St. John Ambulance

St John Ambulance North East Region

Quality Report

Healey Road
Ossett
WF5 8LN
Tel: 0192 4270114
Website: www.sja.org.uk

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St John Ambulance North East Region is operated by St. John Ambulance. The service mainly provides emergency and urgent care.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 31 October 2017.

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

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

Services we do not rate

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

We found the following areas of good practice:

- Staff were committed to providing the best quality care to patients. Staff displayed a caring and compassionate attitude and took pride in the service they were providing.
- Staff checked patients' requirements prior to transporting them to ensure that they were able to meet their needs.
- Staff operated comprehensive systems to make sure that all vehicles, equipment and medicines were safely managed and fit for purpose.
- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- Staff followed evidence-based care and treatment and nationally recognised best practice guidance. All staff had access to the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines 2016.
- The provider had developed systems to accurately monitor whether all staff had the qualification and skills needed to provide high-quality care; a national, skills assessment system ensured that feedback from staff was acted on to improve the range and quality of training offered by the provider.
- The provider had made a commitment to continuously improving the quality of the service. There had been a range of organisational restructuring activities and the implementation of standardised processes. Staff understood the rationale for these activities and cited examples of how this had led to improvements in their day-to-day practice.

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

- The service had a system to monitor the accuracy of patient records through the use of an audit system. However, patient report forms had only been audited for one of the two NHS ambulance trusts that the service worked with.
- The service did not yet have a system for monitoring the clinical outcomes of patients who had been treated while under the care of the provider. There was evidence that some consideration had been given to initiating this type of monitoring, but this was not in place at the time of our inspection.

Summary of findings

- The service did not routinely monitor the promptness of their service, for example, in terms of handover times, for all patients, although this was in place for some patients. Staff performance was monitored in terms of handover times for one NHS trust that the service worked with. However, the same level of monitoring was not used for work with a second NHS trust.
- Vehicles were equipped to monitor patient's health status during patient transfers. However, some paediatric-specific equipment, such as harnesses and pulse oximeters were not available on all vehicles. This meant that risks to children using the service could either not be assessed or had not been sufficiently identified and mitigated.
- There were systems to manage confidential patient sensitive information, but these were not always effective. Staff posted completed patient report forms through the postal system with no formalised or routine system of tracking that the information had been either sent or received.
- Staff feedback was usually well managed. However, staff meetings with frontline staff at one of the locations had not taken place for eight months. This had led to some concerns remaining unaddressed.
- There was a comprehensive staff training programme. However, we found that only 14% of clinical staff were compliant with equality and diversity training at the time of the inspection.
- All operational ambulance staff had received some safeguarding training, however the named, regional safeguarding lead had not completed training to an appropriate level for their role.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with two requirement notices that affected emergency and urgent care services. Details are at the end of the report.

Ellen Armistead

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides. The main service was urgent and emergency services. Other services such as patient transport services were a small proportion of activity; therefore we have reported our findings in relation to patient transport services in the urgent and emergency services section.

St John Ambulance North East Region

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Background to St John Ambulance North East Region

St John Ambulance North East Region is operated by St. John Ambulance, a national first aid charity. 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 nationally provides a number of services including first aid at events, emergency and non-emergency patient transport services and first aid training. The objective of the organisation is the relief of sickness and the protection and preservation of public health. The organisation works with both volunteers and employed staff to provide services.

St John Ambulance North East Region was formed in 2012 following a restructure in the organisation. The service primarily serves the communities of Yorkshire and Tyne and Wear. They have contracts with two NHS Ambulance Trusts and deliver bespoke services for community events. They undertake the movement of emergency and urgent care patients between hospitals, homes and care facilities. The service has specific contracts for transporting patients who are receiving end-of-life care and for managing alcohol-related health concerns.

At the time of our inspection, there was one registered manager, covering all regulated activities related to events. An existing Sector Manager, previously responsible for the North West and West Midlands, had also recently been moved to cover the North West and North-East Regions.

Our inspection team

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

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

St John Ambulance North East Region is an independent ambulance service with a regional headquarters based in Ossett, West Yorkshire and an Ambulance Operations base in Gateshead, Tyne and Wear. There are also offices and ambulances based in Thirsk, Durham, and Hull.

The service is registered to provide the following regulated activities:

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

The service employs 63 people in the emergency and urgent care transport services; 18 in managerial, supervisory or administrative roles and 45 providing clinical services; in the event first aid services team there are also 125 volunteers providing clinical service related to the regulated activities. The employed staff are at a range of levels comprising 14 ambulance technicians and 31 emergency transport attendants on either permanent, fixed term or casual worker contracts. There are also 12 volunteer paramedics.

The services track record on safety from June 2016 to June 2017 showed:

- No never events
- 163 incidents
- 3 complaints

In the period January to September 2017 there were 6495 patient journeys undertaken. This included 4268 journeys in relation to Accident and Emergency services for two NHS ambulance trusts, 1932 journeys for end-of-life patient transport and 284 journeys for a medical treatment unit within one NHS trust. The service works with patients of all ages, including children, although the majority of the journeys were with adults.

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 twice previously. The most recent inspection took place in January 2014 and found that the service was meeting all of the standards of quality and safety it was inspected against.

During the inspection on 31 October 2017, we visited the Regional Headquarters in Ossett and the Ambulance Operations base in Gateshead. We spoke with 28 staff including frontline ambulance crews and members of the management team. We spoke with two patients and four relatives. During our inspection, we reviewed a sample of six patient records. We checked one vehicle at Ossett and six vehicles in Gateshead.

The service had contracts with two NHS Ambulance Trusts at the time of the inspection: Yorkshire Ambulance Service and North East Ambulance Service.

Emergency and urgent care services

Summary of findings

Are emergency and urgent care services safe?

At present we do not rate independent ambulance services.

We found the following areas of good practice:

- Incidents were investigated and lessons learned were shared with staff to prevent a recurrence
- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- Servicing, MOT and insurance for ambulances were all up to date.
- Staff carried out structured patient assessments and clinical observations, which were appropriate for their level of competence.
- Medicines were well managed; there were effective systems for storing, supplying and ordering medicines.
- There were sufficient numbers of suitably qualified staff to meet patients' needs at all times.

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

- The service had a system to monitor the accuracy of patient records, but did not yet have a system for monitoring the clinical outcomes of patients who had been treated while under the care of the provider.
- Vehicles were equipped to monitor patient's health status during patient transfers. However, some paediatric-specific equipment, such as harnesses and pulse oximeters were not available on all vehicles. This meant that risks to children using the service could either not be assessed or had not been sufficiently identified and mitigated.
- There were systems for the management of confidential patient sensitive information, but these were not always effective. Staff posted completed patient report forms through the postal system with no formalised or routine system of tracking that the information had been either sent or received.
- Staff completed a range of mandatory training to ensure that they were competent in their roles. Levels of

compliance were monitored and actions were taken to keep staff up to date with their training. However, at the time of the inspection only 14% of operational crew were compliant with equality and diversity training.

- All operational ambulance staff had received some safeguarding training, however the named, regional safeguarding lead had not completed training to an appropriate level for their role.

Incidents

- The service had an incident reporting policy that was available to all staff. The staff that we spoke with were able to give examples of what constituted a clinical or non-clinical incident. They were aware of the incident reporting process. They were able to locate incident report forms and knew how to submit these.
- We reviewed incident reports that had been completed between June 2016 and June 2017. 163 incidents had been recorded. These covered a range of issues including vehicle faults, driving incidents, patient complaints, patient injuries and fatal events.
- The service had reported no never events or serious incidents between July 2016 and June 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Incidents were monitored nationally by a quality assurance team. They collated the information under a variety of headings such as clinical care, health and safety, medication errors, and vehicle issues. This information was fed back to regional teams at monthly meetings and the figures under each category were expressed as a percentage of the total patient journeys to aid monitoring of service performance in each area over time.
- The quality assurance team provided instructions on further investigations, and actions that needed to be taken to prevent recurrences, to local registered managers and station managers. The local managers then worked with individuals, or teams, to share learning and provide additional training to mitigate the risk of any incident occurring again.
- The national quality assurance team also took action across the organisation where they found that any incident had wider implications for practise. We reviewed one example of an incident which had led to a liability claim. The quality assurance team had summarised and shared learning from this event. The staff that we spoke with were aware of the incident and what they were required to do to prevent a recurrence.
- The quality assurance lead told us that in the event of a joint investigation with a contracting service they received feedback, as required. We were told the service had good working relationships with NHS providers.
- The registered managers were responsible for ensuring compliance with the Duty of candour; they were supported by the quality assurance leads, where necessary, for example to support communication between the service and external contractors regarding incidents.
- The ambulance crew that we spoke with were aware of the Duty of candour and had been provided with a briefing document about “Being open when things go wrong” in April 2016.
- The managers told us that there had been no incidents between July 2016 and June 2017 that had resulted in moderate or above patient harm that would trigger the Duty of candour process.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service did not have a formal, clinical dashboard in place to monitor safety but other systems were in place to monitor the safety of the service.
- The provider had carried out audits related to the accuracy of the completion of Patient Report Forms in October and November 2016. This identified some areas for concern, for example, patients’ NHS numbers or GP names had not always been recorded. The manager leading the audit held discussions with staff which identified valid reasons for missing information. However, an improvement in recording standards was agreed through the additional use of notes in free-text boxes to record the reason why information was missing. The provider planned to re-audit the completion of the records within the next six months to note whether improvements had been made.

- At the time of the inspection, the service did not monitor care episodes for patients. There were systems, for example, to monitor the use of medicines in terms of level of stock, and for ensuring that only appropriately trained staff had access to medicines. However, when medicines were given to patients there were no systems to monitor if they had been correctly used in relation to the health outcomes for that patient.
- We spoke with one station manager who had begun to develop some systems for monitoring patient outcomes, for example, in terms of headache, chest pain and fractures.
- The registered manager working on events showed us that for each event a summary record was kept noting the numbers of patients seen and any treatment given to individuals alongside whether or not emergency transport was required. This summary information was fed into debriefing meetings with their clients and ongoing internal safety meetings.

Cleanliness, infection control and hygiene

- The service had an infection, prevention and control policy that was available to all staff. The staff we spoke with were aware of their responsibilities related to infection, prevention and control.
- Infection, prevention and control training was delivered to all staff as part of their induction training and mandatory training updates.
- Personal Protective Equipment was available on all ambulances. This included, for example, disposable clinical gloves and aprons. Staff were aware of when these should be used and we observed that they were appropriately used
- Staff were responsible for completing daily cleaning checks prior to their shift. We checked a sample of these, finding that they had been completed appropriately on all occasions.
- All ambulances, garages, staff areas and offices were visibly clean and tidy.
- The ambulance stations that we visited had store rooms specifically for the use of the transport services. These were well organised, with all equipment and stock stored off the floor in individual and wipeable containers.
- We observed that there was an ample supply of singly-use linen. The staff that we spoke with confirmed that fresh linen was readily available.
- Cleaning equipment was available in the ambulance stations. A colour coding system was used which separated equipment that was to be used in different areas. For example, in ambulances and in non-clinical areas. There were posters located next to all cleaning equipment to support staff in identifying the correct equipment to use.
- All vehicles had decontamination wipes which were in date. We observed ambulance cleaning down the equipment after the transfer of a patient to ensure that the vehicle was clean for the next patient.
- Ambulance crews fully cleaned their vehicles at the end of their shift. If there had been a high level of contamination, or risk of infection, the crew returned to the depot to do a deep clean and, if necessary, the vehicle was taken off the road to be cleaned by an external contractor.
- All ambulances had spill kits available which were used to clean any bodily fluids. In addition, staff used disinfectant wipes to clean equipment such as wheelchairs and stretchers after use.
- The service contracted an external provider to deep clean all vehicles. This was done every six to eight weeks or, as required, after a high-risk event. A swab of each vehicle was taken before and after each deep clean to measure the number of bacteria present. The external provider used checklists to monitor compliance with each stage of the cleaning process.
- The service had a uniform policy which outlined the roles and responsibilities of all staff members. Staff had an awareness of the need to wash their uniforms separately to all other clothes so that the risk of contamination was reduced.
- At the end of each shift, ambulance crews took the sharps bin and clinical waste bags off the vehicles and these were placed in clearly identifiable, locked bins at the depot. These were emptied on a weekly basis by a private contractor.
- The team leader and service delivery co-ordinator carried out regular audits and ad hoc checks of vehicle cleanliness. We saw examples of audits for infection

control standards within ambulance vehicles and around the buildings of each ambulance station. Hand hygiene audits were also completed, with the most recent having taken place in April 2017. These showed high levels of compliance (ranging from 92% to 100%) with the correct techniques.

- Actions were taken to remedy any concerns identified during audits. For example, in one case a sharps box was found to be overly full; this was removed and replaced and verbal reminders were given to relevant staff.

Environment and equipment

- The services we visited had five ambulances based at the Ossett location and a further six based at the Gateshead location; these were used to transport patients.
- We found the ambulance stations, including the garages and equipment storage areas, were clean and well laid out. They were well lit, tidy and fit for purpose.
- The stations had bathroom and toilet facilities for staff to use during their shifts. These were well maintained.
- The stations had security in place, which included a key coded outer door at Ossett and a fob system for secure areas in Gateshead. CCTV was in use on all entry points into the building.
- Hazardous substances were stored in a locked room, or a locked cupboard, at the various locations. There were appropriate Control of Substances Hazardous to Health assessments in place.
- We observed that staff were responsible for completing a daily vehicle check before every shift. This included checking if the vehicle was in a good state of repair and had the correct equipment available.
- The daily vehicle checks were recorded on a form. We reviewed 20 forms and saw that they had all had been correctly filled out .The forms were reviewed daily by the service delivery manager and we found that appropriate action had been taken to address faults or lack of equipment .
- Consumable stock was stored on a number of shelves in store rooms or at the entrance to the vehicle garage. The level of stock was managed by the service delivery coordinator. The staff we spoke with told us there was never any problem replacing used consumables.
- Other types of stock and equipment were stored in locked rooms. These were well laid out with equipment items neatly stored in separate, labelled and lidded boxes over a number of shelves. There was a separate area where staff could leave defective or broken items. There was also a safe for medicines.
- The Ministry of Transport (MoT) test due dates and servicing schedules were on a database maintained by the fleet coordinator. All St John vehicles have a MoT and full service as part of a national contract with an external contractor. We checked six vehicles on our inspection. They all had a current MoT and the servicing was up to date.
- The vehicles used an airwave handset and a satellite navigation system, that were linked to the NHS Ambulance Trust, in the vehicle. All essential equipment in all the vehicles had been checked. We found that all were in order and had stickers showing the next checking date. All equipment had been safety tested and appropriately calibrated, where necessary.
- At the Gateshead location we noted that three of the six vehicles inspected did not have harnesses for children. We also found that pulse oximeters appropriate for children and babies were not available. We noted that this had been reported at a staff meeting in February 2017; the staff we spoke with also commented on this issue in relation to a patient they had cared for. We asked the registered manager for ambulance operations about the staff's concern in this area. However, they were new in post and not able to say how this concern had been followed up. The management team confirmed, after the inspection, that each vehicle was equipped with a paediatric probe suitable for children from the age of two upwards.

Medicines

- The service had a comprehensive medicines management policy. This was available to all staff.

- Medicine packs were stored in the stock rooms in numerical-coded, locked cupboards. The packs were colour coded so that staff at different levels of training could easily identify which packs they were allowed to use.
- There was also a colour-coded tag to indicate when a pack had been opened, and when it had been used and required replenishing. Packs which needed renewing were placed in a secure drop box and picked up a member of staff responsible for reconciling stock.
- The service had a robust, electronic system of medicines management and stock control. This included accounting for each tablet given against a patient report form.
- All medications packs were signed in and out of the station by ambulance crews on the day that they needed them.
- We observed that each ambulance had a lockable medicines safe which could be used when required.
- Medical gasses were stored in a separate, lockable facility, all smaller cylinders were stored off the ground, although larger oxygen cylinders were stored on the floor. All medical gasses we checked were in date.

Records

- The service used standardised, patient report forms for patient transfers as part of their contracts with two NHS ambulance trusts.
- During shifts, the patient records were locked in a drawer in the dashboard of the vehicle. At the end of shift they were taken to the service delivery coordinator's office and stored in a locked drawer. The records were collected daily, or weekly, depending on the requirements of the contracting NHS service.
- We observed that personal information was being carried in sealed envelopes and that any conversation held about a patient during a handover was done privately so that it could not be overheard.
- The serviced used St Johns Ambulance patient report forms for those events where the service was contracted to transfer patients off site in an emergency. These forms were sent to an external provider and uploaded to an electronic system.
- The management team informed us that forms completed at smaller events were sent in the post to the external provider. These were not sent in tracked mail. We raised this as a concern and were advised that this was a national decision that had been risk assessed. We did not find any occurrence where records had been lost in transit.
- Information about special notes, such as, Do Not Attempt Cardio Pulmonary Resuscitation orders were included as part of the patient records. Staff understood the need to review and hand over any patient information, including hospital notes, when a patient was transferred to a new provider.

Safeguarding

- The provider had a national safeguarding directorate who supported regional safeguarding managers to implement policies and protocols at a local level.
- The current safeguarding policy had been implemented in June 2016. Frontline staff were supported to comply with the policy through the provision of a 'safeguarding pocket card' which included a flow chart for reporting or escalating safeguarding concerns.
- The staff we spoke with gave us examples of what constituted a safeguarding concern and were able to describe the process for reporting this.
- Staff were also aware of guidance related to specific safeguarding issues. For example staff were able to accurately describe the legal requirement for reporting incidents of female genital mutilation. They were also aware of the 'PREVENT' strategy for identify and preventing terrorism, as well as issues related to child sexual exploitation.
- Staff reported safeguarding concerns at the time that they occurred and the national safeguarding team was responsible for onward referral of these concerns to other organisations, such as local authorities.
- There were also named regional, and local district, safeguarding leads in place to support the process of monitoring and managing safeguarding concerns.
- We spoke with a quality assurance lead about the safeguarding reporting processes. They noted that staff were now reporting a wide range of concerns. They commented that the safeguarding assessment team

was working towards developing a fuller triage system to aid more accurate escalation of appropriate concerns for safeguarding referrals. At the current time, the provider had received feedback from CQC that they may be reporting and referring a wider range of concerns than was necessary.

- The provider was in the process of instigating a safeguarding training programme at the time of the inspection. All staff had completed safeguarding training to level one. Information shown to us for the ambulance operations team showed that 95% of staff had completed safeguarding training to level two. The service did not frequently work with children, however the safeguarding training incorporated issues related to protecting both children and vulnerable adults.
- We noted that there were no plans in place for clinical staff working with children and their parents or carers, who could potentially contribute to assessing, the needs of a child where there are child protection concerns, to complete additional level three training. The service had not reviewed and risk assessed whether this level of training was required for staff against the Intercollegiate document on Safeguarding children and Young People: roles and competences for healthcare staff (2014).
- The regional safeguarding lead confirmed that they had completed level two training in protecting children, and that there was an existing plan in place for completing level three training in 2018. In the interim period the regional lead was being supervised by a national safeguarding advisor. The Intercollegiate document states that the identified safeguarding lead should be trained to level 4 for children.

Mandatory training

- Mandatory training included safeguarding, medicines management, infection prevention and control, information governance and conflict management. Training was delivered face-to-face and through online training modules. Employed and volunteer staff completed the same training.
- We spoke with a training standards manager who showed us how they kept oversight of staff training compliance. There was a training standards spreadsheet with records of compliance for each member of staff. This was discussed at a monthly managers' meeting to track progress. Staff were provided with continuing professional development folders for recording their own progress.
- At the time of the inspection, compliance rates for training ranged from 67% (for medicines management) to 90% (for conflict management). One training course showed lower levels of compliance. This was for equality and diversity training, with only 14% of operational crew compliant with this training. The management team provided us with an update, after the inspection, to note that completion of this training had reached 79% by January 2018.
- We asked the training standards manager about how staff who had not completed training were managed. They told us that completion of all training was linked to the appraisal process and pay awards. Staff who were persistently non-compliant with training were not allowed to remain operationally active. The ambulance crews that we spoke with confirmed that this was the case.
- St John Ambulance had a team of volunteer driver trainers for operational driver training, including response (blue light) training. These trainers had been approved by national headquarters and by the Royal Society for the Prevention of Accidents. Blue light training had been completed by 35 members of staff, and 52 volunteers, at the time of the inspection.

Assessing and responding to patient risk

- All ambulance operations staff were issued with a current pocket guide of the Joint Royal Colleges Ambulance Liaison Committee protocols. This gave assurance that patients would be assessed against appropriate protocols.
- Staff completed structured patient assessments and clinical observations on patients, as part of their care and treatment to assess for early signs of deterioration. If a patient deteriorated, crews informed the receiving hospital's emergency department so hospital staff were aware before the patient arrived.
- Vehicles were equipped to support staff in carrying out observations of patients during transport to monitor for signs of deterioration in the patient's health. For example, staff could carry out blood sugar monitoring

and tests of heart functions. However, some staff commented that they did not have access to a paediatric pulse oximeter, and that they had reported this concern following an occasion when monitoring oxygen levels in a child would have been appropriate. We noted that this had been discussed at a staff meeting in February 2017, but that no further action had been taken. The management team confirmed, after the inspection, that each vehicle was equipped with a paediatric probe suitable for children from the age of two upwards.

- Staff had completed online training in conflict management. This meant that they were aware of the need to use minimal restraint or force in response to aggressive or violent patients. However staff commented that they would like to have additional and specific training on techniques that could be used to protect themselves and patients during these incidents.

Staffing

- The service employed 63 people in the emergency and urgent care and patient transport services; 18 in managerial, supervisory or administrative roles and 45 providing clinical services; in the event first aid services team there were also 125 volunteers providing clinical service related to the regulated activities.
- The employed staff were at a range of levels comprising 14 ambulance technicians and 31 emergency transport attendants on either permanent, fixed term or casual worker contracts. There were also 12 volunteer paramedics.
- The service provided three ambulances during week days for the end-of-life patient transfer service and structured the rota with appropriately trained members of staff in line with the contract. There were both substantive and casual workers available to fill the shifts.
- The ambulance operations manager and station managers reviewed staffing levels as part of their key performance indicator monitoring. Data was provided showing the analyses of this information from January to July 2017. Data was collected on a weekly basis and analysed at monthly meetings to identify any concerning trends in staffing levels.
- We found that levels of staff sickness and staff turnover had been monitored. In the last 12 months there had been a redundancy programme due to changes in contracts with external clients. Records showed that with these redundancies included the turnover rate was high at 74%. However, making allowances to remove the impact of these redundancies the turnover rate was lower at 36%. The redundancies were made in response to the loss of a contract. Therefore the services provided under other contracts remained appropriately staffed during this period.
- A report on sickness absence showed that in the period from September 2016 to August 2017, 331 days of work were lost, on 98 occasions, due to sickness. The data had been analysed and identified a stress-related increase in sickness absence during the redundancy management period.
- Twelve members of staff had been supported through an absence management plan to support staff in a phased return to work. We spoke with one member of staff who told us they had felt well supported through this process.
- Staff requiring extra support were identified through supervision and appraisal procedures, as well as through ad hoc contact with line managers. The provider ensured staff had access to services that supported their mental wellbeing, for example, following attendance at a traumatic patient transport event.
- Staff worked for four shifts followed by four rest days. Each shift could last up to 12 hours. Breaks were half an hour, or 45 minutes, depending on the length of the shift. The shift rotas were published a month in advance.

Response to major incidents

- The provider had a national policy for emergency preparedness, resilience and response. The provider had protocols in place for supporting and assisting other services, including the NHS, in the event of a major incident. Planning for events considered the risk of major incidents and how to respond to these.

Emergency and urgent care services

- The service participated in table-top exercises with NHS providers to walk through major incident scenarios. Table top exercises are used to simulate a major incident, as well as the roles and responsibilities that individuals have during an incident.
- Staff received training in respect of their role in major incidents. Staff took part in major incident simulations.For example, the management team informed us of one scenario where the service was the only provider for the first 20 minutes.
- The service had a local business continuity plan which could operate in the event of an unexpected disruption to the service, including loss of premises, for example due to fire or flooding.

Are emergency and urgent care services effective?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- Staff followed evidence-based care and treatment and nationally recognised best practice guidance. All staff had access to the Joint Royal College Ambulance Liaison Committee guidelines 2016.
- The majority of staff within the organisation had received a recent appraisal.
- All staff received training on the Mental Capacity Act (2005) and the Deprivation of Liberty safeguards as part of their induction training. We saw staff members asking patients for consent before starting treatment.
- The service provided well-organised continuing professional development training days, with an associated staff portfolio, to ensure staff had up-to-date skills and knowledge to carry out their roles effectively.
- We observed good multidisciplinary team working between crews and other NHS staff when treating patients. We saw good co-ordinated care and transfer arrangements when handing the care over to NHS staff.

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

- There was inconsistent monitoring of handover times and patient outcomes. Some data was routinely collected for some patients in relation to handover times, but this data was not monitored for other patients. Clinical outcomes for patients were not monitored by the service.

Evidence-based care and treatment

- Staff followed national guidelines, which included the joint Royal Colleges Ambulances Liaison committee and National Institute for Health Care and Excellence guidelines.
- Staff showed as that they carried copies of the Royal College guidelines with them. They told us they regularly used these documents as a point of reference for providing care.
- We observed that staff had access to information on specific care pathways and protocols in the staff room. For example, printed documents were available describing end-of-life care guidance, stroke and asthma management, as well as hypoglycaemic warning signs and treatment. The staff we spoke with were aware of these guidance documents.
- The organisation had received accreditation from The International organisation of Standardisation 9001:2008 for quality management systems. This included the design and development of training courses in health and safety related topics.

Assessment and planning of care

- The service was contracted to two NHS ambulance service providers to transport patients between sites; this included a specialist contract to work with transporting patients receiving end-of-life care, for example, from a hospital ward or hospice to the patient's home.
- The contracts varied between trusts and worked flexibly in terms of the numbers of vehicles and crews required. On the day of our inspection, there were four ambulances in operation at the Gateshead location and another two at the Ossett location.
- Bookings were co-ordinated through an internet-based system when the provider was working with an NHS Trust. Key information about the patient was supplied and staff reviewed this information to ensure a safe

transfer. For example do not attempt cardio pulmonary resuscitation orders were noted, as well as other special notes, such as the requirement for oxygen therapy, or diagnoses that might affect the type of care provided, such as the presence of dementia or mental health diagnoses.

- Staff used this information, together with discussions with staff at the discharging service, the patient and their relatives, to plan each journey and complete the transfer safely and with minimum discomfort to the patient. We observed staff discussing patients' requirements prior to moving patients.
- The staff we spoke with were aware of a range of different protocols for supporting patients with different diagnoses, or complex needs, including mental health issues. We observed information was available at each ambulance station to support this process.

Response times and patient outcomes

- We asked the provider how they monitored response times and patient outcomes. They confirmed that they did not monitor this data for one NHS ambulance trust as it was not a requirement of their contract. For another NHS ambulance trust handover times were routinely examined on a monthly basis. For example, in September 2017, eight out of 221 (3.6%) transfers did not hit the handover target of 15 minutes. ('Handover' time measures the length of time from when an ambulance arrives until the service hand overs the care of the patient to the provider. The monitoring of handover times can be used as an indicator of quality as it relates to both the patient experience of the service and the efficient use of available resources. Patient safety can also be compromised through handover delays, for example, through missed medical appointments). These cases were individually reviewed at the monthly meetings with the NHS trust to identify reasons for delays, and areas for improved performance.
- The service monitored some relevant activities as part of their internal key performance indicators. This included the number of patient journeys completed, the number of cancelled shifts, any variance in contracted hours, staff sickness rates and numbers of vehicles out of operation. This data was regularly reviewed by management staff to identify areas for action, such as staff recruitment or fleet management systems.
- The quality assurance manager told us there was a trial due to start which would consider how best to monitor patient outcomes. This was in the early stages of development at the time of our inspection. Initially this included a limited number of patient outcomes including headache, chest pain and suspected fracture. The management team subsequently confirmed, after the inspection, that the trial had commenced with a review meeting set for January 2018.

Competent staff

- There was a recruitment policy in place for the management team to follow when employing new staff. This included proof of identity, driving licence and enhanced disclosure and barring service checks. References and qualifications were also required. We sampled 12 staff files and found that relevant checks had been completed.
- There was an induction training programme for all new staff. The induction programme was tailored for each new staff member depending on their role. For example, staff working in emergency and urgent care could be required to complete up to four weeks of driver training and five weeks of clinical training. Training covered key topics including moving and handling, medicines management, basic and intermediate life support, and safeguarding. Staff became operationally active upon completion of the induction training courses. Staff we spoke with had completed the induction process in line with the policy.
- Volunteers were required to meet the same standards of training as employed staff.
- All staff working on the ambulances were required to complete two continuing professional development days per year. This included the tests required for validating skills, and other training updates. There were additional online training modules which staff were required to complete.
- We found that the information provided to us showed that only 52% of staff had completed the CPD training days provided in June 2017. The training manager told us, and the staff we spoke with were aware, that they needed to complete the revalidation programme at some point during each year. If they did not complete

the revalidation programme, or any other required training elements, this was linked to a performance pay award and also resulted in individuals becoming non-operational.

- The content of the professional development days and mandatory training programmes were tailored to meet staff needs through the use of an annual review. During the review, the training standards manager collated information from staff at all levels of the organisation to form a plan in relation to what additional training would be most beneficial for staff. For example, this had led to the provision of additional training in relation to some incidents, and training in completing patient report forms.
- All staff were involved in an annual performance development review. This was supplemented by an interim review every six months, and a further six, one to one, supervision sessions. These assessments gave staff the opportunity to discuss any training needs and areas for development. We found evidence of this within all of the 12 staff files we reviewed. Staff we spoke with found this was a useful process.
- There was a process in place to complete driving license checks. Drivers were recorded in the provider's National Driver and Fleet register. The system recorded their full details including qualifications, medical status and eyesight tests and contained scanned copies of the relevant documents. It also stored information regarding driving infringements, incident investigation and outcomes. The driver register system emailed reminders of pending licence expiries to regional managers, and the specific drivers. The managers reviewed this information at monthly meetings so that action could be taken to address any concerns.

Coordination with other providers

- The provider had good working relationships with their NHS providers. For example, The station manager met monthly with one of the NHS ambulance trusts to monitor and discuss the contract and the requirements of the service
- There were agreed care pathways which the NHS ambulance trust shared with the St John Ambulance staff. We noted that staff were aware of specific directions, for example, the need to transfer patients to the major trauma centre for open fractures, rather than to closer, local hospitals.
- Staff completed the NHS ambulance trust's patient report forms. A quality audit had been carried out in October and November 2016 to understand how successfully staff were completing these forms.
- Staff told us clinical advice could be obtained from NHS Ambulance trust. Primarily this was from an on-call paramedic. There were also options to ask for a paramedic to attend and treat a patient, as well as to pre-alert the nearest hospital that an emergency care patient was imminently arriving.

Multidisciplinary working

- We observed good multidisciplinary team working between crews and other NHS staff when treating patients. We saw good co-ordinated care and transfer arrangements when handing the care over to NHS staff.
- We spoke with staff at one hospital that the St John Ambulance staff were working with on the day of the inspection. They were happy with the handover details given on the day and commented that these had been good on previous occasions.
- We observed that ambulance crew asked hospital staff appropriate questions to make sure that they understood the patient`s needs.
- Staff checked that they had received the correct documentation at handover points and raised issues about the completeness of information, if necessary.
- The staff we spoke with were aware of internal report processes that would lead to patients being referred onwards for additional services or care. In one example, we observed the crew asking staff what additional support was being made available to the patient, in terms of adequate nursing care, when they transported the patient to their own home.

Access to information

- Staff had access to policies and standard operating procedures at each ambulance station. For example, we observed that the staff room at the Gateshead location

was equipped with computers with access to the provider's intranet system. This allowed staff to access all key policies and protocols. Some key documents had been printed and were located next to each computer.

- Ambulance crews were provided with key information and special notes regarding care plans. For example, staff were aware of the increased importance of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in patients being transferred as part of the end-of-life care pathway. We observed instances where staff checked this documentation and liaised with other providers to ensure best practice in this area.
- The vehicles used an airwave handset and a satellite navigation system, linked to the NHS Ambulance Trust, in the vehicle. This meant that staff were able to liaise promptly with the service about their whereabouts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had formal policies describing consent processes, as well as protocols for following the terms of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- The service provided staff training on these topics through level one and level two safeguarding courses.
- Staff we spoke with had good knowledge about the importance of understanding patients' mental capacity, how they could act in line with 'best interest' decisions, and the importance of involving patients in decisions about their own care, wherever possible.

Staff also understood the requirements of Gillick competence. Gillick is a term used to describe if a child under 16 years of age is able to consent to their own medical treatment without the need for parental permission or knowledge.

Are emergency and urgent care services caring?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- We observed examples of staff providing compassionate care to patients. The staff that we spoke with showed a commitment to providing the best possible care.
- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.
- Staff were able to give us examples of the support that they offered when patients had become anxious or upset during their journey.

Compassionate care

- We observed examples of staff providing end-of-life transport services. They demonstrated that they worked with patients and relatives in a respectful and considerate manner.
- Staff asked the patients, relatives and hospital staff appropriate questions to ensure that they understood each patient`s needs and that these were taken into consideration.
- All of the staff that we spoke with during the inspection showed a commitment to providing the best possible care.
- Staff showed an awareness of the importance of maintaining patients' privacy and dignity. During the patient transfers, staff ensured that patients were covered in blankets; the transfer from hospital bed to ambulance trolley was done behind a screen.
- We observed that staff were sensitive to their patients' physical discomfort. In one example we saw staff respond to a patient's non-verbal cues indicating that they were uncomfortable which led staff to adjust the position of the trolley and provide additional back support for the patient.
- Staff were also concerned about continuity of care after patients' transfers were completed. For example, they checked with patients and relatives about the availability of ongoing care and support after the transfer had been made from hospital to home.
- The patients and relatives that we spoke with told us that the staff they had met were professional and kind.

Understanding and involvement of patients and those close to them

- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.
- The ambulance crew were supportive of patients and remained committed to involving them in their care at all times. We noted that even when patients receiving end-of-life care were barely conscious, they spoke to the patient by name and explained what was happening as they were being moved.
- In another example, we observed staff talking to relatives about transferring a patient receiving end-of-life care from hospital to home. They discussed the lay out of the patient's home and access to the building prior to making the transfer to minimise the level of distressed caused by moving the patient.
- The patients we spoke with told us that their experience with the ambulance crews was that they were friendly and respectful; they were mindful of their dignity and attentive to their needs.

Emotional support

- Staff understood the impact that they could have on patients' wellbeing and acted to emotionally support their patients during transfers.
- In one example of a transfer of a terminally ill patient we observed that crew put their patients' wellbeing ahead of a technical difficulty with paperwork. The hospital had not produced a discharge letter in a timely manner. The crew continued with the patient transfer to minimise the anxiety and distress to the patient prior to returning to the hospital for the correct documents.
- Staff also supported relatives emotionally during distressing circumstances.For example, they spent time offering verbal, emotional support to relatives travelling with patients.
- We observed one relative explicitly thanking staff for their kindness during the transport process.

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

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- The service worked with local commissioners, such as the NHS ambulance trusts, to provide services that met the needs of local people.
- Staff checked patients' requirements prior to transporting them to ensure that they were able to meet their needs
- There were low levels of formal complaints; complaints that had been received had been responded to in a timely way and in line with the provider's policy.

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

- Staff performance was monitored in terms of handover times for one NHS trust that the service worked with. However, at the time of the inspection, the same level of monitoring was not used for work with a second NHS trust.

Service planning and delivery to meet the needs of local people

- At the time of inspection the service held contracts with two NHS ambulance trusts. This was to transport patients between hospital sites. The number of vehicles provided varied on a day to day basis depending on the needs of the service.
- The NHS trusts and St John's ambulance checked that they were meeting the agreed number of contracted hours and reviewed the number of patient journeys made.
- Staffing levels, shift patterns and availability of vehicles were adjusted in line with the NHS trust contract's requirements.
- Staff involved in transporting patients receiving end-of-life care had received specific training on this topic and were aware of the correct care pathways and protocols.
- The managers monitored resource issues including staff availability, staff sickness rates and numbers of operational vehicles at each location. They also checked if the service provided met the correct number of contracted hours stated in the NHS contracts, as well as the number of patient journeys made. This information was collated weekly and reviewed at monthly meetings. This enabled the service to monitor whether or not resources were available in the time required.

Emergency and urgent care services

Meeting people's individual needs

- There were a range of measures in place to ensure that staff could meet patient's needs.
- All information that had been received as part of the booking process was communicated to staff and additional conversations were held between staff from different services at handover points.
- A telephone interpreting service was available at all times and translation services could be arranged promptly. Staff knew how to arrange the service.
- The staff we spoke with were sensitive to balancing patients' health, spiritual and cultural needs. Staff were able to escalate concerns to NHS or St John's clinical teams to access advice if a patient's health rapidly deteriorated during transfer so that an appropriate plan for management could be made.
- Staff understood do not attempt cardio pulmonary resuscitation orders and checked for the presence of these when working patients who were receiving end-of-life care.
- Staff told us, and we observed that, patient's requirements and preferences were discussed and practical adjustments were made, to meet individual needs prior to transporting patients. For example, longer journeys were planned with comfort breaks, both seated and stretcher vehicles were available, and 'same sex' crew members could be provided, where required.
- All vehicles carried special communication aids, such as picture charts, to support non-verbal communication.
- Staff had completed specific training, such as in dementia care, to meet their patients' needs. This training included discussions around managing and supporting vulnerable adults. The ambulance crew we spoke with were aware of internal reporting procedures for safeguarding concerns.
- Staff had completed online training in conflict management. This meant that they were aware of the need to use minimal restraint or force in response to aggressive or violent patients. However, staff commented that they would like to have additional and specific training on techniques that could be used to protect themselves and patients during these incidents. They had not specifically raised with the management team previously; the training manager told us that they would now explore options for providing this training. The management team provided us with an update, after the inspection, which noted that this training was now scheduled for implementation during 2018.

Access and flow

- At the time of the inspection, we noted that a service was provided at different times over the entire week including shifts during the day and the night, and over the weekend. Three ambulances were required for the end-of-life transport services contract with an NHS trust each day, Monday to Friday. Patients were allocated and referred to the service by the NHS ambulance trusts.
- The service had additional vehicles at the two locations that we visited to ensure that the service could continue in the event of vehicle breakdown.
- Staff performance was monitored in terms of handover times for one NHS trust that the service worked with. The monitoring of handover targets was linked to records of which staff were working on any given shift. This data was regularly reviewed to identify areas for service improvement. However, at the time of the inspection, the same level of monitoring was not used for work with a second NHS trust.

Learning from complaints and concerns

- There was a formal complaints policy. Staff were aware of this policy and acted in line with it.
- We saw that the ambulance crew members carried leaflets with them to hand out to patients about how to complain or provide service feedback.
- The ambulance trusts that the provider worked with forwarded information about any complaints they received in relation to St John Ambulance staff.
- There was a regional assurance manager who had overall responsibility for ensuring the service responded to formal complaints within the agreed timeframe and for keeping the complainant updated if there was a delay.
- The local ambulance station manager was responsible for investigating complaints, such as collecting evidence and statements from staff. They reported the outcome of the investigation to the assurance manager.

- The policy stated an acknowledgement would be sent to patients within three working days of receiving the complaint. A root cause analysis investigation would follow and a full response was provided to patients within 20 working days.
- If a complaint was received by one of the NHS ambulance trusts, but involved St John's staff, then there was a process for sharing the information in a timely manner. Staff told us that, where necessary, there was a process for joint investigation and learning. In the event of the complaint involving sub-contracting organisation such as the NHS ambulance trust there was a process for the joint investigation and learning.
- We noted that the service had received three formal complaints in the past year and these had been dealt with in line with the provider's policy.
- We asked staff how learning from complaints was shared to prevent a recurrence of the concerns raised. They were able to cite examples of actions taken, such as the provision of additional training to groups and individual members of staff.

Are emergency and urgent care services well-led?

We do not currently have a legal duty to rate independent ambulance services.

We found the following areas of good practice:

- There was a national, corporate vision, strategy and values, which most staff were aware of and shared.
- The provider had made a commitment to continuously improving the quality of the service. There had been a range of organisational restructuring activities and the implementation of standardised processes. Staff understood the rationale for these activities and cited examples of how this had led to improvements in their day-to-day practice.

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

- Staff feedback was usually well managed. However, staff meetings with frontline staff at one of the locations had not taken place for eight months. Alternative arrangements had been made to support staff, but some staff concerns had remained unaddressed.
- Risk registers had not been updated to reflect risks to patient confidentiality identified at an earlier inspection of one of the provider's other services. The risks related to posting patient report forms without additional security or tracking. In this case, the provider's efforts to standardise and cascade information to staff across their regional structures had not been effective.

Leadership / culture of service related to this core service

- There had been a review and reorganisation of the senior management and regional management structures within the organisation, this had led to the formation of four "super regions".
- The management team in this region consisted of a sector manager for Ambulance Operations and an Operations Manager for Events. They were supported by a station manager, event delivery managers, service delivery co-ordinators and station team leaders.
- We spoke with the regional director who had oversight of all operations in the North East and was accountable for providing good quality of care.
- There had been a period of service transformation, due to restructuring by the provider and changes to local contracts. This had had direct impact on frontline staff; some staff had been made redundant, some had been moved into other posts and some staff had left the organisation.
- Nevertheless, the staff we spoke with were positive about the leadership team, and were able to identify their roles and responsibilities. The management team were approachable and staff were comfortable in escalating any concerns.
- Several members of the senior leadership team also volunteered for active work on ambulances. This meant that staff who did not come into the ambulance station during office hours met the management team. The management team were also able to support staff and monitor staff behaviours.

- We observed members of staff interacting well with the management team during the inspection.
- There were appropriate staff reporting procedures to escalate concerns about co-workers and colleagues through the operation of a whistleblowing policy.

Vision and strategy for this core service

- St John Ambulance is a national organisation which promotes itself as "the nation's leading first aid charity".
- There has been a period of structural reorganisation dating back to 2012, with ongoing changes at the time of the inspection. In 2016, a new five-year strategy was launched to support the direction of changes to the organisation. For the 2017/2018 period one of the stated priorities for the business is to support communities through specialist ambulance services. The strategy has also included further reorganisation to the business. For example, in the past year there has been a review and reorganisation of senior management and regional management structures.
- In 2015 the organisation also developed a set of core, organisational values to share and promote with staff at all levels. These are: humanity, excellence, accountability, responsiveness and teamwork. The staff that we spoke with were aware of the core values, and these were widely advertised throughout both of the locations that we visited.
- Staff at all levels had an awareness of the structural reorganisations and associated changes to the planning of the business. The ambulance crews and management teams that we spoke with openly discussed challenges to the provision of the service in light of a changing NHS working environment and contracting system. They acknowledged difficulty around retaining staff in an uncertain period. However, the majority of staff we spoke with were satisfied with how these challenges were being managed by the organisation.
- Staff were positive about efforts by the provider to further standardise aspects of the service through the restructuring process and instigation of centralised systems, for example, for reporting incidents, safeguarding concerns and fleet management.

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

- There was a governance framework in place with associated staff policies and protocols. These frameworks and procedures well understood by staff. This ensured, for example, the timely reporting and investigation of incidents and safeguarding concerns.
- Monthly governance meetings were held locally, which were the fed into the national governance meetings. Content of the governance meetings was sufficient to ensure that the discussions held supported the delivery of good care.
- The service had undergone restructuring in 2016 and the new quality and standards directorate had recently commenced work. The service told us this directorate was focussed on consolidating and strengthening the activities of the health and safety, clinical and audit and assurance functions under one directorate, this would provide a stronger governance framework.
- There were risk registers in place for each specific directorate within St John Ambulance, these fed into the national St John Ambulance risk register when the risk was high.
- We looked at the national and the regional risk register for ambulance operations. The registers we reviewed were up to date and included actions assigned to staff members to mitigate the risks highlighted. Progress against the actions to mitigate risks was recorded and up to date. The regional assurance manager met regularly with the registered managers to review the risk registers and ensure mitigating actions remained appropriate.
- We identified one risk to patient confidentiality during our inspection. Patient report forms, which included patient identifiable sensitive information, were being posted through the postal system. There was no formal process for tracking they had arrived at an external scanning and archiving facility. This risk had also been identified at an inspection of a regional St John Ambulance service carried out in March 2017. The actions that the provider told us they would take included adding these risks to the local and national registers, implementing cross-checking of patient record forms by station team leaders and an auditing regime.

These processes were not in evidence at the time of our inspection of the North East region in October 2017. We were informed by the management team, after the inspection, that some sample audits had been conducted using patient report forms from events in September and October 2017. These audits reviewed 58 events in the North region and identified no breach of patient confidentiality.

- The maintenance contract for vehicles was managed through a set of key performance indicators. These indicators are measurable and demonstrate how well an organisation is performing. The indicators were reviewed monthly and acted upon appropriately; extraordinary incidents were handled by the regional teams through a direct contact with the contract provider.
- The service had carried out an audit of patient report forms in relation to activity provided for one of the two NHS ambulance trusts that it held contracts with. The audit was carried out in October and November 2016. The aim was to establish whether or not consistency was maintained and record keeping was in line with best practice. The audit identified areas for improvement which had been communicated to staff. The service planned to re-audit the patient records to check that changes had led to improvements. However, patient records forms had not been audited for the second ambulance trust.
- Patient record forms were sent to an external provider for them to upload to an electronic database. The external provider flagged incomplete or unintelligible handwriting to the quality assurance team. It was the role of staff members or volunteers to review the forms to identify the missing information. All patient records used for the NHS contracted work were returned directly to the specific ambulance trust.
- The service undertook other of audits to identify areas for improvement. For example, audits for infection control and maintenance of vehicles were carried out. Learning was shared through the intranet and posters as it was identified.
- However, we found that the service had limited systems for monitoring the quality of the clinical care that they provided. We also noted that the service did not routinely monitor the promptness of their service, for example, in terms of handover times for all patients, although this was in place for some patients. At the time of the inspection there were some initial plans in place to develop auditing systems for the quality of care, which we discussed with the member of staff responsible.

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

- The provider had a number of systems in place to keep staff informed and receive feedback from their staff. For example, there was a monthly staff newsletter and regular staff meetings at all levels of the organisation.
- We noted that staff meetings at the Gateshead location for ambulance crews had not been held regularly in the past six months. This meant that concerns raised at a meeting earlier in the year had not been fully addressed. The manager for ambulance operations explained that this hiatus was due to changes in staffing over this period; staff meetings had been deemed inappropriate during a period of significant contract changes with risks of redundancies. They noted that staff had been offered alternative feedback arrangements through support and engagement sessions. The regular staff meetings were now due to reconvene.
- We found evidence of staff engagement in four of the staff files we reviewed. This was in relation to the restructuring of the organisation. We found the discussions with staff were thorough and all actions completed. We also spoke with staff who had previously been affected by the reorganisation and been made redundant. They reported this process was sympathetic and organised.
- The provider periodically carried out staff surveys, with the most recent one having taken place in 2016. This identified areas for improvement, such as improving recognition of good performance. The provider was taking action to work on the areas identified through analysis of the survey results.
- In one example, we saw there was a recognition programme to praise staff member's contribution to the organisation. This took the form of individual and team awards with personalised letters received from the regional director.

- There was a volunteer strategy in place. The service set out to increase the impact that active volunteers made across a variety of roles. The organisation planned to increase the volunteer numbers across the service, including increasing the contribution that volunteers make. We were provided with examples of where volunteers had continued to further their career in the emergency service by progressing from volunteers to paid staff members and then undertaking paramedic training.
- The service engaged with public and patients through their website, which included a section for users of the service to provide feedback about the experience of the care that they had received. There was also information about how to make a formal complaint.
- Ambulance crews carried feedback forms, as well as copies of the complaints procedures which could be distributed to patients, as required. There was an option to return written feedback by free post to the local management office.
- The information received was monitored monthly by a station manager. Monthly reports on patient feedback were produced and relevant information was shared with staff to facilitate improvements in the quality of the service. The majority of the feedback received was positive.
- The provider had commissioned an external contractor to provide a market insight assessment in 2016. This included some assessment of the public perception of the organisation. This information had been used to inform the provider's business strategy.

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

- The transport service for end-of-life care aims to provide faster discharge and admission to patients' preferred place of care. This service was shortlisted for a Health Service Journal "Dignity in Care" award in November 2016.
- The service had created a national continuing professional development portfolio which was being rolled out and used by all staff both volunteers and substantive.
- The provider used information collected from staff at different levels to inform and develop a 'national skills plan' each year. This ensured that training was tailored to staff needs. For example, information on the types of incidents recorded was used to inform the type of training that was needed. Specific training on how to complete Patient Report Forms accurately had been included in continued professional development days following concerns in this area.
- The service had developed an electronic ordering and monitoring system for their medicines stocks. This enabled the service to monitor and account for the provision of all medicines received and dispensed, including to the individual patient record forms. This system replaced a paper-based system; early reports found that this had reduced the number of medicines errors and the wider service was reviewing the new system with the expectation that it would be adopted by all of the regions.
- The service worked closely with a local clinical commissioning group and was imminently due to commence a new contract to transfer patients from GP surgeries, as required.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must take appropriate actions to identify, assess and minimise the risks arising from transporting patient records using the postal system. This includes breached confidentiality or loss of patient record risks.
- The provider must take appropriate actions to consistently monitor the quality of services, including the audit and monitoring of patient outcomes and audit of patient records.
- The provider must take action to establish and operate effectively systems and processes to prevent the abuse of service users through the provision of appropriately high-level training for staff in named, safeguarding roles, or for staff who could potentially assess or evaluate the needs of a child or young person.

Action the hospital SHOULD take to improve

- The provider should take actions to improve staff compliance in equality and diversity training.
- The provider should take appropriate actions to identify, assess and minimise the risks arising from the unavailability of equipment required for patient treatment. This includes paediatric-specific equipment, such as harnesses and pulse oximeters.
- The provider should improve systems for monitoring and acting on feedback from operational ambulance staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** • The provider did not effectively operate systems and processes for preventing the abuse of service users through the provision of appropriately high-level training of relevant staff. This is a breach of Regulation 13 (1) (2)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider did not have comprehensive systems for assessing and monitoring the quality of the service with a view to improving the quality and safety of patient care. • The provider did not have effective systems in place to assess, monitor and mitigate the risks related to carrying out the regulated activity. • The provider did not maintain a system for securely keeping patient records. This is a breach of Regulation 17 (1) (2) (a) (b) (c)