Fourteen were compliments, one comment and 10 complaints.
- If a complaint was made to the ambulance provider, whom the contract was with, they would lead the investigation and reporting of the complaint.

Emergency and urgent care services

Are emergency and urgent care services well-led?

Summary

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high- quality person-centred care, supports learning and innovation and promotes an open and fair culture.

There was a local vision for the service, which reflected the national values of the organisation. The service had identified ways to develop and sustain its services. Staff understood the key concerns for the service locally, but did not know about the vision.

Governance arrangements were being developed nationally and locally, with greater attention given to monitoring and reviewing the quality of the service, against a number of key outcomes.

Staff told us leaders were competent, approachable and visible. Staff felt well supported by their immediate manager. Staff told us British Red Cross Abingdon was a friendly and caring place to work.

The service encouraged feedback from patients through satisfaction surveys and from volunteers and staff, through surveys and debriefing sessions.

Staff raised concerns around their personal safety and welfare, due to there being no panic alarm on ambulances.

Vision and strategy for this service

- The service had developed its vision and strategy around the national strapline for the British Red Cross, 'Refusing to ignore people in crisis' and identified how the service could be developed in line with the key points from the corporate strategy. Key priorities had been developed for both aspects of work, contract and event first aid. These included focusing resources where they were needed the most and recruitment and retention of staff.
- Senior staff were keen to ensure they focused resources towards the most needy and ensure services were developed with patients' needs at the centre. They realised the importance of recruiting and keeping the right staff, to enable them to develop their services and deliver against the key priorities.
- Staff were aware of the key values for the organisation, but not the specific vision for this service. However, staff did understand the instability of the work through the contract with the local ambulance trust and the desire of the service to work with the provider to develop a more long-term plan.

Governance, risk management and quality measurement

- The corporate strategy for the organisation had identified the need to improve how data was collected and used, to monitor the quality of its services. At a local level, quality audits had been introduced across a range of areas, including premises, equipment and medicines management. Action plans were developed, however these did not all contain completion dates or a review date. There was no assurance that senior staff were monitoring outstanding actions and escalating if not completed.
- There was no quality dashboard or scorecard, to provide easy access to key performance information on quality, including feedback from patients, number of complaints and incidents. It was not possible to see the performance of the service on a monthly basis or over the last year.
- There was no national audit schedule in place, although this was to be discussed at the next national quality workshop. Local managers were encouraged to monitor their service and complete audits, as they felt necessary to ensure the monitoring of the quality of the service .
- All polices we reviewed were dated and had a review date. However, some did not have a version number, to ensure an audit trail was available for any updates and so staff could ensure they were looking at the most up-to-date document and follow best practice.
- At a national level governance arrangements for providing paramedics at event first aid work were being developed. This would enable expansion of this service at a local level, once the appropriate policies and procedures were in place.

- There was a local risk register, with controls in place to reduce each risk. Service risks were monitored at both regional and national level. The risk register included concerns raised by staff relating to the restriction imposed on their role.
- Monthly meetings were held with the local ambulance trust to discuss service performance and areas for improvement as part of the contract.
- The duty folder for event first aid contained a number of risk assessments, these were out of date (November 2014), but were still appropriate as a reference guide for staff.

Leadership of service

- All staff spoke positively about the leadership of the service. They told us that leaders, at all levels, were visible and approachable. They felt leaders had the appropriate skills and knowledge for their role and managed their aspect of the service well.
- None of the staff we spoke with raised concerns about not being able to access or speak with their immediate line manager. Staff felt confident to raise concerns to a more senior manager when appropriate.
- Senior managers had monthly area manager meetings and a weekly teleconference, for support and sharing of good practice ideas.
- Team leaders and some senior managers, completed clinical shifts each month, to enable them to see and understand the challenges raised by staff.
- Leaders were aware of issues, which may affect the quality of the service and took appropriate steps to address these. For example, a team leader managed a number of issues raised during the inspection, discussing these with the relevant member of staff or escalating when the concern was more serious.

Culture within the service

- Staff told us and we observed a positive culture within the service. Staff commented there was a family atmosphere due to the small team size. Staff clearly cared for and supported each other.
- Staff told us and we saw there was good team working between different departments and services, based at the main offices in Reading and Abingdon.
- Team leaders and senior staff were competent to manage staff performance. Action was taken if staff did not perform or conduct themselves to the expected standard.
- All ambulance crews raised concerns about the lack of radios on ambulances, which meant they could not quickly raise concerns about their personal safety and welfare. They had to use their own phone or the one in the vehicle.
- Senior staff told us they discussed with staff, were possible, proposed changes to services. For the contract work, this was not possible as discussions had to take place and be agreed with the provider first.

Public and staff engagement

- The service gathered the views and experiences of patients through the Friends and Family test, introduced nationally in April. Response rates were very low locally and nationally, around 2.5% of all patient contacts. Services were considering how to improve response rates. Patients could also provide feedback via the compliments, comments and complaints process.
- Volunteer staff provided feedback via the regional volunteer council. Their work was acknowledged through the annual area forum for volunteers, where local awards were presented.
- Debriefs were held after events so volunteers could provide feedback and suggest changes for future events. Senior staff told us, online surveys were also being used to capture feedback after events.
- Feedback was also gathered from commissioners of event services, through a feedback form, which was sent with every invoice. These responses were collated nationally. No local feedback was available for us to review.
- Volunteers and staff were invited to complete the annual 'People survey', which asked their views on a number of key topics. We saw the 2013 survey results, but no action plan was provided so it was not possible to see the changes the organisation had made, in response to the survey.
- A local staff survey, for employed ambulance staff, completed February 2015, asked for their views on four areas, including support from their manager. The majority of staff felt their manager was approachable and would act on concerns they raised, however, staff did not agree that they were given feedback on their performance. This supported what staff verbally told us.

Innovation, improvement and sustainability

- The service had identified some areas for service improvement and sustainability. These included

stopping a community transport service, as this was offered by other providers. The service felt its resources could be used to support patients in more immediate need. There was a national review of the event first aid service, to enable provision at a wider range of events, to increase income at both a national and local level.

- The work for the local ambulance trust remained a financial risk for the service as work was only confirmed a few months in advance. Senior staff were in regular contact with the provider to discuss this.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure all patient records are stored securely at all times.
- Taken steps to ensure that staff are aware of and complying with the duty of candour statutory responsibility.
- Review the effectiveness of the safeguarding adults and children at risk training so that staff are clear about what constitutes abuse and when to report a concern.
- Review the current communication channels and process for requesting support in an emergency, for example if staff are attacked.
- Provide all staff with training on the mental capacity act and mental health act and ensure staff understand how to use the codes of these acts appropriately when caring for patients.
- Ensure all vehicles contain the language and communication guides, to support patients with language difficulties and ensure safe care and treatment.
- Consider providing complaints information on all vehicles.
- Review the provision of equipment for the safe transportation of children.