St John Ambulance South East Region

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St John Ambulance South East is operated by St John Ambulance. St John Ambulance South East region provides emergency and urgent care services and a patient transport service. The South East region is part of the London and South region within St John Ambulance which covers 9 counties. This inspection and report covered the South East region only.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 10 to 11 December 2019.

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.

The main service provided was emergency and urgent services. Where our findings on emergency and urgent services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the emergency and urgent services core service.

We rated it as **Good** overall.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key emergency services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not monitor the temperature storage of medicines which would not assure them of the efficacy of the medicines.
- The service did not provide training for all staff on the use of child restraints.

Summary of findings

- Not all policies had been recently reviewed and therefore the provider could not be assured staff were using up to date policies.
- Not all ambulances contained information for patients on how to make a complaint or compliment.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson
Deputy Chief inspector of Hospitals (London and South East) on behalf of the Chief Inspector of Hospitals.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Good 	The management strategy and leadership model of the service is the same for both the emergency and urgent care service and the patient transport service. Some staff deliver both the emergency and urgent care service and the patient transport service. The service managed 200 vehicles from the Guildford base; 95 of these were operational ambulance vehicles meaning they could be used for urgent and emergency or patient transport services. Where our findings on emergency and urgent care service, for example, management arrangements, also apply to the patient transport service we have not repeated the information but cross-referred to the emergency and urgent care service. We rated this service as good overall because it was safe, effective, caring, responsive and well-led.
Patient transport services	Good 	Patient transport services were a small proportion of activity. The main service was emergency and urgent services. Where arrangements were the same, we have reported findings in the emergency and urgent services section. Some patient transport was purchased privately however, when we inspected, the service had recently (December 2019) been assisting NHS Trusts with the high level of discharges due to the time of year. At the time of the inspection there had been 17 contracted journeys completed and from January 2019 to the date of the inspection there had been 261 journeys.

Summary of findings

Contents

Good

St John Ambulance South East

Services we looked at
Emergency and urgent care and Patient transport services.

Summary of this inspection

Background to St John Ambulance South East Region

St John Ambulance South East is operated by St John Ambulance. The service was first registered in 2012. It is an independent ambulance service and covers the South East of England. St John Ambulance South East region is part of St John Ambulance, which is a national charity providing first aid and other ambulance services. St John Ambulance became a separate legal entity and subsidiary of The Priory of England and the Islands of the Order of St John in 1999.

St John Ambulance primarily provides first aid across the country and services include emergency and urgent care, non-emergency patient transport, and first aid and ambulance provision for events.

St John Ambulance South East region provides first aid cover for events and patient transport services to take patients to and from hospital on behalf of a local NHS ambulance trust. The provision of first aid at events is not in the Care Quality Commissions (CQC) scope of regulation. However, if a patient needs to be transferred to another provider from an event for continuing care needs then the treatment and care given to the patient during transport is subject to CQC regulation. The CQC also has responsibility to regulate patient transport services.

The provider is contracted to an NHS trust to provide blue light transfer of neonatal intensive care and paediatric intensive care transfers, and maternity transfers from a midwifery led unit to an NHS hospital.

The service is staffed by trained paramedics, ambulance technicians and ambulance care assistants.

St John Ambulance South East is registered to provide the following regulated activities:

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

The service has had a registered manager for both regulated activities in post since March 2012 with the current registered manager being in post from November 2016.

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

We inspected this service in 2016 but at that time did not have the power to rate the service provided.

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

We told the provider it must:

- Review the safeguarding training programme to ensure it meets all national recommendations and staff have completed the correct level of safeguarding children training for their role.
- Ensure policy and procedures are followed when vehicle defects are reported, to keep patients and staff safe.

And the provider should:

- Provide a target compliance rate for mandatory training and appraisals and monitor compliance against this target.
- Ensure all volunteers have completed their mandatory training and received an appraisal.
- Provide a review process for staff working for the service on a casual basis.
- Review the provision of equipment for the safe transportation and care of children.
- Ensure all medicines are stored in accordance with regional policies and procedures.
- Ensure the multi-lingual phrase book is stored on all vehicles at all times to support patients to receive safe care and treatment.

Summary of this inspection

- Consider providing a communication aid to support patients who are unable to communicate verbally

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and three specialist advisors with expertise in emergency and urgent services and patient transport services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about St John Ambulance South East Region

During the inspection, we visited the Bicester and Guildford stations. We spoke with 22 staff including; ambulance care assistants, ambulance technicians, co-ordinators and managers. We spoke with six patients and relatives. During our inspection, we reviewed eight sets of patient records. We also reviewed three compliments and two complaints and their responses and human resource recruitment 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. The service has been inspected once, and the most recent inspection took place in October 2016.

Activity (July 2018 to August 2019):

- In the reporting period January 2019 to August 2019 there were 7085 emergency and urgent care and patient transport journeys undertaken. Of these 147 were from events to other care providers. Two hundred and sixty one of the 7085 journeys were patient transport services.

Track record on safety:

- No Clinical incidents resulting in harm, low harm, moderate harm, severe harm, or death.
- No serious injuries
- Eight complaints

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	Good	Good	Good	Good
Patient transport services	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Emergency and urgent care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The service provided emergency and urgent care at events and held a contract with one NHS ambulance trust to assist with front line emergency response work by providing technician led crews. St John Ambulance South East held a contract with another NHS trust to provide neonatal and paediatric intensive care transfers.

During the period of July 2018 to August 2019 the service conveyed 6824 patients who required emergency and urgent care.

Both paid and volunteer staff worked for the service and all staff worked across both the emergency and urgent care service and the patient transport service.

The main service provided by this ambulance service was emergency and urgent care. Where our findings on emergency and urgent care – for example, management arrangements – also apply to patient transport services, we do not repeat the information but cross-refer to the emergency and urgent care section.

Summary of findings

We found the following areas of good practice:

- The service provided mandatory training in key skills including the appropriate level of life support training to all staff and made sure everyone completed it.
- 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.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff managed clinical waste well.
- Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Good

Emergency and urgent care

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer and record medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.
- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. The service mostly made reasonable adjustments to help patients access services.
- People could access the service when they needed it, in line with national standards, and received the right care in a timely way.
- People were able to give feedback and raise concerns about care received and the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and

strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Although information systems were not integrated they were secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

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

- The service had not trained all staff to use some equipment for example the five-point child restraint harnesses.
- The provider did not monitor the temperature of the storage spaces for medicines.
- We found some policies which required updating which did not assure us the policy monitoring system was effective.
- Not all ambulances displayed how to complain posters, therefore there was no information available in the ambulances to instruct patients how to complain.

Good

Emergency and urgent care

Are emergency and urgent care services safe?

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good**.

Mandatory training

The service provided mandatory training in key skills including the appropriate level of life support training to all staff and made sure everyone completed it.

Both voluntary and employed staff received mandatory training when they first started with the provider which included safeguarding, conflict resolution, general data protection requirements, materials management, equality inclusion and diversity, infection prevention and control, basic life support and driver training.

The overall compliance rate for mandatory training for the South East region ranged from 80.2% (for medicines management) up to 98.8% (for Safeguarding level 2 training). We were told the lower compliance rate was due to casual and non-operational staff being included in the numbers.

Sepsis recognition and management was part of mandatory training for all staff, including bank and volunteers as part of their compulsory personal development (CPD). The service's 'Take 5' campaign also featured sepsis. The 'Take 5' campaign encouraged staff to take five minutes whenever they could, to read a service update such as training required or safety alerts.

The electronic mandatory training recording system flagged to managers and staff when their mandatory training was due for renewal. This included notifications every month from four months.

If managers found staff had not completed their mandatory training, managers would mark their files as 'non-operational' on the electronic booking system and the system would not allow them to be booked for shifts or events. We saw evidence of staff marked non-operational and the system not allowing them to be booked.

Staff we spoke with reported the mandatory training was easy to access and accessed with a password protected link, so staff could complete it anywhere. Managers allowed staff two paid CPD days per year to complete mandatory training and staff could also ask managers for additional time if required.

Safeguarding

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

There were clear safeguarding processes and procedures for safeguarding adults and children. All policies were available and easily accessible electronically to staff.

Safeguarding adults and children training completions rates were 99.1% for both level 1 and 2. All staff had been trained to level 1 and 2 in children's safeguarding and members of the safeguarding team to level 4, which was in line with the intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (January 2019). The training included WRAP (preventing radicalisation training) and female genital mutilation information. This was an improvement from the inspection in 2016.

There was a safeguarding lead for the region who was supported by volunteers who had safeguarding experience for example doctors and nurses and all were trained to level 3 or above.

Staff were familiar with the St John Ambulance safeguarding policy and how to access it. They could tell us the procedure to follow if they had safeguarding concerns and could identify the safeguarding leads. Staff we spoke with showed a comprehensive understanding of safeguarding issues for example neglect.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a standardised cause for concerns form for safeguarding. All staff carried a comprehensive safeguarding pocket card with advice, guidance, telephone numbers, policy statements and a reporting concerns flowchart.

Good

Emergency and urgent care

From January 2019 to August 2019 St John Ambulance South East staff had made 22 safeguarding referrals. Evidence provided showed the type of abuse reported, if the case was open and if they had alerted the CQC and social services.

When staff were working with a contracted NHS trust they would complete safeguarding referrals for both St John and the NHS trust. This ensured St John were able to review the safeguarding referral for appropriateness and enabled St John to follow up any concerns.

Cleanliness, infection control and hygiene

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

There had been no incidences of healthcare acquired infections within the service in the last 12 months.

Infection prevention and control standard operating procedures and policies were current and accessible electronically for staff.

Infection control was included in the mandatory training e-learning package and all staff were expected to complete it.

We reviewed seven ambulances, and all were visibly clean and well maintained. These seven included the neonatal and paediatric intensive care transfer vehicles. Staff were responsible for cleaning the vehicles either at the end of start of their shifts. There was clear guidance for staff on what to clean and how to clean. We saw staff completed daily vehicle checklists which showed the vehicle was clean.

The service had a contract with an external provider who deep cleaned vehicles on a 12-week cycle. In addition, the external organisation provided an extra clean if a vehicle had become heavily contaminated.

The external provider carried out swabbing of the vehicles before and after cleaning to make sure the cleaning was satisfactory. We saw audits of the results of the swabs that indicated the cleaning was effective.

We observed all staff across the service adhered to infection control procedures such as being bare below the elbow, having long hair tied up and using the appropriate personal protective equipment which was available on all ambulances for example, gloves, aprons and eye shields.

On each ambulance we saw hand sanitiser gel was available and we observed staff use this effectively when providing patient care. We also observed staff washed their hands in accordance with the World Health Organisations five moments for hand hygiene technique both before and after patient care.

We observed Control of substances hazardous to health (COSHH) documentation was available for all staff to access, to ensure they minimised the risk of harm when working with certain chemicals and medical gases. Safety data sheets displayed on the walls of garages listed the cleaning products and the service used disposable mop heads to prevent the spread of infection.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. However not all staff were trained to use all equipment for example the five- point child restraint harnesses. Staff managed clinical waste well.

St John Ambulance South East had a fleet of 95 vehicles including ambulances. The service had a contract with an external provider which provided a system to monitor servicing and Ministry of Transport (MOT) testing of vehicles. The system sent alerts at 90 days, 14 days and seven days before a vehicle needed attention.

The service held all information regarding the provider's vehicles on a fleet management system which the regional fleet teams updated and monitored. External providers managed tyre replacement, breakdown and recovery and St John Ambulance had dedicated telephone lines to ensure a swift response.

The service was in the process of moving to an electronic system of reporting vehicle defects through a driver application on a mobile phone. This was being implemented in stages and was being supported with the paper process requiring staff to fill in a vehicle defects form. The vehicle defect forms were given to managers

for further action. Staff told us the service promptly attended to defects of vehicles and equipment and if required vehicles were immediately taken off road. This was an improvement from the 2016 inspection.

We found that the ambulance stations and all vehicles were visibly tidy and free from clutter.

Staff locked all ambulances when not in use and parked them in a garage and outside the bases in a carpark. All ambulance keys were stored inside the office in a locked key box. The offices had CCTV internally and staff accessed the offices using a key. This reduced the risk of unauthorised access to the ambulances and base.

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

The service had enough suitable equipment to help them to safely care for patients. Staff ensured all required equipment was on the vehicle by completing a daily check list and were given 30 minutes at the start of the shift to complete this. The checklist detailed all the equipment that should be on the vehicle and recorded that staff had checked the equipment was in working order. We saw some of the completed checklists and actions taken, for example when equipment was required and when faulty equipment needed to be replaced.

The regional fleet management team maintained an asset register for medical equipment. This included the item number, next service date and the frequency of service. We checked a random sample of items and saw evidence of a service date within the last year. The team leaders managed the logistics of arranging servicing of both equipment and vehicles and ensuring the service had enough vehicles to cover the booked activity.

We found appropriate storage for used sharps available on each ambulance and saw safe disposal procedures at each base visited.

All staff were responsible for maintaining stock on vehicles, either by restocking when back at base, or during a shift if needed. Team leaders told us, and we saw staff did a detailed stock check every month for each vehicle in addition to the daily checks.

Most of the consumables we reviewed were in date and appropriate for use however we found three items in a store cupboard that were two or three months out of date. We found equipment was suitable for both adults and children which was an improvement from the last inspection in 2016. Staff returned linen borrowed from NHS trusts at the next opportunity.

Staff disposed of clinical waste safely. Staff followed the organisational policy for the disposal of clinical waste and could describe the process of labelling the waste appropriately with event details and securing bags appropriately.

Ambulances were all equipped with tracking devices with a contract to ensure they were updated regularly so that all crews had access to up to date travel information.

We saw the station managers completed monthly building audits to identify any risks such as building security and hazards to staff. Identified risks were fed up to managers who then added them to the national risk register.

Two members of staff reported they had not received training on how to use child restraints for babies and would therefore ask parents who they had secured on the stretcher to hold babies. This did not assure us staff were using the most secure system to transport babies, although national guidance allows emergency services to transport babies and children on carers laps in the cases of emergencies.

However, after the inspection the provider provided us with staff training figures on the use of child restraint which showed that most staff had been provided with training on how to use the child restraints. They also reported that a new eLearning package had been developed and rolled out in response to our findings, and all volunteers and staff must complete this training to continue to crew vehicles. They also provided evidence of a 'Take 5' briefing sheet regarding the use of the harness.

Assessing and responding to patient risk

Good

Emergency and urgent care

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

Staff completed clinical observations on patients, as part of their care and treatment to assess for early signs of deterioration. If a patient did deteriorate, staff requested additional emergency clinical support from the commissioning NHS trust. Staff had access to suitable equipment on the ambulance to enable them to monitor and assess patients.

If the patient deteriorated during the journey staff would pre-alert the accepting accident and emergency department so hospital staff were aware before the patient arrived. Staff provided an example of when attending to a baby with a head injury they contacted the local NHS trust to discuss the most appropriate area to take the baby to.

To assist with the identification of a deteriorating patient staff used the National Early Warning Score (NEWS2) for adults and the Paediatric Early Warning Score (PEWS) for children.

We saw staff assessed patients against the commissioning NHS trust protocols and used the Joint Royal Colleges Ambulance Liaison Clinical Practice Guidelines (JRCALC). All ambulance operations staff had access to a current pocket guide of the JRCALC protocols and also had access to clinical procedures on the intranet. All staff we spoke with reported they would use these.

Staff completed risk assessments for each patient at the start of any care episode and updated them when necessary and used recognised tools. For example, the FAST test (the FAST test is used to identify a person having a stroke) and the AVPU scale (the AVPU scale is used to measure a person's level of consciousness) were part of the patient report form.

If crews required specialist advice on scene or during transit they were able to contact the commissioning trusts control centre or call 111 to speak with a GP. Staff reported both were responsive and answered their concerns in a timely manner. Technician led crews could only leave patients at home once they had followed set protocols, ensuring that appropriate onward care was planned and documented on the patient report form.

Events requiring ambulances agreed with the provider, if the ambulance needed to convey off site then the event organisers would need to pause the event due to a lack of ambulance cover. Some events requested two ambulances for this reason.

The South events team, which comprised of seven staff members completed event risk assessments. The event organiser completed an online form with details of the event for example the type of event, and number of people expected. The events team would complete a risk and resource assessment using the event operations manual, the organisers risk assessment, site plans and event management plans as a guidance to assess the likely risk impact against the activity required. The events team would then advise the organiser regarding the number of resources recommended.

Volunteer staff were issued with a log in to access the events system and could see on the electronic system the description of the event, the risk assessments and any additional information regarding the event including timings and the event pack (which was also issued on the day). Prior to the event the team leader scheduled a video call with the event team staff to discuss the finer details of the event.

The manager for the event would email the risk assessment so staff could read it prior to the event. They also held a briefing on the day of the event, to ensure all staff were clear about the risks and knew how risks would be managed.

The event pack contained safeguarding referral forms, near miss forms and guidance forms regarding actions to take at specific events.

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, whilst completing their frontline contracted work. Staff would only convey patients who police had detained under the Mental Health Act (1983) and who the police accompanied, as part of the agreement with the NHS ambulance commissioners.

The NHS ambulance commissioner had a flagging system for addresses for patients where there were known risks of violence and aggression towards ambulance staff. The commissioning NHS trusts control room passed on this information to St John ambulance crews.

Good

Emergency and urgent care

Staffing

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

Station managers and team leaders, regularly reviewed staffing levels and ensured there was an appropriate skill mix of staff to cover shifts through the contract with the local ambulance trust and planned event work.

At the time of inspection, the South East had 83 ambulance operations staff and 2342 volunteers – 287 of the 2342 were doctors, nurses, paramedics, technicians and St John ambulance crews.

The current vacancy rate across the South East was 10 vacancies. The provider was able to move the workforce around to support contracts and advised us they would be running a trainee course to build up staffing across the area, linked to their various contracts.

Most of the staff worked on four shifts on and four shifts off rota pattern and reported this worked well. They were able to request their shifts in advance and received their rota's two months in advance. If any changes were to be made to the rotas, staff had to seek their managers approval first. This ensured the managers had good oversight of the rota.

The service ran an on-call system where a member of the management team was always available on the telephone in case staff needed to contact them. Staff we spoke with were aware of how to contact them if needed.

We saw evidence all staff had valid enhanced Disclosure and Barring Service (DBS) checks during the recruitment process. This helped to protect patients from receiving care and treatment from unsuitable staff.

The service undertook pre-employment checks to ensure that staff unsuitable for the role were prevented from working with vulnerable groups, including children. In accordance with the Recruitment, Selection and Retention Policy, the service completed a Disclosure and Barring Service (DBS) check on all potential new recruits and repeated these checks every three years. The service maintained a spreadsheet to monitor compliance and this showed that all staff checks were up to date.

We reviewed six weeks of rotas across the South East and staffing levels were appropriate for the work requested. Staff rosters allowed staff to have adequate time off between shifts.

The South East region had two paramedics who were employed on a flexible job plan contract, which included working clinically at events/ambulance work and some of their time providing clinical supervision. Currently, due to demand, they were working on the operational side in technician roles whilst awaiting trainer training courses.

For contract work with the NHS trust the provider currently had an agreement to cover 22 technician led shifts a week. The control desk rostered all staff on an electronic rota which showed staff who were available to cover sickness or absence if required.

The South East rarely used agency staff to cover the service however the service reported agency staff had been used once since September 2019 for the neonatal/ paediatric transfer contract. Agency staff were given a full induction including an additional induction for the area they would be working in. The provider reported they only use staff from one agency and we saw evidence the provider had visited the agency to ensure the safe recruitment and training of the staff met St John Ambulance standards.

The reported sickness rate for the South East from August 2018 to September 2019 was 3.6% with a turnover of 80%. This high turnover rate was listed on the provider's risk register and was due in part to staff moving on to NHS trusts to complete onward development to paramedic status.

All staff we spoke with reported they were able to take their breaks. The NHS commissioning trust advised front line staff when to take their breaks which ensured staff took adequate breaks throughout their shifts.

Records

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

Staff completed patient report forms (PRFs), There were separate forms in use depending on whether staff were completing contract (they would use the commissioning trusts PRF) or event work.

We reviewed eight PRF's. The records were clear, up to date and complete.

Staff stored completed PRFs securely on vehicles in the cab area, which they kept locked when the vehicle was unattended, for both contract and event work. Secure records storage was available at each station for staff to leave records on completion of their shift.

Managers told us they carried out monthly PRF audits, usually 10 PRFs at a time. We reviewed four monthly PRF audits. Managers reported they addressed any concerns regarding the PRF's in monthly one to one meetings with the staff. The results and actions were published monthly in the national ambulance operations quality report. Actions included alerting staff that pain assessment and taking a set of second observations could be improved.

The service stored patient journey logs securely at the ambulance station. Staff posted all completed patient record forms into a secure box at the end of every shift. Staff who we spoke with understood their responsibilities to maintain patient confidentiality.

Staff were able to request a copy of any PRF's they had completed which had any patient identifiable data redacted. This contributed towards their continuing professional development whilst protecting the privacy of the patients involved.

Staff described if a patient had a 'do not attempt cardio pulmonary resuscitation' order they would review the paperwork was up to date before accepting the patient. This ensured adherence to local policy.

All computers and laptops on vehicles and at the station were password protected and observed to be locked when not in use. This ensured there was no unauthorised access to patient reports and staff details.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. While medicines were securely stored the provider did not monitor the temperature of the storage spaces to ensure they were kept at the correct temperature.

The provider had a version controlled up to date medicines management procedure for staff to follow for the order, receipt, storage, administration and disposal of medicines, including controlled drugs.

The organisation had a Home Office Controlled Drug License. A Home Office drug license was issued in accordance with the Misuse of Drugs Act 1971 and meant the service could hold stocks of certain medicines for use by paramedics, nurses and doctors working on behalf of the company.

The service did not use any patient group directives (PGD's) which enable some staff to administer certain additional medicines. The service advised they held tranexamic acid (a medicine that helps the blood to clot) in their paramedic bags for a small number of events, but it would be administered by a registered doctor and not the paramedic.

There were no employed paramedics in the South East that carried or required control drugs (CD). If paramedics required CD's for any event work, they would collect the medicines from approved locations which was where the service held the Home Office Controlled Drug licence. We did not review any CD medicines during this inspection.

Medicine bags were prepared for staff to use at a central point and sent down to the bases. We saw medicine bags with green tags which indicated they were ready for use stored on the appropriate shelf. However, in the Guildford base we saw a red tagged medicine bag (red tagged meant it required restocking) was also stored on the same shelf which posed a risk it may have been taken for use. We raised this issue and staff immediately removed the used bag.

We reviewed three bags containing medicine and all medicines were in date and the tally against the sheet contained within the bag was correct.

Staff knew which medicines they could administer dependent on their role and scope of practice. This was also outlined in the medicine's management procedure, which was up to date. Paramedics working in the event field had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance, which provided them with clear instructions about the administration of medicine.

The medicines management procedure detailed storage requirements and temperatures medicines should be stored at, however at both the Bicester and Guildford base we did not see any temperature monitoring of where the medicines were held. The same issues had been raised in the 2016 inspection. This could affect the effectiveness of the medicines.

Crews recorded any medicines they had issued and the patient report form (PRF) number so managers could monitor stock levels and the reason for issue be audited. We saw crews storing medicines securely on vehicles.

We saw the service stored medical gas cylinders safely and securely at each location, with hazard warning stickers used. However, in the Guildford base the separate cages where the gases were stored were not labelled empty and full. We raised this with staff at the time of inspection and labels were attached.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. All staff we spoke with told us they received information about updates and changes to medicines in monthly newsletters, emails and updates on the intranet.

The service completed a monthly medicine supply service meeting report. This detailed the outcome of the monthly audits of medicines that had been completed by the quality and assurance department.

Incidents

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

The South East region reported 59 incidents from January 2019 to August 2019. The service classed none of these as serious incidents and most were related to issues with vehicles and none were associated with patient harm.

The provider had an incident management framework and an incident reporting procedure which were both current and version controlled. They detailed how the organisation would learn from and act upon incident reports and improve the quality and safety of its service delivery. The policy set out the accountability, responsibility and reporting arrangements for all staff.

For any incidents that were reported whilst completing contract work with the local NHS trust, the provider would investigate the incident and liaise with the NHS trust to reach a conclusion.

Staff raised concerns and reported incidents and near misses in line with the St John Ambulance policy. Staff reported team leaders fed back learning from incidents that may have occurred locally or across the service during team meetings or if immediate action was required, by email.

Staff we spoke with knew how to report incidents and could give examples of when they would do this. For example, staff told us if they tripped and fell they would report this as an incident or if anything out of the normal happened with a patient. Staff reported incidents using an electronic reporting system.

Staff were able to report learning from incidents. For example, a staff member had not attended a shift for the paediatric intensive care transfer service which resulted in no cover. Although the service followed the business continuity plan, there was some miscommunication between another NHS ambulance provider, the contracting NHS hospital and St John ambulance resulting in the service not being covered. No harm was caused to patients, but the service reviewed and updated the business continuity plan and there were further communications with the NHS ambulance provider and the contracting NHS trust to ensure the same situation did not occur again.

Staff understood the duty of candour. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Duty of candour training was part of the staffs' mandatory training requirements.

Good

Emergency and urgent care

Are emergency and urgent care services effective?

(for example, treatment is effective)

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983. However, we found some policies which required updating.

Upon review of the clinical procedures manual we found it was not current. The infant resuscitation guidance advised 32 to two compressions, however current guidance recommends 15 to two compressions. There was no algorithm for the new born resuscitation guidelines. This meant staff may not be following up to date guidance regarding new born and infant resuscitation.

We raised this at inspection and were told the clinical team were currently updating the clinical procedures manual. However, training was based on both the clinical procedures manual and the first aid manual which did feature the correct resuscitation guidelines and all staff were up to date with their basic life support training.

Through conversations with staff we identified the provider did not have a policy or procedure detailing how to convey children. Immediately after the inspection the provider told us they were requesting the clinical team add this information to the clinical procedure's manual.

Policies detailed on the intranet were overdue their renewal date. Out of nine polices reviewed four were due for renewal with one dated (email policy) as 2013. This did not assure us staff had access to policies that were current and that the service regularly reviewed policies. However, the policies reviewed were in line with evidence-based practice and referenced up to date National Institute of Health and Care Excellence (NICE) and best practice guidance.

Policies were currently available on the provider's intranet which was available on mobile phones. However, if staff had any questions they were able to contact the on-call manager who would have access to the intranet.

Currently each individual area was responsible for ensuring the policies and procedures were up to date and followed national guidance. The provider had recently employed a lead for policy development who was due to start in January 2020 and they would have oversight of the policies moving forward, along with the organisation committing to a policy framework and policy information technology system.

We saw staff providing care and treatment to patients in line with the Joint Royal Colleges Ambulances Liaison committee (JRCALC) clinical practice guidelines. All ambulance operations staff had access to a current pocket guide of the JRCALC protocols and also had access to clinical procedures on the intranet. The provider was currently looking to introduce JRCALC plus which would also track compliance as all updates to guidelines would need to be acknowledged.

There was no evidence that all staff had read the policies which meant the service was not always able to assure itself that staff assessed patients' needs against policies to provide care and transport. We raised this issue in the 2016 inspection report.

However, managers placed a flag on the clinical staffing rota for any clinical updates which ensured staff were aware of updates each time they logged in to the rota and most staff we spoke with reported they were up to date with changes.

Staff had access to a sepsis screening tool to ensure they took prompt action for patients with possible signs of sepsis

Local commissioners contracted the service to provide a neonatal and paediatric intensive care transfer provision. In meeting the contract, the service followed National Institute for Health and Care Excellence (NICE) guidance Quality Statement four: Neonatal transfer services which considered the arrangements to ensure the service was run 24 hours, seven days a week.

The service had processes to protect the rights of people subject to the Mental Health Act 1983. Managers and mental health first aid champions had received mental health first aid training to support staff understanding of mental health concerns.

Pain relief

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

We observed staff asking patients about their level of pain using a scoring system. Zero for no pain up to 10 for the worst possible pain and recorded the pain score on the patient report form. We also observed staff encourage patients who were in their own home to self-administer their own pain relief when they had forgotten to take it prior to the crew arriving.

For patients who had difficulty with communicating staff told us they would use a visual aid with sad and smiley faces to help patients to communicate their level of pain.

We observed staff discuss the patient's pain and medication received when handing the patient over to staff in the emergency department.

Response times

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

Due to the small numbers of patient conveyed to acute hospitals the service did not participate in any national audits.

Response times were set by the commissioning NHS ambulance trust. We reviewed figures from July 2019 to Sept 2019 which showed slight undercompliance with the 30-minute mobilisation target (time for the ambulance to reach the scene).

The service was almost compliant with the see and treat one-hour target, completely compliant with the see, treat and convey 45 minutes target and almost compliance with the 15 minutes wrap up time (time for the crew to prepare and clear ready to respond to the next call).

Managers from St John ambulance discussed response times during monthly meetings with the NHS ambulance provider and informal discussions were held if non-compliance was identified.

Patient outcomes

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

We saw an audit of patient report forms (PRF) for quarter 2 for the whole organisation. Results were not broken down in to regional results. Managers reviewed PRF's for chest pain, head injuries and burns using specific questions. The audits showed areas of good practice including completion of all patient details and reviewed care given in each category. The audit's identified learning and actions required, and team leaders shared learning with staff through team meetings, emails and one to ones.

Learning from the above audit's included the recognition that crews administered aspirin only for acute chest pain patients (where remainder of PRF has suggested it was indicated) one out of three times.

Competent staff

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

The induction training lasted eight weeks; four weeks driver training (including emergency blue light training) and a four-week residential clinical course.

Staff confirmed they had completed an eight-week induction programme which included theoretical and practical learning, reviewing policies, shadowing members of staff and the allocation of a more experienced "buddy" to work with. All new starters received a welcome to St John document which included background about the service, its vison, values, strategy and expectations.

The training team ensured all volunteers and contracted staff were kept up to date with the skills required for their roles. For example, the induction programme was tailored specifically for each role with different elements for specific roles.

The training team was responsible for coordinating appropriate training for all volunteer and contracted staff. All staff we spoke with confirmed that training was appropriate and easily available on line from home and at the training centres.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff underwent a formal, documented clinical competence check every year. If extra training was identified at the competence check then the staff member would not be allowed to work clinically until training, education and re assessment had been undertaken to ensure competence.

Managers made sure staff received specialist training for their role this included emergency driver training, medical gas updates, conflict management training and major incident practical training.

For event work managers would periodically attend events to review the performance of the volunteers and met with them individually to ensure their practice was up to date. However, one volunteer we spoke with reported they had never had their performance reviewed during an event.

All volunteers working for the service must undertake at least 60 hours event cover per year and undertake the mandatory training updates yearly to remain able to volunteer. We saw evidence of staff who were non-operational on the electronic staffing system. This helped to ensure only volunteer staff with current skills and knowledge to practice safely were able to attend events.

An appraisal is an opportunity for staff to discuss areas of improvement and development within their role in a formal manner. All staff we spoke with had received a performance development review (PDR) within the last year and most had had their six-month interim PDR. Most staff reported the PDR was helpful in identifying future competencies and development opportunities.

The PDR completion rate at the time of inspection for contracted staff was 88% with the interim PDR completion rate of 89%. This showed that most staff had received an appraisal.

All staff we spoke with received informal monthly one to one's with their station manager or team leader. Performance concerns, learning from incidents and complaints, general wellbeing and updates to the service were discussed during these sessions. All discussions contributed to the PDR's and staff we spoke with valued this contact and support.

Volunteer staff received informal annual development reviews which covered any identified development needs, any support required or any training they would like to complete. This was an improvement from the inspection in 2016.

The provider expected volunteer ambulance staff to complete 150 hours of volunteer work to remain on the register of current volunteers. This assured the service the volunteers' skills were current and up to date.

Most team leaders were operational and would regularly work shifts. This gave them the opportunity to monitor and review their staff's performance and raise any concerns around the care that staff provided to patients.

Team leaders and station managers would complete monthly spot checks on their staff which included but was not limited to a uniform check, hand hygiene, a review of their driving permit and they were displaying their ID card correctly.

The provider allowed staff two continuing professional development (CPD) days a year to complete any CPD and complete their yearly e-learning mandatory training. Staff reported they were able to have the CPD days and found them useful to maintain their CPD portfolios.

The service conducted Driver and Vehicle Licensing Agency (DVLA) checks at the start of employment and reviewed every six months. All staff knew the need to notify the managers of any changes to their license in line with the driving standards policy.

The South East had a dedicated human resources department that would assist with any staff grievance or disciplinary matters.

Multidisciplinary working

Good

Emergency and urgent care

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

Ambulance staff told us that they had good working relationships with the other emergency services. This included the fire and rescue services, police and the local acute NHS hospitals.

Staff working with the neonatal and paediatric intensive care transfer and retrieval service, understood their role and what they were accountable for. They worked within agreed frameworks set by the commissioner for this service.

Staff worked to agreed care pathways with the NHS trust, to ensure standardisation of care for patients across services and the best outcome for the patients. They took patients to the most appropriate hospital department for continuation of their care. We observed they did not always take patients to the emergency department, if another department was more suitable, or it was more appropriate to leave the patient at home (after following the local NHS trusts guidelines).

We spoke with staff from the accepting emergency departments who reported good working relationships with the provider and staff. The emergency department staff reported "great crews who are always happy and helpful to their patients"

We observed an effective handover between staff and the accepting emergency department. It was comprehensive and covered all aspects of the care provided by the crew.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

All staff had received training on the Mental Capacity Act 2005 and Gillick competencies, when they started working for the service and received yearly updates. This was included within the safeguarding training with clear written guidance in the service's clinical legal handbook.

Staff we spoke with told us they clearly recorded if a patient had capacity and if consent was obtained on the PRF. We saw evidence of this on the PRF's we reviewed. We also saw evidence of station managers audit's which included whether the patient's consent had been gained.

During observations of care we observed staff ask consent from the patient before commencing any investigations for example blood pressures or blood sugar measurement. We observed staff record consent on the patient report form.

Staff did not currently restrain patients as part of their legal powers under the Mental Capacity Act 2005. There was no restraint equipment on vehicles and staff were not routinely sent to respond to this type of call. Staff requested police support if a patient needed to be restrained.

Are emergency and urgent care services caring?

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During the inspection, we observed staff treat patients with dignity and respect. We observed staff took time to interact with patients and those close to them, in a friendly way and with good humour. We saw staff treated patients in a considerate and respectful way.

Staff were supportive, sensitive and encouraging during their interactions with service users and their relatives. We observed staff responding in a timely and appropriate way when a patient was experiencing discomfort and emotional stress.

Staff introduced themselves and explained their role and went on to fully describe each step of care provided.

Good

Emergency and urgent care

Staff followed policy to keep patient care and treatment confidential. We noted handover of care in the hospital was done discreetly so as not to be overheard by other patients.

One patient reported "the crew worked well together, with good communication". The patient and their family felt that nothing could have been improved about their experience.

Another patient reported "I couldn't fault the service or treatment and I hope St John Ambulance come out to me if I require an ambulance in the future".

The South East region had received 32 compliments to date these included: "Many many thanks for all your help and hard work last week. A wonderful medical team which worked brilliantly together and made this year the easiest Blenheim so far" and "I suffered a very serious blood clot on my lung and collapsed at halftime - I have no recollection of this however I was told first-hand how incredible your first responders where - for this I will be truly thankful as it potentially has saved my life".

Emotional support

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

Staff sought to ensure patients were comfortable and settled at all stages of their transfer. We observed staff ensure the patient was warm and comfortable by adjusting the temperature in the vehicle and offering the patient a blanket. Staff frequently asked how the patient was feeling throughout the journey, and staff acted accordingly to support the patient's needs.

Staff supported the patients emotionally. We observed staff reassuring patients to reduce any fears they might have had, for example we observed staff chatting to a patient to relieve their anxiety about what might happen in hospital.

At each stage of the journey we observed staff explain to the patients what they were doing, and explanations were clear and in a way the patient could understand.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff talking with the patient throughout the journey's and asking questions regarding their current state of health and impact it may have on their wellbeing.

Understanding and involvement of patients and those close to them

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

We observed staff welcomed and encouraged relatives and carers to travel with the patient, where appropriate. Staff involved relatives and carers throughout the transfer.

Patients we spoke with told us they felt they were involved with decisions about their care and treatment and were aware of what the next steps were. For example, we saw staff discuss with a patient with regards to being taken to hospital or not. They involved the patient in the decision about their care from the first point of contact.

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

(for example, to feedback?)

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service had a contract with a local NHS ambulance trust to help them meet patient demand for their services.

Managers planned and organised services well to provide safe transport to hospital or other providers if needed at all events they covered. Staff confirmed that each event

was given a risk score using the electronic planning system, this meant that staffing numbers and skills required were consistently measured and used in planning the service.

The service only accepted event work where there was potential for transport off site, an ambulance was contracted, following a risk assessment and were sure they had enough vehicles and personnel to provide safe cover.

The events service had several contracts to provide event first aid, for local and national events within the area and during many events, the service would convey patients from the event and to an accident and emergency department.

Meeting people's individual needs

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

Staff had access to communication aids, such as picture charts, to support non-verbal communication on all vehicles and a multilingual emergency phase book with prompts in 41 different languages and instruction on sign language. Staff could contact a translator by phone if required. This was in line with the Accessible Information Standard (AIS) which the government introduced in 2016 to make sure people with a disability or sensory loss were given information in a way they could understand.

However, not all ambulances had these aids included on them, but we observed staff were aware the service had them and reported they had used them. We raised the same issue during the 2016 inspection. After this inspection the provider sent an email reminder to all to staff to return any phrase books to the ambulances and added it as a check criterion to the daily ambulance check sheets and audit checks. If staff identified missing items they would raise this with managers who would do their upmost to replace items.

Vehicles had different points of entry, which included a sliding door and tailgate so patients who were mobile or in wheelchairs could enter the vehicle safely.

Staff told us they encouraged a family member or carer to accompany the patient if possible as this could reduce patient's anxiety. For example, staff encouraged carers or family members of patients living with dementia to accompany them in the ambulance.

Staff we spoke with had received dementia training from an external provider within the last year. This ensured staff were aware of the additional needs or challenges a person living with dementia may face.

For patients living with dementia and those with reduced mental capacity staff assessed their support needs at the point they accessed the service and recorded this on the patient report form.

The service did not have provisions to transfer bariatric patients. However, managers reported that if needed they would liaise with other St John Ambulance locations to request the transfer.

All staff received training on supporting people experiencing a mental health crisis or responding to challenging situations. Where the police had detained patients under section 136 of the Mental Health Act, staff would follow the guidance and procedures of the ambulance contract provider and a member of the police would accompany the patient.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

The service provided emergency and urgent care services 24 hours a day seven days a week. The local commissioning NHS ambulance trust requested shift cover and the provider sent the trust availability of staff two months in advance. The provider was currently offering 22 shifts a week cover for the local NHS ambulance trust.

The service offered 24 hour a day seven day a week cover to the neonatal and paediatric intensive care transfer service and followed national guidance requirement.

During October 2019 the service had cancelled seven shifts with the local NHS ambulance trust and 16 shifts in November 2019. This was all due to staff sickness.

Good

Emergency and urgent care

The contract provider monitored response, on scene and turnaround times for St John Ambulance crews through data captured using the on-board trackers. They reported on these figures at monthly meetings between the service and the contracted NHS provider.

Crews also completed a written daily worksheet as they did not have access to the on-board trackers, which enabled St John Ambulance managers to monitor the time crews spent on calls, how long it took to handover at the hospital and the total length of the shift. Managers used this information if contract providers raised concerns around performance times to provide rationales for any delays.

Learning from complaints and concerns

People were able to give feedback and raise concerns about care received, however not all ambulances displayed how to complain posters. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, carers and members of the public could provide feedback verbally or through the St John Ambulance 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.

There was information in some but not all ambulances on how to make a complaint. The service had a postcard size poster on some of the vehicles with a phone application to enable people to make complaints or comments through the internet. This did not consider everyone's needs or abilities and relied on patients using technology as phone numbers were only available through the internet.

Staff we spoke with told us if a patient wanted to give feedback they would ask them to email their manager and would pass on the managers email address.

Managers investigated complaints and the service had up to date policies and procedures to support this. The service reported that from November 2018 to June 2019 the South East & London Ambulance Operations received eight complaints. The service responded to all eight complaints within their target time of 20 days.

Managers we spoke with reported they had received root cause analysis training which equipped them to be investigating officers when required for complaints from outside their region.

The service reported the number of compliments and complaints using the monthly ambulance operation assurance and quality report which managers presented to the executive team at the quality risk group.

Managers shared feedback from complaints with staff. All staff we spoke with reported they received feedback either directly from their manager or by the monthly newsletter, intranet updates or at face to face training sessions where the service used learning from complaints as learning tool.

Are emergency and urgent care services well-led?

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Leadership

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

The ambulance operations manager currently oversaw the station managers who oversaw the team leaders. Team leaders were responsible for supporting the crews on a daily basis and would often undertake shifts.

The provider was undergoing a restructure at the time of this inspection. Station managers and team leaders were being interviewed for various roles due to the restructure. Some managers told us were unsure where they would be working in the future due to awaiting interviews for newly developed roles.

At the time of inspection, the local managers reported to the Head of Ambulance Operations who in turn reported directly to the Ambulance Community Response Director.

The registered manager for the South East was also the Head of Ambulance Operations for the whole of St John Ambulance and had been in post since 2016 and volunteered at events (roughly two shifts a month). This helped them keep their paramedic qualification up to date and have an awareness of challenges to staff on the ground.

Staff described their immediate managers to be approachable, visible, and respected that several of their managers, had an operational and clinical background. Staff were able to describe the role of each manager or lead which demonstrated they understood the current structure of the service and most understood the proposed new structure. However, most crews we spoke with reported the executive team were less visible.

All employed staff and volunteers we spoke with told us managers encouraged them to develop new skills and reported there were opportunities to work towards promotion and gain new experiences.

We observed members of staff interacting well with the management team during inspection.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply the vision and strategy and monitor progress.

The service was in the process of restructuring its management structure. The managers told us the vision 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 across the country.

There was a national vision and strategy for the service, which reflected the values of the organisation. Their values were humanity, excellence, accountability, responsiveness and teamwork. Staff knew and understood the vision and values of the organisation and how they could apply them in their roles.

The service's vision was that "By 2022, our people strive to deliver the best outcomes for patients and communities, we will provide them with the best possible experience and care, whether as volunteers, employees or supporters, in clinical roles or non-clinical, whether fundraising or supporting our heritage, treating or training others."

St John ambulance strategy was aligned to local plans in the wider healthcare economy. The strategy included plans for the next ten years and described being at the heart of communities, helping to transform out of hospital care, having a positive impact on the people treated and supported, and the communities served, and to develop the ambulance services and to be recognised as the nation's ambulance auxiliary service.

Culture

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

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

Managers reported one of the aims of the restructure was to bring the volunteer element together with the employed staff to ensure consistency across the service. Most staff reported this would be a positive change and would help bridge a gap they felt existed currently.

Staff described working for the service like being 'part of a big family'. We observed staff were professional, supportive of each other, wanted to make a difference to patients and were passionate about performing their roles to a high standard.

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

Staff described an open, learning organisation where they felt able to raise issues within a no blame culture. We saw the local whistleblowing policy, which explained how staff could provide concerns regarding the staff or service, internally to the manager or externally to regulators. Staff we spoke with were aware of the whistleblowing policy.

Staff were supported in speaking up and a positive culture of speaking up was promoted. Staff could access a Freedom to Speak Up Guardian and their activity was reported nationally. Freedom to Speak Up Guardians help protect patient safety and the quality of care and improve the experience of workers.

There was a strong emphasis on the care of patients. Staff promoted openness and honesty and understood how to apply the duty of candour. All staff were aware of what the term duty of candour meant.

The service used an external company for staff to access if they required help with mental health and wellbeing issues. Details of this service was displayed in the staff rest areas.

Following a recent bereavement of an ex member of staff, staff reported how supportive the managers had been including from director level. Staff described how they had been signposted to external support if required.

Throughout our inspection, the registered manager responded positively to feedback. They told us of improvements they had introduced immediately following feedback from inspections at other St John Ambulance locations. This demonstrated a culture of openness and willingness to learn and improve.

Governance

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

The service had a clear governance process to continually improve the quality of service provided to patients. Staff were clear about their roles, what managers expected of them and for what and to whom they were accountable.

Following the recent restructure, the provider was revising the governance systems and processes and new groups including the clinical operations group, ambulance steering group, forums as well as the governance committee and audit/risk committee. As these were newly formed groups there were no minutes of meetings to review.

The service held monthly governance meetings locally, which reported to the monthly executive leader team meeting. We saw minutes of the meetings and the content included discussion about incidents, learning and any extra training requirements, complaints, service issues, risks and any up and coming changes or challenges.

We reviewed the minutes for the regional operation board meeting which was chaired by the Head of Ambulance Operations. Items discussed included events, logistics, fleet, assurance and quality clinical issues and the CQC. Each item had an action to be taken column which gave ownership to individuals for the action.

A station manager liaised monthly with the contracted NHS ambulance trust regarding staff performance. We saw minutes of these meetings and feedback given to staff around any concerns.

All station managers held monthly meetings which then fed into monthly team meetings and managers emailed copies of the minutes to staff and placed minutes on the notice boards in the staff rest areas to ensure all staff who could not attend were aware of what was discussed. Topics discussed included health and safety, manager updates, and quality and assurance.

Volunteer district team leaders held monthly meetings with other district team leaders across St John Ambulance to discuss items such as building infrastructures, training requirements and new starters.

The service provided us with a copy of the fit and proper person checklist that directors signed before starting work with the organisation. This assured us the directors had the appropriate skills for their roles.

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

We saw assurance from one base only that staff completed a sign off sheet to confirm they had read any updated policy or procedure information. The other base did not have a mechanism to assure themselves all staff including volunteers had read updated policies or procedures.

Management of risks, issues and performance

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

The service had an assurance and quality team led by the Head of Assurance and Quality, who worked closely with the Medical Director and reported to the People and Organisation Executive Director.

The assurance and quality team produced a monthly ambulance operations assurance and quality report which was broken down into regions and included service highlights such as incidents, feedback on clinical audits and safeguarding referrals. The provider shared the report with station managers to feed back to staff during team meetings.

The provider had recently moved from having local risk registers to one national risk register for ambulance operations. Station Manager meetings included a discussion of risks with the head of ambulance operations and if graded high, added to the national risk register. Station Managers kept oversight of lower level risks such as building maintenance or staff vacancies. We saw these risks were captured in the Station Manager minutes.

Risks within the register included volunteer and paid staff employment, age of vehicles and poor information technology systems amongst others. All risks had a risk owner, actions required and a review date.

However, Station Managers we spoke with advised they were unaware of what risks were on the current risk register which did not assure us Station Managers had full awareness of the organisational risks. We raised this concern at the time of inspection and have received evidence that all Station Managers are now in receipt of the risk register.

When we asked staff what they thought the top three risks to St John Ambulance South East were, the risks reported matched the risks detailed on the national risk register. This assured us the senior management team had a good oversight of ongoing risks.

The service had a current version-controlled business continuity policy which detailed actions for staff to take in the circumstance of a major incident where there was a loss of premises, information technology or severe weather for example. The policy detailed action and response action templates which would assure the service they were fully prepared for any unexpected major incidents. For example, if there was a fire at the base, the service could use an alternative location to store ambulances and equipment relevant to the service provided.

Employed and volunteer staff we spoke with reported they had been involved in major incident training. Staff described these sessions as useful and feedback was positive.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Although information systems were not integrated they were secure. Data or notifications were consistently submitted to external organisations as required.

The provider demonstrated a holistic view and understanding of performance. We found the managers had oversight of all areas of the business and ensured they were fully compliant with regulations, guidelines and the law. We have received regular notifications that the provider was required to submit to us.

The service was aware of its performance, collecting information by using key performance indicators and other metrics. This data fed into the quality and assurance team who reviewed this information for assurance and improvement monthly.

The service collected data at regional level which included London as well as the South East. When requested the provider was able to break down the data in to individual regions. Data for patient transport services and urgent and emergency care was integrated

and the provider was not able to easily separate the data for the South East region. This was due to the patient transport service activity being low. However, managers told us if they identified a theme regarding the patient transport service a deeper dive into the information would take place.

The service held most information electronically such as training records and personnel files to make monitoring more effective. For example, the recruitment system was on an electronic system and held within a central point. We observed staff could easily access information when required.

The service produced monthly quality reports with data for each region which analysed performance and trends. The quality reports included 17 months' worth of data on performance. For example, complaints, compliments, incidents, vehicle cleanliness, patient report form compliance and safeguarding referrals.

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

The provider had identified there were different information technology systems that did not communicate with each other and identified this issue on their risk register. For example, the lack of booking/ rostering system was restricting bidding capability and operational efficiency gains. Plans were in place to identify efficiency gains by using an integrated system.

Access to electronically held records and information was password protected. This meant only authorised members of staff had access to the information. We saw that all staff locked computers when left unattended.

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

To inform the revised 2019-2022 strategy over 5000 conversations took place with staff, volunteers and stakeholders to facilitate the ownership of the direction of travel by both staff and volunteers.

Comment cards were available on some but not all the ambulances for patients to share their view of the service in some of the ambulances. Requests and how to give feedback through the St John website were on the copy of the patient report form given to the patients following completion of their care.

Staff received regular emails and messages on a secure mobile telephone application to provide updates on both internal and external matters about the service. This ensured managers kept staff up to date with regards to any policy and service changes.

Several employed and volunteer staff from each region supported national staff forums. A programme of quarterly meetings took place. The service used the forums to enable staff to raise concerns and make suggestions for improvement with the service leads.

The service had several different ways of communicating and engaging with staff, including newsletters, emails and staff forums. Most staff told us they felt the service kept them informed and they could be involved with any decisions that affected their team.

The service held debriefs following events so staff and volunteers could provide feedback and suggest changes for future events or service improvements.

The contracting NHS ambulance trust alerted St John Ambulance if there were any serious incidents which enabled managers to complete welfare checks on staff. The service gave staff time off to attend the contracting trusts own debrief.

Innovation, improvement and sustainability

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

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

Good

Emergency and urgent care

All staff we spoke with explained how training and learning was readily available to improve the services and patient care and that managers supported their requests to improve their skills.

The service had a formal process for quality improvement. We saw a document outlining a seven-point improvement model. This process included defining, measuring and improving the service with input from patients and service users.

The provider is currently reviewing the opportunity to introduce Joint Royal Colleges Ambulance Liaison Clinical Practice Guidelines (JRCALC) plus online application for staff to have on their mobile phone devices. This should enable the provider to track compliance to guidelines and polices as the application requires staff to acknowledge all policy and guideline updates.

As part of St John Ambulance strategy for community involvement, they have developed the annual Restart a Heart event with the aim of teaching CPR to as many people as possible.

Good

Patient transport services

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Patient transport services were a small proportion of activity. We inspected the Guildford site. The main service was emergency and urgent services. Where arrangements were the same, we have reported findings in the emergency and urgent services section, we do not repeat the information but cross-refer to the main service section.

Summary of findings

We found the following areas of good practice:

- The service had systems to provide assurance of safety regarding the premises, vehicles and equipment which were well maintained and clean.
- Staff received comprehensive training in safety systems on employment and this was regularly refreshed. All staff were up to date with mandatory training and there were effective systems to monitor this.
- Staff received support through supervision and appraisal.
- There was a system to ensure thorough recruitment checks were undertaken.
- Staff undertook risk assessments and took precautions to protect patients and themselves from harm.
- Staff had been trained and understood their responsibilities to report safeguarding concerns.
- There was a process to ensure staff understood the Mental Capacity Act (2005) and how to apply the principles in practice.
- The service investigated incidents, including complaints, and took appropriate remedial action.
- Managers were visible, approachable and respected by staff. Staff felt valued and well supported.
- Feedback from patients was very positive. We observed friendly and attentive staff.

Good

Patient transport services

- People could access the service when they needed it.
- The service took steps to support patients with complex needs and those in vulnerable circumstances.
- Staff completed accurate records of patients' care and treatment and kept them securely.
- Staff respected their managers and felt supported and valued by the organisation.

Are patient transport services safe?

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Mandatory training

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

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

Safeguarding

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

The service had a safeguarding policy. The policy was version controlled and within review date. It contained information on how to safeguard those in vulnerable circumstances; for example, those with learning difficulties or complex needs and children under 16 accessing services without requirement of parental consent. They also included information on modern slavery and female genital mutilation.

We accompanied staff on two journeys during the inspection. We saw staff were concerned about the safety and wellbeing of a patient and after they had settled the patient into their home they raised a safeguarding alert. As part of their openness and transparency when working with others, they shared with the NHS trust that they had raised a safeguarding alert.

This confirmed staff had had training on how to recognise and report abuse, and they knew how to apply it**.**

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

Cleanliness, infection control and hygiene

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

Good

Patient transport services

There was guidance for staff in the event of transporting an infectious patient, this included equipment and the cleaning of the vehicle after the journey.

Staff received training in infection prevention and control and this was refreshed annually. All staff were up to date with this training.

There was guidance on hand hygiene contained in the infection prevention and control policy and during our inspection we saw staff follow this. Staff were bare below the elbow during patient care and we saw staff decontaminate their hands before and following patient contact. There was personal protective equipment available, including gloves and aprons in a sealed pack and there were hand cleansing gel and decontamination wipes for cleaning internal surfaces and equipment.

The service's manual cleaning process and environment cleaning and disinfection process were accessible to all. 'Take 5' processes prompted questions and featured in monthly lessons learnt bulletins. We observed staff were following the processes.

On the day of our inspection, the service's ambulances were visibly clean. We observed staff using the correct personal protective equipment when transporting patients.

Environment and equipment

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

The Guildford base was situated in an industrial park. It had garages, an office and a car park. The environment was secure and suitable for the storage of ambulances and equipment.

The keys to vehicles were held securely at the base. There were kitchen and bathroom facilities for staff. Store rooms were secure and were well organised, so equipment and consumables could be easily accessed.

Staff carried out ambulance assurance checks, these were used along with daily checklists to ensure all correct equipment was onboard and processes were followed.

We inspected the store room and found stored items had expiry dates clearly displayed, and all of these were in-date.

Staff told us they had access to enough equipment to undertake their roles safely. If equipment became damaged or defective, there were processes to report this to shift leaders and to obtain replacements.

The service had systems to ensure all vehicles were serviced, maintained and had a current Ministry of Transport safety test (MOT). There was a system to track vehicle defects. Records were checked daily by the fleet coordinator.

We inspected three vehicles during our inspection. They appeared to be in good working order. There was no visible body work damage and doors and lights were working properly. All essential equipment was available and there was evidence this had been safety-tested. There were suitable harnesses and belts to safely transport passengers.

We did note on one vehicle that the handle tape on a carry chair and the flooring under the ramp were looking worn and posed an infection control risk as the service could not be assured that they could be cleaned thoroughly. We fed this back to senior staff on the day of the inspection and they undertook actions to remedy these issues.

There was a clinical waste disposal policy which described the procedure for waste disposal. We saw clinical waste was disposed of at the base in a secure marked bin and collected monthly by a waste contractor. During our inspection we saw staff cleaning equipment after use and correctly disposing of used linen.

Assessing and responding to patient risk

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

There was a policy describing risk assessments and all staff had received first aid training to at least emergency first aid level.

Staff told us they were provided with information at the time of booking regarding any risks associated with a patient transfer. The information was gathered by the booking staff and given to the ambulance crew to make any adjustments. This included information about the booking, to assess eligibility, patient's mobility and additional relevant information.

Good

Patient transport services

Staff told us they undertook their risk assessment and could seek specialist operational or clinical advice through the on-call manager 24 hours a day. In the event of a deteriorating patient, staff told us they would call for emergency support (by 999), record patients' observations and commence treatment in accordance with their level of training.

Staffing

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

We reviewed four staff files and there was evidence that recruitments checks were carried out and that the records were audited. The records we saw were in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection the Guildford base employed 21 members of staff of which eight were patient transport services only. These staff worked weekdays between the hours of 8am-7pm. All staff were required to complete an induction and mandatory training.

The provider also had an ongoing recruitment programme to meet the demand of the current winter pressures work (which included St John ambulance conveying patients from the accident and emergency departments and wards home to help patient flow) and the commissioning NHS trust.

Records

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

Staff did not complete patient report forms as they were not providing treatment. However, staff reported if they were required to assist a patient in any way they would complete a St John Ambulance patient report form and would leave a copy with the patient.

Transport bookings were made through the control room at the base. Staff recorded information provided on an electronic system. The system had required fields to be completed before the booking could be confirmed.

Staff provided us with a clear explanation of the expectations regarding the recording of patient care. During routine discharge journeys, only patients' names, addresses and journey timings were recorded.

We reviewed ten patient records including one from the day of the inspection. The manager showed how the booking had come to them and how they assessed what was needed to support the patient home. The records showed that information had been gathered to ensure patients were transported safely.

Medicines

The service did not use any medicines or medical gasses for the patient transport service.

Incidents

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

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

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

Not sufficient evidence to rate

We did not have sufficient evidence to rate effective for patient transport services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Good

Patient transport services

Staff were trained to escalate any patient care to the NHS Ambulance Trust if a patient's condition deteriorated.

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

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Staff told us they only carried bottled water. However, if they carried out a long journey, they ensured food and drink could be made available and they sought the patient's wishes on what they would like to do regarding food and drink. Rest stops were always planned for, on long journeys, giving patients a choice of access to food and drink

Pain relief

Staff were not required to assess and monitor patients to see if they were in pain. However, if they were concerned about a patient, they would contact the ambulance base or the hospital for advice

The service did not provide pain relief for patients

Response times

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

The station manager explained the time on the vehicle varied from patient to patient. Some of the journeys were relatively short and the patient could be on the vehicle for only a few minutes, others could mean the patient was travelling to a destination several hours away.

The service only transported one patient at a time to assist with the travelling time, so the patient would not have to wait for travelling companions to be collected or dropped off before them. The crew also used a satellite navigation system to determine the fastest route to avoid traffic, which achieved the shortest possible time on the vehicle for the patient.

Patient outcomes

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

Competent staff

The service ensured staff were competent for their roles. Managers appraised all staff's work performance to ensure they provided support and development.

Managers ensured staff received specialist training for their role. This included driver training and conflict management training, consent, Mental Capacity Act and Deprivation of Liberty Safeguards. A new member of staff started work three days before their training/induction to look at 'housekeeping' such as introduction to the workplace, building safety, working with computers used at the service and online training. The induction training lasted eight weeks; four weeks driver training and a four-week clinical residential course.

Records showed staff had all received an appraisal in the last 12 months and had one to one meetings with their line manager at least every two months.

Staff were expected to be aware of the training that needed to be updated. The station manager told us they looked at training records each month and gave staff a reminder at least six weeks before training was to be renewed. They then checked with staff a month before to see if they needed any support with the training such as time to complete it.

Multidisciplinary working

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

The manager showed us how multidisciplinary working started with the contacts they had with local NHS services and local authority.

Staff described how they worked with staff in the acute hospitals when transporting patients and how they expressed their concerns if patients became unwell. They gave an example of a patient who became unwell on their journey home and the staff rang the hospital to say they were returning with the patient. This was recorded as a failed discharge. The staff said that because they had liaised with the teams at the hospital the patient received the care they needed.

Good

Patient transport services

Staff reported they would check the paperwork for any patients that had a do not resuscitate order in place before they transferred the patient to ensure it was completed correctly. This evidenced staff were following the correct guidance.

Seven-day services

Key services were available to support timely patient care.

The service was available Monday to Friday between the times of 10 am and 7 pm on a pre- booked basis but could be flexible to meet demands/requirements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

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

Are patient transport services caring?

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Compassionate care

Staff spoke to patients with compassion and kindness, showing they respected their privacy and dignity, and took account of their individual needs.

We accompanied a crew on an ambulance transfer and observed the crew were attentive and friendly towards the patients. One patient was elderly and had been in hospital for some time and the crew recognised their anxiety and sought to reassure them throughout the journey. The patient said they were cold, and the crew said they would get them an extra blanket, but this did not appear. When the crew checked with the patient later they said they had warmed up.

On the second transfer the crew also accompanied the person into their home and were concerned the house was cold, cluttered and with out of date food. They raised a safeguarding alert to ensure the local services were aware of their concerns.

The station manager said staff often went above and beyond for example; going to get milk, making patients a drink and putting the heating on before they left the patient.

We saw recent feedback forms completed by patients or commissioners. Comments included: "Excellent service and great manner," patient feedback included comments such as: "Patient and professional", "They were really nice people."

Staff feedback to us included: "On occasions when we have taken patients home and if we know they are on their own until their carer arrives, we make sure if they have a panic button it is near them, we offer to make them a cup of tea, we place their phone near them and if it's cold, we switch the heating on."

Staff we spoke with told us about how they maintained patient dignity during long distance transfers. The service tried to ensure at least one female member of crew was present when transporting a female patient. If the crew were male and female they would switch roles; for example, if a patient needed to use the bathroom. We saw the staff transporting patients and their care was compassionate and they respected people's dignity.

Ambulance drivers drove safely and there was always a separate member of staff in the back of the ambulance to accompany patients. This staff member checked on patient's wellbeing throughout the journey.

Emotional support

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

Staff spoke to patients in a manner to reduce their stress and anxiety and showed understanding of their personal, cultural, social and religious needs and how they may relate to their care.

Good

Patient transport services

We saw staff interacting well with patients and the health staff at the hospital. We were unable to observe staff supporting or involving families or carers.

Understanding and involvement of patients and those close to them

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

Staff said they explained to the patient where they were going and kept patients informed about the journey. Staff said they told patients about the length of the journey and asked the patients to let staff know when they wanted to have a comfort break.

Staff explained how they would telephone a relative who was waiting for the arrival of the patient to inform them of their progress. When we accompanied a crew on a transport of a patient home during the inspection, the crew were in touch with the relative to inform them of estimated time of arrival and reassured them when the ambulance would be arriving.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Service delivery to meet the needs of local people

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

The service mainly accepted requests from individuals for support with transport, repatriation from an airport or ferry dock to the patient's home or a hospital. They also supported care homes in moving patients and staff told us how they transported one patient at a time.

The service was involved in helping with the additional winter pressure work from NHS England which included conveying discharged patients from the hospitals, home. This helped to keep the flow within the NHS emergency departments moving.

The service delivered a contract which catered for local people on behalf of two NHS trusts.

Meeting people's individual needs

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

Patient eligibility for transport was assessed by the local ambulance trust's call centre, so staff received all relevant information on the booking to meet their individual needs.

We saw two staff transporting patients in wheelchairs and with limited mobility. Staff knew and followed the correct transfer policy. They used straps and harnesses to safely secure patients on the vehicle's tail lift.

Staff we spoke with had had dementia training with an external provider in the last year.

Patients whose first language was not English had access to telephone translation services through Language Line. Staff we spoke with confirmed this was always easily accessible.

The vehicles had visual aids in the form of a book to help staff support patients who may have communication difficulties.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

The provider never cancelled private patient transport bookings due to the provider requesting pre-payment upon booking. The provider would ensure staff were made available for the journey in the case of staff sickness.

The service did not record waiting times as crews saw patients soon after being referred by the local ambulance trust.

The service arranged journeys based on the booking requests by patients or their carers/family.

Good

Patient transport services

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

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

The patient transport service did not use patient report forms for journeys, so patients did not have service contact information for direct feedback.

Complaints were kept on a central system for both the patient transport service and urgent and emergency care. However, the station manager was able to show us a complaint regarding the patient transport service from October 2019. A family had made the request to transport their parents which included a female member of crew for personal care as it was a long journey. Due to a miscommunication and misunderstanding on the part of the crew the wrong transport was taken for the journey. The action and learning for staff were to read the instructions thoroughly and if they had a query to ask senior staff.

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

Are patient transport services well-led?

Good

We did not previously rate independent ambulance services. At this inspection we rated it as **good.**

Leadership

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

The station manager was responsible for liaising with clients, scheduling and planning. They also investigated complaints and incidents and were responsible for staff recruitment, supervision and appraisal.

We spoke with four staff, who told us they felt supported by very approachable managers. They told us how they had been supported and encouraged to apply for further training and development opportunities.

Staff we spoke with had had regular meetings and yearly appraisals with their line manager up until the end of November.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had good communication links with the local ambulance trust control and external providers. We heard how staff engagement with external healthcare professionals was good.

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

Culture

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

The service promoted equality and diversity. We saw the organisation's equality, inclusiveness and diversity policy launched in October 2013. This included a discrimination policy and considered the Equality Act 2010 and the protected characteristics. It is against the law to discriminate against someone because of a protected characteristic.

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

Governance

Leaders operated effective governance processes, throughout the service and with partner

organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

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

Management of risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

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

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

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

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the organisation's five values clearly displayed throughout the service's main regional office and most staff could recite them to us.

Innovation, improvement and sustainability

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

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

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should update their clinical procedure manual to include guidance regarding conveying children and the use of child restraints and send a copy to the CQC
- The provider should enable all staff to have updates and or complete training in the use of child restraints and notify the CQC when this has been completed
- The provider should consider monitoring the use of child restraints to ensure the provider has an oversight in to the appropriateness of their use.
- The provider should maintain an oversight of their policies to check they are in date and reference current guidance and have a system to assure themselves all staff had read updated policies.
- The provider should monitor the medicines storage area temperature.
- The provider should place how to complain information in prominent positions on ambulances for the publics reference
- The provider should provide communication booklets on all ambulances.