St John Ambulance

St John Ambulance London Region

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St John Ambulance London Region is part of St John Ambulance, a national first aid charity. St John provides a variety of services, including contracted emergency and urgent care, non-emergency patient transportation, bariatric transfers, paediatric and neonatal transport and first aid cover at events. The strategic direction of the organisation nationally is to provide an effective and efficient charitable first aid service to local communities. The services provided by St John Ambulance involve both employed and volunteer staff.

St John Ambulance London region provides emergency and urgent care for one London NHS ambulance trust and paediatric and neonatal transport services for two NHS hospitals. They provide a small ad-hoc patient transport service. St John Ambulance London Region has contracts with a number of organisations, which hold events in the local area and provides first aid at these events including the provision of an ambulance.

We inspected St John Ambulance London Region on 15, 16 and 19 November 2016. This was an announced comprehensive inspection, part of our national programme to inspect all independent ambulance services. We visited two locations, those being the head office and, Park Royal station, whereby, we attended emergencies and urgent care with an ambulance crew. We also attended a large event and spoke with staff and inspected equipment and vehicles. Patient transport services formed a very small part of the service; however, we attended a shift with crew to inspect patient care.

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

We found the following areas of good practice:

- We saw staff providing compassionate and kind care to patients and were supportive of their needs. Patients received dignified care and their privacy was respected. Staff were kind and provided emotional support to relatives and carers.
- There was a good system for staff to report incidents and for investigations to take place. The learning from incidents was fed back to front line staff. Lessons learnt showed actions were taken to change behaviours and provide support and training for staff.
- There were established processes for staff to follow to protect patients from the spread of infection. We saw staff using good infection control procedures and vehicles were kept clean and tidy and were well stocked.
- We saw good multidisciplinary team working and the sharing of information to provide consistent good care for patients. Staff knew the scope of their role and when to escalate concerns so patients' needs were met quickly and efficiently.
- All staff both employed and volunteers received good induction training and were able to access further training for their role.
- The planning of services was managed well and cover for contracted and event work was provided only if the suitable qualified staff were available. The service planned ahead to meet delivery and meetings between contract providers ensured the service ran as smoothly as possible. After events, meetings were held with organisations, which allowed for reflection and shared discussion so improvements could be made for future events.
- The organisation had a national vision and strategy, and regional and national support helped the strategy to be implemented locally. The organisation recognised the need to review their service and make changes to the structure if necessary.
- Staff were supportive of the leadership both regionally and locally and felt they could voice their opinions and were listened to.

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

Summary of findings

- Staff were not trained to the required safeguarding children level expected for them to perform their role. The safeguarding training for staff was not in line with the Safeguarding Children and Young Peoples: Roles and Competencies for Health Care Staff Intercollegiate document: March 2014. We were informed all staff were trained to safeguarding level one. We were told this applied to staff across the whole organisation.This concern has been identified as an organisation-wide issue and we have requested that St John's Ambulance inform us of how they intend to address it.The organisation have since provided us with a plan which details the actions they have taken to address the concerns we raised.
- The monitoring and recording of controlled drugs was slightly disjointed. We found an alteration to a recording with no reason given or signature to explain why the alteration had been made. A more streamlined system of having one book would allow for better tracking and tracing.
- We found some patient records were not being kept in the secure folders when we accompanied crew on their shifts. Some records were kept behind sun visors and this posed a risk to patient confidentiality.

Information on our key findings and action we have asked the provider to take are listed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve. We observed staff providing kind and compassionate care and patient's privacy and dignity was respected. Staff attended to patient's individual needs and were thoughtful and considerate in their approach. Staff were able to support those patients who were vulnerable and provided emotional support to patient families. Staff followed guidelines relevant to their role to provide effective patient care and treatment. The organisation met with other providers to ensure services were planned to meet the needs of local people. There was a good training system and a comprehensive induction programme. Staff were required to complete annual competency assessments to ensure they were up-to-date with latest guidelines and were competent to provide care and treatment within the scope of their role. The environment and equipment was visibly clean and staff followed guidelines to control the spread of infection, such as following good hand hygiene practices and wearing personal protective equipment when necessary. There was a national vision and strategy, which reflected the values of the organisation. Staff understood the vision of the organisation. The organisation recognised the need for restructure and reorganisation to improve the quality of the service. There was recognition for the need to improve the quality of data being collected. However: The safeguarding training for staff was not in line with the nationally recognised safeguarding children training levels. Staff were not trained to the correct level for their role. However, staff were able to describe signs of abuse and how they would refer safeguarding incidents.This

Summary of findings

concern has been identified as an organisation-wide issue and we have requested that St John's Ambulance inform us of how they intend to address it.The organisation have since provided us with a plan which details the actions they have taken to address the concerns we raised.

We found a recording in the controlled drugs book had been altered with no explanation why. The service had two controlled drugs books, which made the system slightly disjointed.

Staff we observed on an emergency shift did not keep the patient records in the zipped wallet provided by the service. Records were kept behind the vehicles sun visor and we found confidential documentation dating back from June 2016 in the glove box of the cab compartment of the vehicle.

St John Ambulance London Region

Detailed findings

Services we looked at
Emergency and urgent care.

Detailed findings

Contents

Background to St John Ambulance London Region

St John Ambulance London Region is part of St John Ambulance a national charity which provides first aid. 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 provides first aid across the country and services include emergency and urgent care, non-emergency patient transport, and event first aid ambulance provision. The aim of the organisation is to offer first aid to those who need it and to ensure communities are provided with first aid trained staff. Both employed and volunteer staff work within the organisation.

St John Ambulance London Region provides contracted emergency and urgent care for one NHS trust. Currently through the contract, St John Ambulance London Region provides four ambulances for emergency and urgent (including bariatric) care. The service is operated from two locations, the main hub being Park Royal and a smaller hub based at Crystal Palace. St John Ambulance provides a paediatric neonatal transport and retrieval service for two NHS hospitals. The service has seven bespoke ambulances and one paediatric support unit. The prime purpose of the service is the management and safe transportation of medical teams, paediatric patients, and relatives to and from district general hospitals to other paediatric intensive care environments under emergency conditions. St John Ambulance provides a small ad-hoc patient transport service and first aid support at public events. Specific vehicles for first aid events are based at various locations across London.

The London Region was formed in 2012, following an organisation restructure. Little changed geographically, but the management structure was streamlined and the regional management team was developed to provide a more people and patient care centred approach, which included key outputs of increasing quality and controlling finances. The Ambulance Operations became its own function and a new management team was recruited to cover four sectors, North West and West Midlands, North East and East Midlands, South East and South West and London and East.

The organisation is undergoing a review and restructure of their senior and regional management team to support their strategic delivery.

We visited head office and their main emergency and urgent care station at Park Royal. We completed interviews with senior management at head office and the duty station manager at Park Royal. We travelled with the emergency ambulance crew who attended emergency and urgent care patients. We visited the neonatal and retrieval services based at two NHS hospitals. We visited an event and checked both emergency operation ambulances and those being used in events. We travelled with a crew for the transport of patient's service.

We inspected St John Ambulance Service London Region on 15 and 16 November 2016 and inspected an event on 19 November 2016. This was an announced comprehensive inspection to check whether the service

Detailed findings

at this location was meeting the legal requirement for regulated activities associated with the Health and Social Care Act 2008 and to ensure the service was safe, effective, caring, responsive and a well-led service.

Our inspection team

A CQC inspector led the team with assistance from another CQC inspector and two specialist advisors, one a paramedic and one with a paramedic and management background.

Specialist advisors are granted the same authority to enter registered persons' premises as the CQC inspectors.

How we carried out this inspection

We visited the emergency and urgent care services over a two-day period and visited an event for one day. We visited the main emergency operations station at Park Royal and spoke with the Duty Station Manager and inspected ambulance vehicles and the sluice room within the station. We travelled with emergency crew on one ambulance during their operational shift to observe crews care while interacting with patients. We visited the neonatal and retrieval service at two NHS hospitals and spoke to staff. The inspection team accompanied crew for the patient transport service and attended an event to speak with staff and view the operation, equipment, and vehicles. We viewed staff records to check up-to-date certificates of employment and training documentation. We also viewed local and national policies to ensure staff were working to these. We checked medicine management of prescription and controlled drugs at head office and during operational shifts. We viewed records to prove servicing of vehicles was current and spot-checked eight vehicles to ensure equipment and cleanliness was up to standard.

Prior to the inspection, we viewed a range of documentation the provider had supplied and information we held about the service. We also asked other organisations to share their views on the service.

During the inspection, we spoke with 21 staff, including emergency transport attendants (ETA), emergency medical technicians (EMT). Members of the senior team included the regional director, sector manager emergency operations, the regional assurance manager, regional clinical manager and the head of safeguarding, Park Royal station manager, and other lead managers for training, fleet, and human resources. We also spoke with relatives of patients.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

These five key questions formed the foundation of our inspection and were the areas we looked at during the inspection.

We would like to thank all the staff and patients for sharing their time, views and experiences of the care provided by St John Ambulance London region.

Facts and data about St John Ambulance London Region

Incidents

For January 2105 to June 2016 there were 947 incidents reported:

417 classified as insignificant

514 classified as minor

Detailed findings

15 classified as moderate

1 classified as major

Staff sickness

Between September 2015 to September 2016

Permanent staff sickness = 412. 11 days lost

Appraisal rates

Employed staff 100%

Volunteer staff – 21 out of 72 cohorts had received an annual appraisal. (The deadline for completion is end of March 2017).

Complaints

For 2016, the service had received 10 complaints.

Notes

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

St John Ambulance London Region provides emergency and urgent care services for one London NHS ambulance trust under a contractual agreement. There are two stations, the main one based at Park Royal and another small hub at Crystal Palace. The service provides four ambulances and emergency transport crews supporting the NHS ambulance trust with emergency calls. One of the vehicles is adapted to provide bariatric support. Regular provision incudes: responding to emergency calls via the NHS ambulance service control, treatment of patients, transportation of patients and relatives and reporting treatment on the NHS ambulance trust paperwork. For the contracted emergency operations, the service provides seven day a week cover. Shifts are 12 hours and operate from 7am through to 7pm.

The service provides paediatric neonatal transport for two NHS hospitals. They provide trained emergency transport attendants operating 365 days per year on a 24 hour, seven-day week schedule. The service performs with seven bespoke ambulances and one paediatric support unit. The service also provides a small ad-hoc patient transport service.

St John Ambulance provides an event service offering first aid care in communities and at major events.

Summary of findings

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

- We saw staff were compassionate, kind and considered patient's needs. Patient's privacy and dignity was respected and staff were understanding of the emotional support families, friends and carers required. Staff provided support to vulnerable patients when providing care and treatment.
- There was a good incident reporting system and staff were confident to report incidents of all levels. Incidents were investigated and actions were taken to improve quality of care. The sharing of lessons learnt was fedback to staff through team meetings, the organisations intranet, and newsletters.
- Staff followed national guidelines to provide effective care to patients. There were good systems to ensure sufficiently qualified staff covered shifts. The planning of services was made in advance so alternative arrangements could be made if a shift could not be covered.
- New staff received good induction training and staff were required to complete an annual competency assessment to ensure they were and up to date with latest guidelines and policies to fulfil their role.
- We saw staff using cross infection techniques to prevent the spread of infection. For example, good hand hygiene and wearing personal protective equipment when necessary. Vehicles were visible clean, maintained and well stocked. All vehicles had an MOT, insurance and had received regular servicing.

Emergency and urgent care services

- There was a national vision and strategy and staff understood the values of the organisation.
- At the time of our inspection, the organisation was restructuring and developing new ways of collecting data to improve and monitor the quality of the service.

However:

- Safeguarding training was not in line with national safeguarding children standards. Staff were not trained to the required safeguarding level as set out in the Safeguarding Children and Young Peoples: Roles and Competencies for Health Care Staff Intercollegiate Document: March 2014.This concern has been identified as an organisation-wide issue and we have requested that St John's Ambulance inform us of how they intend to address it.The organisation have since provided us with a plan which details the actions they have taken to address the concerns we raised.
- We noticed a discrepancy in the controlled drugs book with no explanation or justification why. There were two controlled drug books and this caused confusion with tracking and tracing.
- Staff we observed on one shift did not use the secure wallet to keep confidential patient record forms. We found forms kept behind the sun visor and we found confidential paperwork in the glove compartment dating back to June 2016.
- Stations did not have their own risk register, which meant there was a possibility of local risks not being captured and acted upon.

Are emergency and urgent care services safe?

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

- Although staff knew how to report a safeguarding concern, we were concerned staff had not been trained to the required safeguarding level for adults and children. Staff did not know what level of safeguarding training level they needed to complete their role.
- We found the recording of controlled drugs confusing with two books and we found a log had been crossed out and altered with no account why.
- The service was unable to monitor staff compliance with mandatory training, as there was no target. The training spreadsheet showed not all staff had completed their mandatory training.
- During our inspection, we observed some patient record forms (PRF) were not stored in the required zipped bag but stored behind the sun visor. We found confidential documentation dated back to June 2016 kept in the glove compartment.

However:

- Staff we spoke with knew how to report incidents. There was a good system to report incidents of all levels, and staff could describe learning that had taken place as a result of outcomes from investigations.
- Staff followed infection control guidelines and took measures to stop the spread of infection. Vehicles and stations were clean and tidy. Servicing, MOT and insurance for ambulances were all up to date.
- There were systems to measure the quality of patient's records. Staff used the correct forms provided by the NHS ambulance service to ensure consistent records were kept for patient care and treatment.
- There were good systems and processes to provide sufficient and suitable qualified staff to cover contract and event work. Staff knew how to request additional support if a patient deteriorated.
- St John Ambulance worked well with other organisations to put in place effective systems should a major event occur.

Emergency and urgent care services

Incidents

- The service had an incident reporting procedure policy to guide staff. The policy indicated a pathway for staff to follow in the reporting of incidents and investigatory processes.
- Staff reported incidents using an incident reporting form (IRF). There was a separate IRF for vehicle incidents, which allowed staff to provide detailed information on the type of vehicle incident, third party involvement, and detail of witnesses.
- Incidents were categorised as moderate, major, or catastrophic impact and were reported to the service manager or on line call manager. Incidents were collected regionally and the quality and assurance group reported at a national level.
- We spoke with the regional assurance manager for London who told us the reporting culture in London was the highest nationally. Staff in London reported incidents of all levels and types and they therefore, had more low-level incidents reported than across the country.
- St John Ambulance had a clear and transparent incident reporting system and an open culture where staff told us they felt they could raise incidents when required. Incidents of all natures were reported regardless of the severity. Staff said they received the feedback and learning from incidents.
- Staff we spoke with said feedback was received through the form of an action tracker, which was fed back to the reporter and shared through one to one discussion with their line manager and during team meetings. We were told a monthly regional briefing and poster was provided which gave details of incidents and actions taken.
- There were 947 incidents reported in the reporting period January 2015 to June 2016. There was one incident rated major, 15 incidents moderate and 514 incidents rated minor and 417 insignificant. The majority of incidents related to near miss incidents in vehicles. The major incident related to a patient falling while in the care of ambulance staff. The reporting log showed the actions taken as a result, with the sector manager ambulance operations London and East regions leading the investigation. The two staff members involved received retraining in patient handling and amendments. A letter of apology was sent to the patients relatives and the CQC was notified of this incident.
- The Incident Reporting Analysis 2015/2016 for Quarter 3 was detailed and segregated each incident into categories. For example, for service administration incidents there were 36 incident reports covering areas such as, breach of contractual terms in staffing, equipment out of date, personnel shortage, and loss of service user.
- There were 83 incidents under the heading training, which related to delivery of internal assessments and delivery of training.
- For medical devices there were 56 incidents reported, 52 were reported by mid-August 25% related to equipment out of date. All incidents reported were received from event services treatment centres. No out of date equipment was reported by emergency operations.
- Unavailable medical devices made up 18% of total medical device incidents. One report was received from ambulance operations the rest from event services involving vehicles and treatment centres missing basic essentials. Unavailable medical devices largely pertained to inadequate kitting of event services vehicles and treatment centres.
- 32% of incidents received for non-medical devices in 2015 related to broken storage receptacles on ambulance operations and event services vehicles and damaged furnishings in stadia treatment areas.
- There were 108 clinical incidents for the reporting period for such subjects as, poor documentation standards, understaffing/skill mix concern, delayed care, lack of equipment, care provided by inappropriately trained staff.
- The organisation, as part of their health and safety training provided staff and managers with training in investigatory processes, which involved root cause analysis (RCA). Senior management had received RCA training through The National Examination Board in Occupational Safety and Health.
- The duty of candour (DoC) is a regulatory process, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The organisation had a clinical procedure 'Being open when things go wrong and the duty of candour.' This procedure gave directions on how St John Ambulance would meet the requirements of the DoC. Clear

guidelines were listed on how staff should conduct themselves and actions they should follow to meet the requirements. However, during our inspection ambulance, staff we spoke with were not familiar with the term DoC and they told us had not received training related to this regulation. We did, however see a good example of DoC, whereby, following an incident the organisation contacted the patient to apologise, and followed through an investigatory process, which involved sharing the learning and outcomes of the investigation.

- If an incident occurred whilst staff were completing NHS work, they would 'joint' report the incident through the NHS provider's incident reporting forms as well. We were told regular meetings took place between St John Ambulance and their NHS providers and feedback on incidents were discussed and lessons learnt shared. We viewed minutes of meetings between the NHS providers and St John Ambulance, which showed discussions, took place on incidents and outcomes were discussed.

Mandatory training

- Mandatory training took the form of practical sessions and e-learning modules. Both employed and volunteer staff completed mandatory training.
- Managers had overall responsibility for ensuring staff completed their training.
- We viewed the ambulance crew training master sheet, which listed all staff members' names and the core courses of training staff took. Courses included introduction to safeguarding, resuscitation training, medicine management, information governance, and conflict management. Staff then took additional courses relevant to their role. For example, bariatric training was offered to those staff operating bariatric ambulances and patients.
- We were told infection prevention control (IPC) was not part of mandatory training, but staff had ad-hoc training and cross infection assessment annually as part of their revalidation. However since our inspection, we have been told IPC was covered in the organisations role competency training and as part of annual revalidation/ clinical competency, whereby assessment tested IPC skills and knowledge.
- The compliance target for mandatory training was 100%. We were told if not completed employees and volunteers were made non-operational until such time as they completed their training. From the training sheet provided, we could see certain staff were required to complete training as dates indicated so. We were told the spreadsheets were updated on a monthly basis and sent to the national training team for monitoring against specific deadlines.

Safeguarding

- Staff were trained to level one safeguarding. This was not sufficient for the role staff undertook when providing emergency and non-emergency treatment for patients. We were told this applied to all staff across the organisation.This concern has been identified as an organisation-wide issue and we have requested that St John's Ambulance inform us of how they intend to address it.The organisation have since provided us with a plan which details the actions they have taken to address the concerns we raised.
- The safeguarding children training was not in line with the Safeguarding Children and Young People: Roles and Competencies for Health Care Staff Intercollegiate Document of March 2014. The document clearly states ambulance staff including ambulance communication centre staff should be trained to level 2. Level 2 is all clinical and non-clinical staff that have any contact with children, young people, and/or parents/carers.
- Staff had completed an introduction to safeguarding which involved completing five modules, but these modules were only specific to training provided for level one safeguarding. We were therefore, not assured staff had received the appropriate safeguarding training for their role.
- Staff had not received training for female genital mutilation (FGM), child slavery, or child sexual exploitation, even though the organisations safeguarding policy had procedures in place to deal with incidents of this nature.
- Two staff we spoke with in frontline emergency and care duty were not familiar with the Gillick competency and Fraser guidelines. These guidelines are used for consent in children under 16 years of age. However we were told the role competency training for clinical roles included consent and the Mental Capacity Act.
- Staff updated safeguarding training every three years. The training spreadsheet showed blank dates for many staff for the introduction to safeguarding.
- Station managers had not received the relevant additional safeguard training to support staff. Staff said they would speak to the regional or national

safeguarding lead for advice. The safeguarding policy had recently been updated to reflect new guidance in line with the intercollegiate document. However, there were no separate policies for children, and young adults and a separate adult's policy as expected.

- Staff we spoke with on the frontline operations did have a general good understanding of safeguarding and signs of abuse and gave good examples of safeguarding alerts and when to escalate a concern. However, they told us they did not always receive feedback unless they contacted the safeguarding team.
- Staff working for the NHs ambulance trust used the guidance and proforma used by the organisation for safeguarding alerts. Staff were able to contact an operational line for advice from the NHS provider. All safeguarding concerns for the NHS ambulance trust were referred directly and managed by the trust.
- Volunteer staff at the event we inspected kept a small safeguarding pocket sized booklet, which provided guidance on actions to take with a safeguarding concern.
- Safeguarding incidents reported for the London region from January 2016 to March 2016 were 19. For April until June the figure was 31 and from July to September, the figure was 47. So far, from October, there were 10 reported incidents. There were a larger number of reported incidents from July to September due to 21 referrals being made during a large event.
- We viewed safeguarding cases reported and a clear pathway had been followed for actions taken. Several safeguarding incidents involved children under 16 years of age.

Cleanliness, infection control and hygiene

- We viewed the new infection prevention control (IPC) policy, which was relaunched in June 2016, to provide more clear guidance to staff on IPC.
- All staff completed infection control training on induction and completed an assessment to test competence at their clinical re-validation.
- The main station we visited was visibly clean and tidy. We checked eight ambulances and all appeared clean, including areas not visible to patients.
- We viewed records kept of vehicles deep clean schedule, which an external company completed every 12 weeks. Deep cleaning involved steam cleaning ambulances to ensure harmful bacteria was eliminated. A swab testing audit was then competed pre and post cleaning to see if the deep clean had been effective.
- We viewed the audit pre and post swab testing results for September 2016 for 17 crusader ambulances and other vehicles. Tests included swab taking of areas such as, trolley beds, sink area, grab rails, carry chair and drivers inner door handles. Results showed an average score above 85%, the majority being above 90%.
- We saw detailed guidance on hand hygiene. Staff were told to follow the 'five moments of hand hygiene', that was:

1. before patient contact
2. before n aseptic task
3. After bodily fluids
4. After patient contact
5. After contact with patient surroundings

- We viewed a random selection of five hand hygiene audits conducted over the last six months. The supervisor conducted observations of staff and results showed 100% compliance for all audits. Audits showed staff had followed the five 'moments to hand hygiene' and were 'bare below the elbows', which is best practice for preventing the spread of contamination
- Staffs were given advice on how to use washbasins that did not have elbow operated taps. Instructions included how to turn the tap off using paper towels.
- Cleaning equipment for ambulances were marked with yellow stickers and equipment for general stations were coded blue. We noted colour coded mops and buckets for cleaning were used in line with good practice.
- We viewed a vehicle IPC audit of 29 September 2016, undertaken by the station team leader at Crystal Palace. Areas checked, for example, included vehicle steps, tail lift and rails, vehicle cab interiors, radio equipment and phone, whether deep clean records were present, heating and ventilation, medical gases, bags and equipment and sharps box not being ¾ full. A comment was made next to each area as to whether they were compliant. We saw the vehicle had last been deep cleaned on September 28 2016 and this was recorded in the audit. The audit report, included areas the station team leader could comment on deficiency details and corrective action taken and who this was reported to. For this audit, there were no actions to take.

- There were 24 IPC incidents reported for the year 2016. Eighteen related to unsafe waste management, four to exposure of body fluids one to lack of personal protective equipment (PPE) and one related to 'other. Actions taken included extra training and reminders to staff of the correct procedures to follow.
- All ambulances we viewed had hand-sanitising gel available. Staff had access to handwashing sinks at hospitals' emergency and other departments and at the main station.
- We observed staff washing their hands after caring for patients. PPE, such as gloves, aprons, shoe covers and full body disposable suits were provided for staff, and there was plenty of stock available at the main station. Protective masks were available; however, we observed on one operational ambulance they were not sealed and appeared somewhat dirty.
- We were told staff cleaned all areas of the ambulance in between patients and spillage kits were made available on all ambulances we viewed. We saw cleaning schedules staff had completed to show they had cleaned the ambulances.
- Staff were provided with sufficient uniform to allow for change if need be. Staff were responsible for cleaning their own uniform.
- Volunteers acted as vehicle custodians for the neonatal paediatric service, to oversee the cleaning of the two vehicles being used.
- A national audit programme introduced in 2016 included infection control audits such as hand hygiene. Regional assurance managers reported quarterly on IPC audits.

Environment and equipment

- From January 2016 to June 2016 there were there were a total of 49 ambulances in operation and five cars.
- We were told the average age of the fleet for NHS contracts was four years. There were 40 ambulances within the fleet less than seven years old.
- Information provided told us 100% of the drivers were up to date with their licence information uploaded onto the system and 100% of drivers had their qualifications confirmed and recorded.
- Staff completed a vehicle daily inspection checklist at the start of the day. Such checks include vehicle exterior, engine compartment, primary response bag, medications, oxygen bag, PPE, and lifting equipment.
- We checked one vehicle at the neonatal unit and one vehicle at the retrieval service in London. Both vehicles were in good condition and well maintained. They both had service records up to date MOT and insurance and equipment was in working order.
- Ambulances used for NHS trust contracts were laid out to the trusts specifications. For the neonatal unit and retrieval units, ambulances were adapted and equipped to meet the needs of the patients and to allow the NHS service to bring additional equipment on board if necessary. Each ambulance was EC Whole Vehicle Typed Approval (ECWVTA), which is based around EC directives and provides for the approval of whole vehicles in addition to vehicle systems and separate components. This certification is accepted throughout the EU without the need for further testing until a standard is updated or the design changes. We were told the neonatal ambulances had the latest Euro six engine vehicles, which met EU emission standards.
- For emergency services, again ambulances were set out to the trusts specifications. One bariatric ambulance had stretcher chair and ramp adapted to accommodate bariatric needs. During the inspection, the crew told us the pump, which inflates the additional mattress segments when the stretcher was being used for bariatric cases, was broken and as such, one was being shared between two vehicles. This had been reported and we were told the organisation was in the process of having this repaired.
- Each ambulance was set out the same way in respect to the position of the stretcher chair and internal cupboards and fixings. All consumables were laid out the same so staff could access equipment easily in an emergency.
- The older ambulances were used for events and incidents reported on lack of equipment or broken equipment were higher for the volunteer event section. We viewed an ambulance at an event we inspected and found all equipment to be serviceable and in date. The ambulance was readily stocked with consumables, equipment and the ambulance was visibly clean and tidy. Documentation on deep cleaning for the vehicle was up to date.
- Single use blankets, PPE, defibrillators, and masks were available on all vehicles we inspected.
- We viewed the schedule of funds made available for the replacement of defibrillators to be spent by the end of

2016. The documentation showed there were plans and sufficient funds in place to provide a newer more updated version of defibrillators to be delivered through 2017.

- A vehicle daily checklist was completed by staff prior to a shift. We were told staff had 30 minutes to inspect and prepare the vehicle. Checks included vehicle exterior, cab area, saloon, engine, medications, PPE, lifting equipment; oxygen bags were checked and logged.
- We viewed the service and maintenance work for the month of September 2016. The list showed each ambulance planned service schedule and task details involved.
- A maintenance company contracted nationally serviced and repaired vehicles. The company went through a tender process and a service level agreement was in place. A third party agency completed audits for the garage to ensure they were compliant.
- The same maintenance company provided emergency cover if a vehicle broke down and needed a tyre replaced. A direct emergency number was provided for staff to use in emergencies.
- Another company also supplied emergency cover for vehicle breakdown. We were told the organisation was in the process of negotiating with a large emergency breakdown provider to provide emergency assistance that would give priority to their vehicles.
- The process for servicing of vehicles was to book the vehicle six weeks in advance. A display screen in the man station flagged up when the vehicle was due an MOT.
- From 1 October 2016, a new post for the fleet regional manager for the South was put in place. They oversaw the complete fleet management. A fleet coordinator for London oversaw all vehicles were complainant.
- We viewed the main station at Park Royal. The station was spacious, secure, and visibly clean. The NHS ambulance trust completed regular environment audits of the station. The station had a sluice room which was colour coded to allow a good flow from the dirty zone through to the clean zone. Staff were able to use the sluice room to get equipment to clean ambulances.
- We saw a good stock room with plenty of stock for staff to replenish vehicles. We were told stock was on a next day delivery and staff on the frontline told us they did not have a problem with running out of consumables.
- Keys for ambulances were kept in secure locked cupboards within the station.
- We observed containers kept on vehicles for the disposal of clinical waste and sharps containers were secured in place to avoid spillage. At the end of shifts, staff were able to disposed of clinical waste into special containers for specialist collection.
- Control of substances hazardous to health (COSHH) information was available for staff to access. COSHH information allowed staff to follow best practices when handling certain chemicals and medical gases.
- Child restraints were available in all NHS ambulances and were in good working order.
- Faulty equipment on board ambulances were reported to the station manager and a decision would be taken as to whether the vehicle should be taken off the road. For the NHS ambulance trusts, other vehicles were available in case a vehicle needed to be withdrawn from service. The maintenance garage was situated close to the main station and were able to fix any problems speedily.
- During our inspection staff told us, the satellite navigation system frequently sent the vehicle down roads inappropriate for the size of the vehicle (in excess of 3.5 tonnes).
- Staff told us the hand held radios issued, the batteries frequently failed and there was no ability to charge them on the vehicle, which meant the vehicle had to be returned to the station in order for batteries to be replaced. Staff told us the issue had been raised with their managers.
- Staff said only one radio was issued per vehicle instead of per person. In the event of an emergency and crew being separated from, each other there was no way for them to contact each other or the control room.
- There was a system to ensure vehicles taken out of service were disposed of correctly to make sure they did not end up in undesirable situations. We were told the service used the NHS security system for the disposal of old vehicles.

Medicines

- There was a medicine management policy dated June 2015 and local operating procedures for staff to follow. Staff we spoke with knew what medicines to use and how to use them within their scope of practice.
- Medicines were sourced on a local basis from pharmacies with appropriate licence to supply.

Medicines were supplied for use by employees and volunteers who were appropriately trained in standard delivery packs. These packs contained general sales list of medicines for the alleviation of pain and allergy.

- Where advanced life support was required, mainly at events, appropriately trained employees or volunteers were issued with a full range of prescription only medicine to fulfil the need within the scope of schedule 17 of the Human Medicines Regulation.
- Controlled drugs (CD) were issued to appropriate doctors and paramedics for use from the licensed site.
- Health care professionals (HCP) non-prescribers were required to undertake mandatory medicine management annually through e-learning modules. All HCP including doctors and prescribers had to complete e-learning assessments to ensure they were aware of policy as applied to first aid staff.
- The protocol for CD access from headquarters involved an authorised list of staff and they had an access code to take the CD key from a secure safe, which tracked who had access the date, time and when it was returned.
- The authorised person accessed the outer CD storeroom via a key fob and entered a safe code into an inner room where the safe was kept. CD's were then checked and booked out to an event in the master CD book.
- Individual CD books were taken to an event for recording and if overnight storage was required, a personal safe was issued to the authorised staff member. Post event, the CD's were returned and recorded in the master CD book. We viewed documentation, which showed staff followed this procedure.
- During our inspection, we visited the headquarters where prescription medication and CD were kept. We were told about 10 people had access to the storage room. The first storage room contained the red drug packs, which were sealed. There was a labelling system to indicate when to use. A red tag meant do not use, amber, meant the bag was being prepared and green meant ready to use.
- The second storage room contained a large metal drugs cabinet for CD's.
- We checked the CD drugs book. There were two books both being used and both containing lists for morphine. We found the system somewhat complicated and a single use CD book would have simplified and streamlined the process. One book indicated there were 15 ampules of morphine, the other book indicated 18 giving a total of 33. However, one book had a different total and this had been crossed out without an explanation and 33 added. Since the inspection, we have received evidence to show this was reported as an incident with actions taken as a result.
- For prescription, drugs there were 15 cyclazine in store but the book indicated 112. We were told others were in large event boxes, prepared red bags and out on vehicles. We were told there was a database, which could track the drugs, but to update the system a physical count was required. It is not a legal requirement to have an audit trail of prescription only drugs, but it is good practice.
- During our inspection, we found one drug pack, which had been collected from the storeroom, was untagged and documented on the log sheet the most recent administration date made eight days previously. This had been reported as an incident.
- All medicines we inspected at the station were stored securely and kept in locked secure rooms, whereby only authorised staff could enter. We were told when taking a drug pack, staff would sign this out on a sheet including the bag batch number. We viewed the log sheet, which showed staff had followed this process. If the bag had been used it was placed in a drop box and checked. The station received delivery of stock the next day. The station manager told us every tablet was accounted for by staff using the PRF documents and any medication missing would be reported as an incident. We viewed a selection of PRF forms, which showed staff logged medication given to patients.
- The regional assurance manager recognised a more robust system of medicine management audits needed to take place. A random 5% of PRFdocuments were audited as a check, as all administration of drugs were recorded on PRF documentation. We were told but did not see evidence, there had been no issues detected so far.
- Red drug packs were prepared at a single location and locked away prior to distribution to units. No current spot checks were undertaken as the area had controlled access and packs were secured in a locked environment. When any drug packs required resupply the entire pack was returned to logistics and a new pack was issued.

- Stock checks for CD's were done on a monthly basis and lists we saw showed all drugs were accounted for.
- We saw checklists for advance life support kits, which listed all medication, batch numbers, and expiry dates.
- Medical gases and oxygen were stored in a secure container outside the main station. However, there was no lock on the container but CCTV camera and fencing ensured security.
- Logs were kept of all disposed medicines to ensure traceability and safe disposal. A responsible approved service was used for collecting disposed or out of stock medicines.

Records

- Ambulance crew completed patient report forms (PRF), which were based on the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) guidelines.
- PRF forms were stored in opaque zipped folders to retain confidentiality and kept at the front of the ambulance. However, during our inspection, we observed PRF forms stored behind the sun visor screens. Staff told us this was to avoid the forms becoming wet if placed in the door area, when it rained.
- Vehicles were kept locked when unattended and staff were able to place completed PRF forms in a locked container at the station at the end of their shift. The container was kept in a locked room with CCTV coverage.
- Standard operating procedures were used for the management of records covering such areas as storage, security, and destruction.
- Staff told us they completed the forms in the cab area of the ambulance for both contract and event work.
- The original copy of the form was given to the hospital who took the patient. St John Ambulance kept the second copy and the third copy was sent to the ambulance provider.
- The next day after the forms had been dropped into the secure box, they were checked against the call sheets to ensure there was a form for each activity. The daily sheets were submitted to the ambulance trust in a sealed envelope. The trust audited forms on a monthly basis and provided the service with written feedback. We saw two feedback sheets, whereby the trust gave reasons why the form was not compliant and who the crew member was. The station manager was then able to provide feedback to the staff member and provide support and further training if necessary.
- If the NHS ambulance trust were aware, a patient had a do not attempt resuscitation document (DNAR) they would let the St John Ambulance staff know in advance so the patient's wishes could be respected.
- Staff were aware and knew how to check for information in a patient's home through the 'message in a bottle' scheme. This was a system designed to encourage people to keep their basic personal and medical details on a standard form in a common location, which is the fridge.
- At events staff told us they would accommodate a patient's wishes but not in the event of a cardiac arrest, staff would always follow current guidelines and start resuscitation

Assessing and responding to patient risk

- Clinical observations were completed on patients to assess signs of deterioration. Suitable equipment was on board to monitor patients, for example, their blood pressure. Additional assistance was requested should a patient show signs of deterioration.
- Staff we observed followed JRCAL guidelines when assessing patients.
- Staff were trained during their induction to provide the skills and knowledge required for their role. Staff told us they knew their limitations within their role and there was a good system to get assistance from specialist clinical advisors.
- For the events service, we observed there was a clear escalation process in place. St John Ambulance co-ordinated and worked well with the NHS ambulance present at the event and the sporting stadiums own doctors who were present throughout.
- Staff received training at their induction to manage challenging behaviour. Police travelled with patients detained under the Mental Health Act and carers travelled and were responsible for those more vulnerable patients.
- There were policies to manage disturbed behaviour and clear guidelines for staff to follow.
- Staff we spoke with were clear on the protocols they would follow to meet the demands of challenging behaviour.

Staffing

- Staffing levels were regularly reviewed by senior staff to ensure the appropriate staff with the right skill mix covered shifts for both contracted work and planned events.

Emergency and urgent care services

- For the NHS ambulance trust, St John Ambulance provided an agreed number of ambulances with two members of suitably qualified staff to cover each ambulance.
- The station manager along with team leaders used an electronic system to plan shifts. We were told shifts were planned at least two weeks in advance so any shortfalls could be communicated to the trust so additional cover could be found. The station manager often completed shifts if no suitable cover could be found.
- There were 16 employed crew based at Park Royal station and nine based at Crystal Palace. Twenty-three casual staff assisted in covering a mixture of the services for NHS ambulance trust, neonatal and retrieval service and patient transport service.
- If a casual member of staff had not completed a shift within six months they had to complete a two-hour training update before they became operational.
- The local event lead was responsible for planning staffing for the event and ensuring they had the correct competency through an electronic planning system. An online form was completed whereby a score produced how many staff were needed to cover the event and the skill mix. Recruitment of volunteers was a challenge and was listed on the national and regional risk register. The event we observed was covered by the appropriate number of suitably qualified staff. Certain regular events tended to be covered by the same regular volunteer staff, which provided consistency.
- The event lead told us to help cover an event that required 12 hours of staff coverage a staggering of shifts helped with the recruiting of volunteers.
- For NHS ambulance work, shifts not covered would result in a financial penalty being placed. We were told so far for 2016 the service had not received a penalty fine.
- For all contract work, staff worked an agreed shift pattern of four shifts on and four shifts off and were up to 10-12 hours in length. Staff we spoke with were happy with the system and said they received adequate rest in-between shifts. However, staff did mention they were unable to have fixed lunch breaks. We were told staff had a paid lunch break and were allowed to take food into the front of the cabin.
- Senior staff told us a challenge they faced was the NHS ambulance service reducing the number of ambulances required, which meant they had to 'step down' staff from duty. This caused unsettlement for job security and was a problem the organisation faced nationally.

Anticipated resource and capacity risks

- St John Ambulance met regularly with their NHS ambulance provider to inform them if there were changes to the level of staffing which would affect the level of service.
- St John Ambulance told us they had a reduced capacity from six to four ambulances for the emergency operations, but the changes had come from the NHS ambulance provider and not themselves. We have since been informed the service will increase again to six ambulances to help the NHS ambulance service cope with the extra demands of the winter season.
- St John Ambulance had a mixture of permanent and casual staff to help operate their contracts with service providers. We were told there was a 'stepping down' of staff process if services were not required and these would mainly be casual staff.
- For event work and contacted services, plans were in place to manage services in the event of a disruption, such as shortages to staffing. For the paediatric neonatal and retrieval services, there was an extra vehicle to be used if one of the vehicles needed repairing.
- St John Ambulance had a fleet of 4X4 vehicles, which could be used in extreme weather conditions.

Response to major incidents

- Staff received training during their induction on responding to a major incident.
- Although St John Ambulance did not attend major incidents as this was outside their remit, they would be used to assist in the event of a major incident or when the NHS ambulance service was on black alert. Black alert is the highest level of pressure an NHS ambulance service can be placed under and escalation processes must be in place to cope and provide services to patients. Volunteers were asked to attend to duty of a major incident occurred.
- For events, mangers attended planning meetings prior to the event to discuss major incidents and what role St

John Ambulance played. For example, for large regular events, major incident plans were embedded into the structure of the organisation and St John Ambulance staff were aware and participated in discussions.
- During our inspection of an event, we saw actions staff should take in the event of a major incident displayed on a screen in the staff room and information was provided in briefing notes. These included maintaining radio silence, not to invent and or deploy new call signs, to stay in their teams and to listen and take action from the control centre at all times.

Are emergency and urgent care services effective?
(for example, treatment is effective)

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

- Staff provided care in line with national guidelines. The service had systems in place for staff to get additional advice if necessary.
- There was a comprehensive induction plan for both contracted and volunteer staff. All staff completed an annual assessment to test competency and provide support and relevant training if necessary.
- Staff followed consent guidelines and asked patients for consent before starting treatment.
- There was good multidisciplinary team working between ambulance crew and other organisations so seamless consistent care was provided for the patient.

Evidence-based care and treatment
- Care and treatment was provided and staff followed national guidelines, which included the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines.
- Staff we spoke with told us the JRCALC guidelines were accessible within the organisation and staff had copies of the guidelines for reference. They sometimes referred to the guidelines for medicine administration.
- Staff we observed followed the National Institute for Health Care and Excellence (NICE) guidelines QS61 'Infection prevention and control.'
- Staff followed NICE cognitive assessment training for a number of core topics, for example, diabetes and chest disease.
- The organisation had received certificate of approval from The International Organisation of Standardisation (ISO) 9001:2008 for quality management system, which was applicable to commercial training services. This included design, development of training courses in health and safety related subjects.
- Staff were provided with training and followed best practice when dealing with deceased patients.
- Events were risk assessed beforehand and staff followed best practice guidelines set by the type of event they were operating and protocols set by the events Health and Safety Executive.
- We spoke to the Health and Safety Executive of an event at a big stadium and they were able to tell us that St John Ambulance staff followed best practice and national guidelines for the event on that day.
- The assurance and audit plan 2016 gave a clear list of all audits the organisation undertook for the year 2016. Those audits included, equipment exception audit, fleet ambulance compliance fleet records, health and safety national audit, responding to issues, control of contractors, IPC clinical waste, IPC, hand hygiene, IPC pre/post deep clean swabbing, medicines reconciliation, PRF documentation standards. As this was a new system, some audits had yet to be completed.

Assessment and planning of care
- Staff followed best practice local and clinical guidance when assessing and treating patients.
- Staff were able to contact the NHS ambulance providers support desk for clinical advice. Staff told us they often contacted the service for issues relating to the Mental Health Act. Staff said the clinical support desk was an important tool they used to support the patient further.
- Staff used and completed the NHS ambulance providers clinical proforma paper templates for patients. Such paper templates included, a checklist for assessing 'best interests' for patients aged 16 or above.
- The NHS ambulance provider distributed their clinical update newsletter, so staff were able to use the latest up to date clinical guidance to assess patients. We viewed the newsletter for July 2016, which gave useful information, such as assessment and management of suspected severe sepsis in paediatric patients.

- Event staff were able to contact the commander on call if they needed to escalate concerns or gain extra support for planning patients care.
- The NHS ambulance provider provided a PAN London acute appropriate care pathway for staff to use in the event of gaining the correct access for cardiac patients.
- We viewed the care pathway which gave the list of different acute hospitals patients could be taken to. There was a list for crew to follow in terms of the different types of cardiac conditions. The list included actions to take for patients with known Kawaski disease, emergency arrhythmia centres, hyper acute stroke units, Segment Elevation Myocardial Infarction(STEMI) confirmed by 12 lead ECG and major trauma units.
- St John Ambulance did not ordinarily provide transport services to individuals being detained under the Mental Health Act, unless the patient being transported between two inpatient settings were supervised by an appropriately qualified escort. The crew completed a patient record form (PRF) to confirm the patient remained under the full responsibility of the escort. For patients needing transport from a public setting and were under the supervision of police would be escorted by the police and again a PRF would be completed to confirm the patient was the responsibility of the police. If the patient was being admitted to inpatient care from their home address, an appropriate health care professional or approved mental health practitioner would accompany the patient and remain the responsibility of the escort. A full risk assessment current at that time, as per Chapter 11 in the Mental Health Act Code of Practice, 2008 would have been completed before transportation. A PRF would be completed to reflect the patient's journey and care. All patient section papers remained and travelled with the patient.
- Staff at events would take the patient to the nearest accident and emergency department to be treated. If a patient was treated as a 'see and treat' and did not require further assistance, they would be given written documentation on what to do and who they should contact if their condition deteriorated.

Response times and patient outcomes

- St John Ambulance did not set their own response times and St Johns Ambulance did not monitor response times on vehicles set by the NHS trust. Once the crews booked on with the relevant NHS trust the despatching was undertaken by them and the response times monitored as part of the trusts' own figures.
- We viewed the contact performance review chart for July 2016 for St John Ambulance. This was produced by the NHS ambulance provider. Figures showed St John Ambulance was performing generally in line with expectations
- For July 2016, crew responded to 66.7% of Category A incidents within eight minutes. Category A incidents are patients with conditions which are immediately life threatening and should receive a response within eight minutes. The target rate is 75%.
- St John Ambulance scored 73.4% for being mobile in 45 seconds. That meant the time it took for activation to the turning of the vehicle wheels.
- The organisation were allowed 3% for vehicle off road (VOR) time, for example to go back to base if equipment was needed. For July 2016, St John Ambulance VOR was 2.5%.
- St John Ambulance would be fined if they did not meet their key performance indicators (KPI) set buy the NHS ambulance organisation. So far for this year they have not received a fine.
- Information provided showed that for the period January 2016 to September 2016 the total amount of patients transported were 16005. Within that period, the number of hours available were 55881 and the amount of hours worked were 53233. Therefore, the number of cancelled and declined shifts totalled 121.

Pain relief

- Staff we observed asked patients about their pain and administered pain relief to those patients to make them as comfortable as possible.
- Staff recorded the pain score and medication given on the patient record.
- Staff told us making patients comfortable and ensuring they were pain free was an essential part of their role.
- For those patients who were unable to communicate verbally, staff used the faces pain assessment tool. This tool had a picture of six faces, for patients to choose, which described their pain the best.

Competent staff

- Staff completed induction training when they first started St John Ambulance. A role specification listed which topics staff covered dependent on their role. All

staff including volunteers completed the welcome induction programme, whereby modules for safeguarding, infection prevention and control, equality, diversity and inclusion, conflict management, information governance, and medicine management were completed.

- During week one of training for drivers they completed assessment to drivers skills test, eyesight test and reversing exercises. By week three operational drivers completed police theory test, police response (standard or advanced) tests and tests in line with the Royal Society for the Prevention of Accidents.
- Staff had driving standards observational tests every five years, which is above what most NHS ambulance services require. If a staff member was involved in a collision, they would be requested to undergo observational tests to ensure competency.
- We viewed a sample of employee driver records, including driving licenses, St John Ambulance competency testing, and all were found to be complete and up to date.
- We viewed the operational driving course, which lasted seven days and was equivalent to 56 learning hours. Core skills covered, included, pre-driving checks, vehicle checks, vehicle inspection, reversing, concerning, and overtaking, motorway driving, and skidding. This course was a mixture of on road learning and classroom activities. At the end of the course, staff completed a theory and practical advanced driving assessment.
- During our inspection, we observed crew twice performing a reverse manoeuvre without having anyone to watch them back up. Staff told us they had been trained for a staff member to get out and help assist with the manoeuvre but in reality this did not happen 'on the road', unless necessary.
- The vehicle tracking system was able to monitor driver standards. We were told by a consultant at the NHS hospital trust they often monitored drivers competency to ensure they were not driving too fast and meeting agreed standards.
- St John Ambulance managers also used the tracking system to monitor driver standards and used this as part of staff appraisal and additional development and training if required.
- We were told all staff completed annual revalidation, which was a mixture of e-learning modules and practical assessments. We saw the due date for staff revalidation was recorded on the training spreadsheet. Managers we spoke with told us if staff did not compete or safely pass modules, they were offered more training and support. When asked what would happen if staff failed to complete all modules, we were told staff would be downgraded from their role until they could prove competency.
- All staff received an annual appraisal and personal development review every six months. We were told but not see evidence that 100% of frontline permanent staff had received their annual appraisal. We were told 21 of the 72 cohorts of volunteers had received an appraisal, however they had up untill end of March 2017 to complete these.
- Staff we spoke with were happy with their role and felt they had received the appropriate training. Some staff told us there were no development opportunities due to the small size of the London region, while others told us how they developed through the system to their current role.
- The service had recently developed and were due to change the current role of the ambulance crew to become more in line with he recognised Associate Ambulance Practitioner (AAP) role, used by most NHS ambulance services. The organisation was due to implement the role by January 2018. The changes would enable staff to progress to the AAP role.
- Those staff who held professional registrations followed guidance and instructions from their professional bodies for renewal. We were told the regional assurance manager checked national registers to check those staff who were registered.
- All staff had an up to date disclosure and barring certificate (DBS). A third party company provided checks for the service and staff who did not have an up to date DBS would not be able to work for the organisation.
- We viewed 20 staff records, which include a mixture of permanent and volunteer staff. We saw all certificates of registration with professional organisations were up to date, certificates of ad hoc training and recruitment processes were in place, driving licence details, the right to work in the UK and identification.
- The organisation recognised there was a need for more clinical observations during shifts and we were told these would be taking effect from next year and led by the team lead.

- The service received a monthly alerts list from the healthcare and professional council on practice proceedings and upcoming hearings on healthcare professionals.

Co-ordination with other providers

- Staff had good working relationships with their NHS providers.
- We viewed agreed care pathways the NHS ambulance provider expected St John Ambulance staff to follow. These included the PAN London acute appropriate care pathway for staff to use when dealing with cardiac incidents. Safeguarding pathway forms and mental health assessment forms were other pathways provider expected staff to follow.
- Staff working for the neonatal paediatric and retrieval services understood their role and what they were accountable for. They worked within agreed frameworks set by the provider and regular meetings between St John Ambulance and the NHS providers allowed one hundred and eighty degrees feedback, in terms of how they were performing and any issues that needed rectifying.
- Staff told us they had good working relationships with other emergency services, which included the London fire brigade, police, and acute hospitals.
- There were good systems for issues to be escalated to the NHS ambulance trusts. Incidents and safeguarding concerns were raised directly to the ambulance trust through direct telephone contact numbers and regular meetings.
- We viewed the 7 September 2016 meeting minutes for the retrieval service. Topics discussed included equipment issues, incidents, and training actions that needed taking.
- The neonatal paediatric meeting minutes of 27 July 2016 showed discussion took place on projects and work in progress.
- We spoke with NHS staff who worked within the neonatal paediatric service and they told us of the good working relationship they had with St John Ambulance. They told us they were able to deal with any issues swiftly and how cooperative St John Ambulance staff were. A registered nurse and consultant travelled with the patient on all journeys.
- Staff working for the retrieval service were able to give an example of good co-ordination between themselves and the NHS staff. For example, before a patient travelled on the ambulance, staff would be given clear instructions on how to handle the patient in terms of driving the ambulance. Crew were then able to adapt their driving skills to the needs of the patient, for example, not taking the ambulance around corners too quickly.
- Good examples of co-ordination with other providers was evident from the information we received regarding major and local events across London, whereby St John Ambulance were the providers for first aid. We viewed meeting minutes that took place prior to a major event, which included police and fire services involvement on the co-ordination of the event and working together to achieve safe outcomes.
- The service had a national policy for emergency preparedness, resilience, and response. The policy was a formal statement of their principles and commitment to the UK Ambulance Services National Memorandum of Understanding Concerning Provision of Mutual Aid.
- The framework set out a consistent infrastructure throughout St John Ambulance, organised through independent groups collaborating to facilitate communication in the event of an emergency or incident. In particular, to enable support across St John Ambulance regional, NHS trust local authority and local resilience forum boundaries.

Multidisciplinary working

- We observed good multidisciplinary 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 the NHS ambulance trust during an event and prior to the inspection. We were told the organisation was good at communicating with them and informing them of actions they had taken and decisions made which may affect their operation. They told us the organisation was reactive to the operational requirements made of them.
- Staff had clear pathway guidance to follow from the NHS trust ambulance provider when treating patients and where they should be taken. This ensured patients were not necessarily being admitted to hospital.
- We received good feedback from the neonatal paediatric team on the service St John Ambulance staff

provided. This was a small unit and we observed good multidisciplinary working together. St John Ambulance staff knew the scope of their role and what was expected of them.

- We observed volunteer staff at an event working well with NHS ambulance trust staff and the health and safety team of the event stadium. We spoke to an NHS ambulance staff member who gave positive feedback on how St John Ambulance staff helped their service and how invaluable they were for such events.
- We viewed documents on the multidisciplinary working between the service and other organisations for major and small events. Documents provided showed plans and meetings arranged before the event, de-brief reports and feedback meetings. The organisation and multidisciplinary working between St John Ambulance and other emergency services was thorough.
- We observed staff working together with other emergency services sharing the same control room, which enabled collaborative working.

Access to information

- Staff working with other NHS hospital services did not always have access to patient's special notes. For the paediatric and neonatal services, a consultant or registered nurse from the hospital would always travel with the patient, so a discussion took place beforehand between staff on the patient's condition.
- Staff who completed paperwork when attending patients would ensure one set of notes followed the patient throughout their care and treatment. Carbonated copies were kept by the individual services.
- When attending emergency and urgent care patients staff did not always have access to patient's special notes regarding patients pre-existing medical condition or care plans. The emergency services would not always know in advance, however staff said they would check to see if care plans were kept at the patient's home.
- Staff working for the NHS ambulance provider used the NHS trusts paperwork to ensure there was consistency with patient care. Hospitals across London were familiar with this paperwork.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explaining treatment and procedures and providing patients with the opportunity to ask questions before gaining consent. Consent for treatment was recorded in the patient records.
- Staff completed training on the Mental Capacity Act (MCA) 2005 and Mental Health Act as part of their initial training. MCA was not part of mandatory training. However, we were told staff completed training assessments as part of their annual competency assessments' development. During the inspection, two staff members told us additional training for mental health would be beneficial.
- Staff we spoke with had a some understanding of the MCA 2005.
- We viewed the 'management of the legal aspects of care, treatment, and support 'document which included standard operating procedures for consent. When seeking consent there were legally recognised circumstances in which treatment was given without consent. These included: in an emergency when intervention was required to preserve life or limb. This applied to patients who were unable to consent; whether they were, children or adults. Treatment required in the best interest of mentally incapacitated adults. This meant preserving life, preventing deterioration, maintaining dignity, and keeping the patient comfortable and pain free. Treatment of patients for their mental illness under the Mental Health Act 1983.
- We viewed the Mental Capacity Act 2005 checklist in place for crew working for NHS ambulance providers to complete for patients. The checklist was used by the NHS trust and the checklist helped determine patient's best interests when considering life-sustaining treatment. Checks such as, 'Does the patient have the capacity to make a decision about their treatment; or a lasting power of attorney; or an advanced decision. 'Does the patient have the capacity in relation to the matter in question?
- Staff told us they would contact the NHS trusts clinical desk for any additional help they required.
- Staff we spoke with had a good understanding of the requirements to be met in order for a do not attempt resuscitation (DNACPR) to be valid.
- The organisation had a withholding or withdrawing resuscitation of treatment procedure for staff to follow. Staff we spoke with knew when to provide treatment to patients without consent, such as in an emergency to maintain life.
- The NHS ambulance provider audited on a monthly basis if staff recorded mental health concerns as part of the patient report form audit. For July 2016, compliance

was 82%. The NHS provider was able feedback the staff member name that recorded details incorrectly or did not record enough details on the patient form. This was then feedback to the staff member concerned to see if extra training was required.

Are emergency and urgent care services caring?

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

- Staff showed compassion and treated patients with dignity and respect throughout their treatment of care. They were kind and emphatic to the patient and respected their privacy throughout their care.
- Staff kept carers or relatives informed of what was happening and involved them in discussions about care of the patient. They provided emotional support and recognised the importance of supporting them as well as the patient.

Compassionate care

- Staff we observed were kind, compassionate, friendly, and attentive when providing treatment of care to patients.
- Staff spoke clearly and in a gentle manner, which made patients feel at ease. They were polite to relatives and carers travelling with patients and always introduced themselves by name.
- Staff told us they had an understanding of patient's different cultures and beliefs and would do their upmost to respect them within the scope of their role.
- Staff we observed ensured the patients dignity was respected at all times by providing blankets to cover patients in public places and inside the ambulance.
- Ambulance doors were closed after the patient was placed inside to ensure they were kept warm and to provide privacy.
- We heard ambulance crews speaking to patients in a kind and supportive manner while treating them. They interacted with patients on a personal level and spoke to them in a reassuring manner.
- The two patients we observed for emergency and urgent care were happy with the standard of care they received and praised the staff for their compassion and professionalism
- We spoke with a carer who attended with a non-communicative patient and they spoke highly of the kindness the patient had received and was happy with the standard of care provided by staff. They said they had been kept informed of what was happening at all stages of the patient journey.
- We observed staff treat a bariatric patient with dignity by ensuring they were covered with a blanket at all times and equipment on-board the ambulance allowed staff to be respectful of their needs. For example, the ramp on the bariatric ambulance was wider and allowed the patient to transport in and out of the ambulance in a dignified manner.
- Staff told us they would report any concerns about disrespectful, discriminatory, or abusive behaviour through their reporting incident system and would inform their line manager immediately.
- The patient experience survey for London from October 2015 to 2016 data showed 22 out of 24 (91.67%) patients said staff treated them with dignity and respect.

Understanding and involvement of patients and those close to them

- Staff we observed gave good instructions on the treatments and options available to patients. They were clear and did use technical jargon the patient would not understand.
- We observed patients being involved in the decisions of their treatment. Staff ensured the patients consent was given before any treatment was given.
- Relatives and carers were involved and kept updated of the patient's treatment details. Staff showed kindness and were professional in their approach. We spoke with a carer who spoke highly of the staff's care and how they had involved them in every step of the patient's journey.
- Staff told us they would invite family or friends to accompany a patient if the patient wanted.

Emotional support

- Staff we observed demonstrated empathy and kindness to patients carers and relatives.
- We did not observe any situations where staff had to deal with distressed relatives or carers. However, they were able to explain how they would provide the time and support to those people in such situations. They said they would ensure privacy was maintained at all times allowing the person to be able to ask questions and be there to listen to their concerns.

- We viewed the training guide staff were provided on the care of deceased. Staff received training on how to be respectful and dignified when such occasions occurred.
- Staff we spoke with were complimentary about the staff welfare support provided by the organisation if they experienced a difficult or upsetting situation.
- Staff were aware of the different types of needs of people and how those who experienced mental health issues required extra support.

Supporting people to manage their own health

- At events, most patients were not taken to hospital but directed to a pharmacist or their GP, dependant on the nature of their condition.
- Alternative care pathways were provided to patients if there was no need for them to attend hospital. Written discharge information was given to patients to help them manage their own health and what to do if their condition changed.
- The NHS ambulance trust was able to identify frequent patients and offer the appropriate support before calling upon St John Ambulance service. If staff needed to attend a frequent patient, they followed the appropriate pathway set by the NHS trust.

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

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

- There was effective planning with contract ambulance services and commissioners for events to ensure the services met the needs of the local people.
- Response times for ambulance crews were monitored by the ambulance trust and fed back on a monthly basis to measure quality and plan for improvements.
- The service took into account the individual needs of patients when providing care and treatment. Staff had received training to support those patients with vulnerable conditions.
- There was a good system to deal with complaints in a timely manner. Learning from complaints was shared throughout the organisation and staff could describe changes made as a result of complaints.

Service planning and delivery to meet the needs of local people

- The organisation had contracts with one NHS ambulance trust and two NHS hospital trusts to help support and meet the demands of patient services.
- We were told regular meetings took place on a monthly and quarterly basis between St John Ambulance and the NHS trusts to discuss demand and plan their service. We were told the NHS trusts were good at forewarning them in advance of anticipated demand and whether there was a need to increase their service. We viewed minutes of meetings showing such discussions took place.
- The NHS trusts also knew the level of demand St John Ambulance could offer in terms of vehicles and staffing as per their service level agreements. Therefore, unreasonable demands were not made on St John Ambulance. However, it was recognised that the 'stepping down' of staff when demand decreased had an impact on staff morale. We were told that this was not a major issue for the London region, but more so in other regions.
- We were told during the inspection that another bariatric ambulance was being ordered to meet increased demand.
- For the events service, we viewed planning meeting schedules of two big major events. These gave details of agreed planned staffing numbers for first aid. Post event briefings gave details of what went well and how things could be improved in the future to meet the needs of patients.

Meeting people's individual needs

- St John Ambulance staff took the needs of different people into account when providing care. There was shared understanding between staff that every patient had individual needs.
- St John Ambulance provided bariatric ambulances for the NHS ambulance provider. These ambulances were equipped with the necessary equipment to accommodate patients. Drivers had undertaken special licenses to drive the heavier vehicles.
- There was a translation system for those patients who did not speak English. The system called Language Line, enabled staff to contact a direct number, whereby the patient could choose the language they required and treatment details could be explained to them. We were told all staff had received details and knew about this

service. However, two crew members during a shift we inspected were unfamiliar with the system. The system which relied on a mobile signal, was potentially risky as if a mobile signal was not available, there was a potential risk to patient care.

- Staff working for neonatal paediatric and retrieval service, met with the registered nurses and consultants of the NHS trusts to discuss the needs of the patient before they were transported. For example, details would be provided of the patient's condition and how they ambulance needed to be driven to accommodate their needs.
- Staff told us they would communicate with hard of hearing patients, by writing treatment options down on paper.
- Staff had not received training in dementia, but were able to describe how they would support and provide care for those patients. They provided good examples of how they would deal with patients who appeared confused and the pathway and support they would follow in getting the right help for those patients. The organisation recognised dementia training needed to be implemented in future training programmes. Staff working for the NHS ambulance trust were able to use the trusts assessment guidelines to help dementia patients.
- Neonatal paediatric and retrieval services had an extra seat in the ambulance so relatives could travel with a young patient, which made situations less stressful for the patient.
- Staff respected patients' cultural and spiritual needs and contacted their respective line mangers if there was a conflict regarding health needs. For emergencies, patients were taken to hospital.

Access and flow

- The NHS ambulance trust and NHS hospitals were able to monitor data captured from the satellite and navigation system utilised by the urgent care, neonatal and retrieval teams. Such data included response times, and turnaround times. These figures were fedback to St John Ambulance and monitored on a monthly basis. Comparisons were made for response times and targets but there was recognition that on a monthly basis the type of calls and the difference in the number of calls responded was difficult to compare.
- The NHS ambulance trust were able to monitor 'activation to wheels' time, this being the crew were able to be mobile in 45 seconds. Average turnaround hospital times and being available again were monitored and fines were given to St John Ambulance if they were unable to meet their targets for turnaround. We were told that for 2016 they had not received a fine. Time was also factored to allow crew to return to base to collect equipment.
- St John Ambulance were able to provide shift cover and rotas to the NHS providers at least two weeks in advance, to allow them to plan for cover.
- Care access pathways were used by the service to ensure patients were taken to the correct place for care and treatment.
- During our inspection ambulance, crew told us, in spite of knowing there were alternative pathways available to use instead of transporting a patient to accident and emergency department (A&E), in order to do so a paramedic from the NHS ambulance service was required to attend the scene to arrange this. Staff said it was often quicker to transport the patient to A&E.
- Staff completed written daily worksheets, which enabled the service to monitor how long the crew had spent on each call. They in turn were able to feed this information back to the NHS ambulance service if problems arose on performance times.

Learning from complaints and concerns

- The service had a management of patient complaints framework and feedback policy, which gave detailed directions on the pathway, followed with patient complaints. For example, 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.
- People who used St John Ambulance services were able to provide feedback via their website, by telephone or by letter. The website gave guidance on how the complaint process worked, with response times and acknowledgement of complaint.
- The assurance manager took responsibility for complaints. The purpose of the complaints framework and policy was to provide a simple procedure that was easy to follow and was fair and proportionate. Duty of candour was part of the complaints policy.

- Staff were encouraged to deal immediately with complaints during care, treatment, or transport. If resolved locally, patients were provided with St John Ambulance feedback leaflet, which provided contact, details if the patient wanted to raise the matter formally.
- Complaints received formally, were forwarded to the regional assurance manager. An acknowledgement would be sent within three working days of when the complaint was received and provided with a written response within 20 days.
- A manager was allocated and oversaw the complaint, whereby a root cause analysis investigation was completed with actions taken.
- We were told learning from complaints was shared at local and regional meetings. Complaints were discussed on a national level to determine if there were trends that needed attention.
- For the year 2016, the service received 10 complaints, two related to regulated activity. There were no specific trends seen as a result of these complaints.
- We viewed a recent complaint received and the processes followed from beginning to end. We saw an acknowledgement was sent to the person and investigatory procedures were followed including root cause analysis. The person had been replied to in the agreed period and an action tracker gave a systematic account of the complaint and actions to take. We saw actions taken as a result which included evaluating training for the staff involved. The full incident of the complaint was reported to the CQC
- If a complaint was made to the NHS trust about St John Ambulance, a joint investigation would take place. We were told complaints would be discussed in their regular meetings. The minutes we viewed showed no complaints had been raised to discuss.

Are emergency and urgent care services well-led?

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

- There was a national vision and strategy and staff were aware of the values of the organisation.
- Governance had been reviewed and restructured to be more in line with the quality strategy of the organisation. The complete restructure was not yet fully implemented at the time of the inspection.
- Staff were complimentary of the leadership of the organisation; felt they were visible and approachable. Staff told us they were supported by their line manager and found they were approachable.
- There were good staff engagement forums for staff to provide feedback and participate in the organisations plans.

Vision and strategy for this service

- St John Ambulance had a national vision in place, 'everyone who needs it should receive first aid from those around them. No one should suffer for the lack of trained first aiders.'
- The vision was linked and supported to the five values known as HEART: humanity, excellence, accountability, responsiveness, and teamwork.
- The service had an overall five year strategy in place 'strategy 2020', underpinned by the values and aims. The goals of the strategy were to review the organisation as a whole and to review the senior management team and operational leadership tea. Key changes from the strategy included the first aid services directorate, incorporating the regions, young people, and community and ambulance operations. The quality standards directorate would bring together clinical, audit, assurance, health, and safety. The reasons for this was to make the organisation more joined up and efficient.
- There was a volunteering strategy 2020 with three aims, which supported the strategy, those being, community focused, professional and rewarding, known as CPR. The service would achieve this through five key areas of advocate, equip, teach, treat, and transport.
- Staff we spoke with were aware of the vision and values of the service and how these applied to their roles.
- Local managers ensured the correct resources were available for the most vulnerable and made sure patients received first aid.
- During our visit to an event, we saw the vision displayed on a screen in the staff meeting room. We also saw the vision displayed on posters at the main station.

- The national staff survey for 2016 showed 84% of staff understood the aims and objectives of the service. However, overall only 44% of staff could quote their five values.

Governance, risk management and quality measurement

- The organisation had moved to a more centralised system to capture data and monitor performance through audits, as the corporate strategy identified a need to improve how the organisation collected data.. A centralised system enabled trends to be captured, so specific improvements could be made to patient care.
- As part of the centralised system, a national audit was put in place. The regional assurance manager was responsible for overall control and reporting to the national regional assurance group and regional quality, risk and assurance group. The national audit system was a recent addition and therefore not all audits had been completed.
- We viewed the May and June 2016 assurance report produced by the regional assurance manager for London. Topics reported were, complaints, infection prevention and control, incidents, audits conducted, health and safety and primary areas of concern.
- The regional management team met on a monthly basis to discuss, accounts, organisational updates, the assurance report, event services, fleet, training, risk register and clinical reports. Each manager was responsible for providing feedback to each of their team members. Staff told us they regularly received updates from their managers through team meetings or on a one to one basis and through the staff intranet system.
- There was a national and regional risk register. We viewed both up to date registers, which showed management of actions in place and further actions to take to mitigate risks. There were review dates against each risk. For the London risk, register there was mixture of current risks and potential risks. Park Royal station did not have their own risk register. Therefore, there was a missed opportunity for local risks to be captured.
- Risks on the register, matched concerns staff had about the service. For example, the loss of service contracts resulting in reduced workload.
- We were told team meetings took place at stations, but we did not see any minutes of meetings to see what discussions took place. However, staff we spoke with were confident they could speak to their manager when they wanted and any issues could be discussed and shared.
- St John Ambulance held monthly meetings with their contract providers. We viewed minutes of meetings from the NHS ambulance trust and NHS hospital. A set agenda of performance monitoring and targets incidents, shared concerns and quality of service was discussed at each meeting.

Leadership of service

- The London and East operations manager led the London ambulance operations service and events service. The regional assurance manager was responsible for ensuring quality and assurance performance arrangements. The operations manager was the registered manager.
- The regional management team had and were undergoing changes to their structure. The ambulance operations were now led by a regional manager with a station lead and team leader for each location. Management recognised there was unsettlement amongst some staff, especially in the events section as the new organisation was taking shape. They recognised keeping staff informed at every stage was key to a smooth restructure.
- Staff we spoke with were positive about the leadership of the service and told us leaders were accessible and visible. Staff were happy with their line managers and were able to talk to them when they wanted. They felt included in decisions made and spoke well of the good communication links. They felt their line managers had the appropriate skills for their role.
- For staff working within the neonatal paediatric and retrieval services, management took the form of direct line management from St John Ambulance but also management from the NHS hospitals themselves in terms of day-to-day operations. We spoke with a consultant from an NHS trust that had overall responsibility of the service. They would report any difficulties with a staff member directly to their line manager and felt confident issues were dealt with.
- The station manager often worked with crew on shifts and staff told us they often had visits from the sector manager of ambulance operations.

- Station managers had monthly area manager meetings with the regional manager, for support and sharing of good practice ideas.

Culture within the service

- Staff spoke positively of the organisation and felt proud of the work they did.
- Staff were confident to speak to managers to raise concerns and said they were handled well. Staff were able to use their imitative to deal with situations and said they had the support of their managers.
- Managers were able to address performance and behaviour in a fair and proportionately. They told us the systems in place enabled clear instructions and gave clear guidance for performance issues. For example, we viewed an incident, whereby staff two members of staff involved in the incident were retrained in a certain area to help improve their performance to provide care and treatment for the patient.
- The safety and welfare of staff was acted upon. Staff provided good feedback on the welfare support they had received when they experienced difficult situations during work.
- Shifts were manged well by managers and they ensured staff received sufficient and adequate rest between shifts.
- During the inspection, ambulance crew told us they did not have sufficient allocated lunch breaks. Crew were allowed to take food into the driving section of the ambulance, but due the nature of the emergency role, it was difficult to factor structured lunch breaks into shifts. We were told staff were paid for their lunch hour.
- Staff we spoke with were unfamiliar with the new ambulance roles and what it entailed. This would corroborate with the staff survey, which scored low on communication regarding changes within the company.
- Some staff were aware of the duty of candour while others were not too sure. When asked, staff were able to say it meant being open and honest and explaining fully to patients what happened if things went wrong. Duty of candour was part of the incident reporting and complaints procedure

Public engagement

- The St John Ambulance website gave information to the public about the organisation. This included information such as what services they provided including events and how the public could provide feedback and complain to the service. People were able to leave feedback on their experience with St John Ambulance on their website.
- The patient experience survey for London from October 2015 to October 2016 was a patient satisfaction report. The report showed they had received 23 responses. The organisation recognised there was a low return rate for their survey. The survey showed that 70.8% of patients thought the vehicle they had travelled in was comfortable and 66.7% thought the vehicle was warm. 91.67% of patients felt they had been treated with dignity and respect and 79.2% said their consent had been sought (the remainder did not know).91.67% of patients would recommend their services to family or friends. The feedback was received from a mixture of patients who attended events and had used the emergency and urgent care services.

Staff engagement

- St John Ambulance had a plan in place called the 'Pulse action plan', the aim to drive staff engagement upwards. The main themes from the plan covered support and management effectiveness, communications, involvement and recognition. Specific actions included regular one to one meetings between staff and their line mangers, ensuring all policies had quick guides to them to make them easy to understand and accessible, involving more volunteers in improvement projects through articles on their internet site. Staff told us they found the policies and procedures easy to access and understand.
- The pulse action plan derived from the results of the national staff survey 2016, which showed the service scored well for teamwork learning and development, enjoyment of their role and engagement overall. However, the survey scored low for support in terms of equipment and resources to perform the role. Recognition, communication that is how well the reasons for change are communicated and change itself. The overall score for how the changes within the organisation affect staff and are well managed was 24%. There were no figures to show how many staff had completed the survey.
- The service communicated and engaged with staff in a number of different ways. Team meetings, e-mails, forums and the organisations intranet as well as one to one with line managers.

- A national newsletter was sent to all staff including volunteers and regional and operational newsletters were shared which included more local information.
- Volunteers attended regular meetings, which were monitored by the district manager for attendance.
- De-brief sessions were held after an event where any lessons learnt during the event and how well an event went were shared.
- District managers attended a monthly event meeting at headquarters. We viewed minutes from meetings, whereby, discussions on future events and actions to take were discussed.
- During our inspection of an event, information was displayed on a staff room screen. Information included actions to take in case of a major incident, instructions on the stadium how to report incidents and responding to calls.
- Staff who worked for the NHS ambulance trust and for the neonatal and retrieval services unit were invited to forums held by the trust, whereby discussions took place on any outstanding issues and equipment problems and operational service. Minutes we viewed showed good participation from both sides with actions to take.
- For the period of end September 2015 to October 2016, the service had lost 20 permeant and 34 temporary staff. The London region recognised and told us, retention of staff was difficult, due to the high cost of living in London and the fact that training staff had received from St John Ambulance was used as a 'stepping stone' to other services, in order to become a paramedic.

Innovation, improvement and sustainability

- The ambulance service reviewed the ambulance crew skills levels for employees and volunteers across the organisation. This was in response and acceptance of the new Associate Ambulance Practitioner qualification that is used by the majority of NHS ambulance trusts for their staff. Plans have been made for staff to achieve a qualification that meets the needs of external customers. It is hoped the additional training and revised restructure of roles will help retain staff, which in turn will help sustain the financial business.
- For events, a recent national tariff was introduced to provide better consistency with customers and help business sustainability.
- St John Ambulance were highly recommended in Marketing News 2016 brand of the year awards.
- In partnership with the NHS hospital, service contracts St John Ambulance provide bespoke intensive care vehicles. St John Ambulance were the first retrieval services to routinely offer parents a seat of the ambulance to allow them to accompany their child to intensive care.
- St John Ambulance were involved in helping to develop the ambulance child restraint.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve
Action the location SHOULD take to improve

- Make sure staff are trained to the required safeguarding children level expected for them to perform their role. We were informed all staff were trained to safeguarding level one. We were told this applied to staff across the whole organisation.This concern has been identified as an organisation-wide issue and we have requested that St John's Ambulance inform us of how they intend to address it.The organisation have since provided us with a plan which details the actions they have taken to address the concerns we raised.
- Provide a target rate for mandatory training in order for compliance to be monitored.
- Provide a more streamlined system for the recording of controlled drugs and make sure staff record the entries correctly, with any alterations to be given clear explanations and reasons with staff signatures, dates and for staff to inform mangers.
- Make sure staff are safely storing patient record forms to maintain confidentiality. For the organisation to devise a system, whereby, the forms do not get wet in the area crew are storing them.
- Provide extra training for the duty of candour so it is embedded within the organisation.
- Stations to have their own risk registers, which can be fed into the regional and corporate registers, allowing for staff contribution and local risks to be identified and acted upon

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.

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...