St. John Ambulance

St John Ambulance East Midlands 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 East Midlands Region is operated by St John Ambulance. St John Ambulance East Midlands Region provides emergency and urgent care and patient transport services.

St John Ambulance East Midlands Region is part of St John Ambulance, a national first aid charity. St John Ambulance provides a number of services including first aid at events, emergency and non-emergency patient transport services and first aid training. The objective of the organisation nationally is the relief of sickness and the protection and preservation of public health. Both volunteers and employed staff are involved with the services provided by St John Ambulance East Midlands Region.

St John Ambulance East Midlands Region provides ambulance services across a number of counties in the East Midlands Region, through a contract with one local NHS ambulance trust. The service also provides a falls service known as FIRST (Falls Intermediate Response Support Team) contracted through the local clinical commissioning group. There is an events service that provides first aid support at public events. St John Ambulance East Midlands Region has contracts with a number of organisations, which hold events in the local area and provides first aid at these events. However, some aspects of events activity is un-regulated, the CQC only regulates activity where patients need to be transported from an event for further medical treatment.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection between 6 and 8 March 2017, along with an unannounced visit on 15 March 2017.

We visited three ambulance operation bases at Newark, Derby and Chesterfield which is also the main administrative base. We visited the falls service (FIRST) and attended one event where St John Ambulance East Midland's Region staff and volunteers provided cover.

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

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

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

We found the following areas of good practice:

- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- Servicing, MOT and insurance for ambulances were all up to date.
- Staff knew how to report incidents. There was a system in place to report incidents of all levels, and we saw changes had been made because of incidents.
- Staff demonstrated a good understanding of their responsibilities around safeguarding.
- Staff carried out structured patient assessments and clinical observations, which were appropriate for their level of competence.
- Staff followed evidence-based care and treatment and nationally recognised best practice guidance. All staff had access to the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines 2016.
- The majority of staff within the organisation had received a recent appraisal.
- All staff received training on the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards as part of their induction training. We saw staff asking patients for consent before starting treatment.

Summary of findings

- St John Ambulance had recently launched the national continuing professional development (CPD) portfolio to ensure staff had up to date skills and knowledge to carry out their roles effectively.
- 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.
- Staff showed compassion and treated patients with dignity and respect throughout their treatment or care. They were kind and emphatic to the patient and respected their privacy.
- Patients and their relatives were involved in decisions about their care and treatment. We observed staff explaining details of the plan of care and checking to ensure understanding and consent.
- Staff supported patients to manage their own care and wellbeing and maximise their independence.
- Service leads worked with a local NHS ambulance trust and other commissioners to provide services, which met the needs of local people.
- Staff had access to translation services for patients who may not speak English as their first language.
- The service received low levels of complaints. Those that were received were resolved appropriately and in a timely way.
- There was a national vision, strategy and values, which most staff were aware of and shared.
- Following the restructuring in 2016, the organisation had formed a new quality and standards directorate. Service leads were focusing their efforts on strengthening the governance framework with health and safety, audit and assurance under one directorate.
- There was a national action plan to drive improvements in substantive staff and volunteer engagement.
- There was a publicly accessible website, which contained information for the public including details of services offered and how to make a complaint.

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

- Security arrangements for ambulance stations were not robust. The ambulance station at Newark was unsecure and inspection staff were able to access buildings, equipment, medical gases, medicines and vehicles unchallenged.
- Medical gases at Newark ambulance station were stored in cupboards, which were not always locked. The stock control system was ineffective as there was not always spare stock of medical gases stored within the ambulance stations.
- Staff were not following the organisational policy for the disposal of clinical waste at ambulance stations.
- There were no effective systems for the management and control of confidential patient sensitive information. Staff posted completed patient report forms through the royal mail postal system with no formalised or routine system of tracking that the information had been either sent or received. Following our inspection the organisation said there was a system in place for tracking patient report forms had reached the intended destination. During our inspection we did not find evidence to suggest this was carried out in this region. No further assurances were provided to the inspection team following the inspection.
- Staff were mixed in their view of the leadership of the service. Not all staff were able to describe leaders as accessible, visible or supportive.
- We found morale amongst substantive staff was generally low and related to communication, job security and career development.
- There were small pockets of staff within Ambulance Operations who raised concerns about some management practices at some locations. Staff described a blame culture and fear of reprisal, although said that this was around personal issues rather than patient issues.
- There was alignment with most of the issues recorded on the risk register and those the leaders has identified as challenges. However we found the risk around patient sensitive information had not been identified or assessed.
- Issues highlighted during our announced inspection were not shared with local managers before our unannounced inspection seven days later; therefore, we had no assurance around the cascade of information to staff.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected urgent and emergency services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		We have only inspected and reported on urgent and emergency care services provided at St John Ambulance East Midlands Region. Patient transport services (PTS) were a very small ad-hoc proportion of the activity of this provider therefore we have not reported on PTS as a separate core service. We have not rated this service, as we currently do not have the legal duty to rate independent ambulance services. This was a comprehensive inspection, which inspected all elements of the five key questions, and we observed patient care. We found systems in place to protect patients from avoidable harm, this included incident and near miss reporting, infection control and vehicle and equipment maintenance. Staff demonstrated a good understanding of their responsibilities around safeguarding. All staff knew who the lead was and also had details to access more specialist knowledge and support if required. Staff had access to policies and procedures which were evidence based and Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines from 2016. All staff had the required documentation present in their personal files and received appropriate levels of training for their role. Staff showed compassion and treated patients with dignity and respect throughout their treatment or care. They were kind and emphatic to the patient and respected their privacy throughout their care. Staff involved patients and relatives in decision-making and supported patients to manage their own care and maximise their independence. However, we had concerns relating to the security of vehicles and equipment at ambulance stations and the management of confidential patient sensitive information. Staff were mixed in their view of the leadership of the service. Not all staff were able to describe leaders as accessible, visible or supportive.

Summary of findings

We found morale amongst substantive staff was generally low and related to communication, job security and career development.

Some staff raised concerns around management practices at some locations and described a blame culture and fear of reprisal.

St John Ambulance East Midlands Region

Detailed findings

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Emergency and urgent care;

Detailed findings

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Background to St John Ambulance East Midlands Region

St John Ambulance East Midlands Region is operated by St John Ambulance. The service was first registered in 2011. It is an independent ambulance service based in Chesterfield, Derbyshire. Ambulance Operations primarily serves the communities of Derbyshire and Nottinghamshire while Event Services cover Lincolnshire and Northamptonshire as well.

St John Ambulance East Midlands Region is part of St John Ambulance, which is a national charity providing 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 Ambulance provides first aid across the country and services include emergency and urgent care, non-emergency patient transport, and first aid and ambulance provision for events. 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.

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

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

The current registered manager has been in post since July 2016.

Our inspection team

The team that inspected the service comprised a CQC Interim Inspection Manager, four other CQC inspectors, and specialist advisors with expertise in urgent and emergency care (paramedics). A Head of Hospital Inspection oversaw the inspection team.

Facts and data about St John Ambulance East Midlands Region

St John Ambulance East Midlands Region provides emergency and urgent care under contract for one NHS ambulance trust. At the time of our inspection, St John Ambulance East Midlands Region provided four ambulances each day for emergency and urgent care. The service was operated from three locations, Chesterfield, Derby and Newark. In addition to urgent and emergency care work, the service was also contracted to provide a falls service known as FIRST (Falls Intermediate Response Support Team). St John Ambulance provided a

Detailed findings

small ad-hoc patient transport service and first aid support at public events. Specific vehicles for first aid events were based at various locations across the East Midlands.

We visited the East Midlands Region head office and their main emergency and urgent care stations at Newark and Derby. We completed interviews with most senior management at head office. We travelled with the emergency ambulance crew who attended emergency and urgent care patients. We visited an event and checked both emergency operation ambulances and those being used for events.

As part of our inspection, we held four focus groups based at two locations, one for substantive staff and one for volunteer staff.

We spoke with 32 staff including; registered paramedics, technicians, volunteers, administrative and support staff and management. We spoke with 10 patients and one relative. During our inspection, we reviewed 15 patient report forms.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in February 2014, which found that the service was meeting all standards of quality and safety it was inspected against.

Track record on safety

- Zero never events
- One hundred and two incidents, the majority of which resulted in no harm.
- Four complaints

- In the reporting period May 2016 to January 2017 there were 3,553 emergency and urgent care patient calls attended. In addition to this FIRST attended 441 calls.
- Five registered paramedics, 2 technicians, three trainee technicians and 12 emergency transport attendants (ETA) worked at the service, which also had a bank of casual and volunteer staff that it could use.
- In the 12 months prior to our inspection the turnover rate for volunteer and permanent ambulance crew was 21% and for casual (bank) crew 56%.
- In the 12 months prior to our inspection, the sickness absence ratio was 6.78 %, which equated to a total days sickness absence of 374.43. Casual workers sickness was 100 hours in the same period.
- The accountable officer for controlled drugs (CDs) was the regional assurance manager.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

St John Ambulance East Midlands Region is operated by St John Ambulance. The service was first registered in 2011. It is an independent ambulance service based in Chesterfield, Derbyshire. The service primarily serves the communities of Derbyshire and Nottinghamshire.

St John Ambulance East Midlands Region is part of St John Ambulance, which is a national charity providing 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 Ambulance provides first aid across the country and services include emergency and urgent care, non-emergency patient transport, and first aid and ambulance provision for events. 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.

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

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

The current registered manager has been in post since July 2016.

Summary of findings

We always ask the following five questions of each service:

Are services safe?

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

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

- Security arrangements for ambulance stations were not robust. The ambulance station at Newark was unsecure and inspection staff were able to access buildings, equipment and vehicles unchallenged.
- Medical gases at Newark ambulance station were stored in cupboards, which were not always locked. The stock control system was ineffective as there was not always spare stock of medical gases stored within the ambulance stations.
- Staff were not following the organisational policy for the disposal of clinical waste at the ambulance stations.
- There were no effective systems for the management and control of confidential, patient sensitive information. Staff posted patient record forms through the royal mail postal system with no formalised or routine system of tracking that the information had been either sent or received. Following our inspection the organisation said that there was a system in place for tracking patient report forms had reached the intended destination.

Emergency and urgent care services

During our inspection we did not find evidence to suggest that this was carried out in this region. No further assurances were provided to the inspection team following the inspection.

However, we also the following areas of good practice:

- Vehicles and stations were visibly clean and tidy, with evidence of regular deep cleaning of vehicles.
- Servicing, MOT and insurance for ambulances were all up to date.
- Staff we spoke with knew how to report incidents. There was a system in place to report incidents of all levels, and we saw changes that been made because of incidents.
- Staff demonstrated a good understanding of their responsibilities around safeguarding.
- Staff carried out structured patient assessments and clinical observations, which were appropriate for their level of competence.

Are services effective?

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

We found the following areas of good practice:

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

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

- St John Ambulance East Midlands Region was not routinely collecting formal patient outcomes as this data was collated by the local ambulance NHS trust. Service leads recognised this and there was a plan in place to collect more data from April 2017.

Are services caring?

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

We found the following areas of good practice:

- Staff showed compassion and treated patients with dignity and respect throughout their treatment of care.
- Staff were kind and emphatic to the patient and respected their privacy throughout their care.
- Patients and their relatives were involved in decisions about their care and treatment. We saw staff explaining details of the plan of care and checking to ensure understanding and consent.
- We observed staff supported patients to manage their own care and wellbeing and maximise their independence.

Are services responsive?

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

We found the following areas of good practice:

- Service leads worked with a local NHS ambulance trust and other commissioners to provide services, which met the needs of local people.
- Staff had access to translation services for patients for whom English was not their first language.
- The service received low levels of complaints. Those that were received were resolved appropriately and in a timely way.

Are services well-led?

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

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

Emergency and urgent care services

- Staff were mixed in their view of the leadership of the service. Not all staff were able to describe leaders as accessible, visible or supportive.
- We found morale amongst substantive staff was generally low and related to communication, job security and career development.
- Some staff raised concerns around management practices at some locations and described a blame culture and fear of reprisal.
- There was alignment with most of the issues recorded on the risk register and those the leaders has identified as challenges. However we found the risk around transfer of patient sensitive information had not been identified or assessed. Following the inspection we asked the organisation if this featured on any risk register and were told that it did not. We received an action plan following our inspection which indicated this would be added to the local risk register and that discussions would be taking place to add it to the national risk register.
- Issues highlighted during our announced inspection were not shared with local managers before our unannounced inspection seven days later; therefore, we had no assurance around the cascade of information to staff.

However, we also found the following areas of good practice:

- There was a national vision, strategy and values, which most staff were aware of and shared.
- Following the restructuring in 2016, the organisation had formed a new quality and standards directorate. Service leads were focusing their efforts on strengthening the governance framework with health and safety, audit and assurance under one directorate.
- There was a national action plan to drive improvements in substantive staff and volunteer engagement.
- There was a publicly accessible website, which contained information for the public including details of services offered and how to make a complaint.

Are emergency and urgent care services safe?

Incidents

- There were no never events in this service between January and December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between January 2016 and December 2016 there were 102 incidents reported relating to ambulance operation services. The top three incident categories related to vehicles (41), medical devices (15) and clinical care (9). The majority of incidents reports were recorded as minor or moderate harm.
- The organisation had an incident management framework policy and an incident reporting policy that set out how the organisation would learn from and act on incident reports from all personnel to improve the quality and safety of its service delivery. The policy set out the accountability, responsibility and reporting arrangements for all staff in relation to incidents. This policy was under review at the time of our inspection following organisational change and the implementation of a revised quality and standards directorate.
- Staff reported incidents using incident report forms. These forms were available to staff on-line and we saw blank copies were available in the ambulance stations. Staff told us they would report all incidents to their team leaders. In addition, staff told us incidents relating to the service provided to the local NHS ambulance trust would be reported directly to them. However, feedback and learning from the incidents reported by staff to the local ambulance NHS trust was limited. The registered manager was working with the local ambulance NHS trust to address this.
- Falls Intermediate Response Support Team (FIRST) had not had any reported incidents. Staff were aware of incidents and learning from the urgent and emergency care teams, shared through station meetings. Staff told us there were some inappropriate referrals into the service but these had not been reported as incidents.

Following our inspection, the organisation told us falls crews were not expected to report inappropriate referrals as incidents. The process for logging inappropriate referrals was on the 'job closure' sheet .This was then logged on the key performance indicators and send to the service commissioners for onwards management.

- Incidents were reported to, and reviewed by the regional quality risk and assurance group on a monthly basis. Exceptions were reported to the national quality risk and assurance group on a quarterly basis in order that the effectiveness of the incident management framework could be monitored.
- The quality dashboard included lessons learned because of incidents. For example, we saw action had been taken because of identified training gaps in the discharge of vulnerable patients. This had been added to the regional training plan for 2017.
- Staff told us learning from incidents was cascaded to them in several ways; at quarterly team meetings, displayed on notice boards and through email. In addition, we were told of a newsletter for ambulance staff called 'On the Road', which kept staff, informed of current topics.
- The organisation also used a monthly lessons learnt bulletin known as 'TAKE 5'. This encouraged staff to take five minutes to carry out quick checks on certain areas such as those identified from incidents or poor practice. The topic changed each month. We saw bulletins on waste management and medicines management. Staff could access these bulletins on the internal intranet through computers as station or through their mobile phones.
- We saw that safety alerts and clinical bulletins were emailed to team leads from the St John Ambulance national headquarters and from the NHS ambulance trust. These were shared with staff verbally and also put the information on staff noticeboards. We saw a recent alert had been sent relating to patients falling from moving aids which was a locally agreed never event (LANE) rather than a never event recognised in other organisations. We saw ambulance staff had signed to say they had read any safety alerts, to show they were aware of changes they needed to make to their practice.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- There were no incidents requiring duty of candour to be applied, however leaders were aware of the actions they should take should a duty of candour incident occur.
- All staff received training in the duty of candour as part of the St John Ambulance induction. Staff were aware of the duty of candour and could give us examples of when this was required.
- Leaders in the organisation told us there would be joint responsibility with the commissioning NHS Ambulance Trust for the application of duty of candour if an incident requiring duty of candour occurred.

Cleanliness, infection control and hygiene

- The ambulance stations we visited appeared visibly cleaned. We checked 14 vehicles, including ambulances and FIRST vehicles; all were visibly clean and tidy.
- A national St John Ambulance infection control policy was in use, supported by procedures for staff to follow and annual training.
- There was an updated national audit programme introduced in 2016, which included infection control audits, such as hand hygiene. Regional assurance managers reported quarterly and there was a monthly national call with the infection control leads to discuss any concerns. At the time of our inspection, the local infection control lead had recently left, and service leads were actively seeking a replacement.
- Managers were required to complete a quarterly infection control audit of their buildings and complete an action plan at the end of the audit and escalate any concerns. We saw a copy of the quarterly audit for Newark Station from February 2017. There were minor issues reported, for example the storage of mop heads, which we saw had been rectified. We reviewed hand hygiene audits for January and February 2017. Managers observed staff undertaking washing and drying hands and using sanitising gels to ensure correct decontamination and all staff were compliant in the majority of tasks observed.
- All staff completed infection control training on induction and had an assessment of their infection prevention and control knowledge and skills as part of their annual revalidation.

- We saw staff using wipes to decontaminate equipment in between patient use. Staff also had access to decontamination packs which were kept on all vehicles in the event of a spillage of blood or bodily fluids.
- Staff completed daily vehicle checks which included reviewing the cleanliness. If there were any deficiencies found, this would be rectified at the time. Staff were allocated 30 minutes at the end of every shift for cleaning of vehicles and equipment. Cleaning materials were available for staff to use for daily cleaning. The service used colour coded buckets and single use mop heads for cleaning the vehicles in line with best practice guidance.
- All vehicles were stocked with personal protective equipment and sanitising hand gel. We observed staff following good infection control principles; they were bare blow the elbow when giving direct clinical care, wore gloves when appropriate and used the sanitising hand gel.
- All staff were responsible for laundering their own uniforms. There was a policy for all staff to follow in regards to decontamination of their uniforms. All staff we observed had visibly clean uniforms.
- All vehicles inspected had single use disposable linen, including pillow cases, sheets and blankets.
- An external company had been contracted to carry out deep cleaning on all vehicles every six to twelve weeks, depending on the use of the vehicle. This external company was also contracted to provide emergency decontamination on a call out basis and we saw a report from the company showing this service had been required on two occasions. The deep clean process involved steam cleaning of vehicles to eliminate harmful bacteria. Set locations on the vehicle, were swabbed pre and post deep clean to check if the process was effective. We saw records of deep cleaning kept on each vehicle we inspected which showed they had all been recently deep cleaned. We reviewed the audit of pre and post swabs from June 2016 to December and saw that decontamination was effective. We saw a vehicle undergoing the deep cleaning process at our unannounced inspection.

Environment and equipment

- Ambulance station garages at Newark and Derby were unlocked prior to the ambulance operation's shift commencing at 9.30am and again at the end of the shift at 10.00pm. Staff told us the stations were secure outside of these hours. However, at Newark we had concerns about the security of the garage, which was open and unmanned at times during our announced inspection. This could mean unauthorised persons may be able to access the garages and the storeroom to the rear which was where all equipment and vehicle keys were stored.
- We returned to Newark Ambulance Station as part of our unannounced inspection. The station was not secure, the inspection team were able to access the building unchallenged. We saw the key safe had been left open for vehicle deep cleaning contractors working on site that day. This meant we were able to take to a key and enter an ambulance unchallenged. We entered the main office and walked all the way around the building and grounds. We were also able to access the medical gas cupboard which was unlocked.
- The organisation had a policy in place for effective management of requests to use new medical devices by the organisations volunteers and employees. In addition we reviewed a policy for the effective management of medical devices used to ensure that medical devices were suitable for its intended purpose, properly understood by the user, maintained in a safe and reliable condition and stored and disposed of appropriately.
- The service operated 27 emergency vehicles in this region. We checked nine double crew emergency and urgent care ambulances, three event ambulances and two FIRST cars all of which were well maintained.
- St John Ambulance used a nationwide inspection, service, and repair and recovery company to support all vehicles through a network of repairers. We saw an up to date agreement for the provision of vehicle fleet management services between St John Ambulance and the external provider. We saw completed and up to date vehicle maintenance schedules.
- Vehicle details were constantly updated by the regional fleet teams and monitored by the fleet coordinator locally.
- There was an effective system in place for the MOT and servicing of vehicles. The service made appointments with their nominated agents for work to be carried out.
- Staff were allocated 30 minutes at the beginning of every shift for vehicles checks. Every vehicle was subject to a vehicle daily inspection by every driver who used it, faults were recorded and reported and certain defects rendered the vehicles unfit for service; this was defined

in the fleet policy. Faults were required to be rectified and checked by a manager before it could be used again. We observed the daily check of an ambulance based at Newark prior to the start of a shift. The vehicle ramp was found to be defective and we saw the vehicle taken out of service and swapped for another vehicle. Vehicles taken out of service for any reason had a card placed in the front windscreen so all personnel would know it was not available.

- There was no standard operating procedure in place to support staff making decisions as to whether an equipment fault should result in a vehicle being taken off road. This meant there was a risk that staff may take a vehicle out on the road without being suitable, or a vehicle being taken off road unnecessarily.
- We saw faulty equipment was tagged with labels to indicate it was out of use.
- We saw all equipment including fire extinguishers had been safety tested and checked with stickers on the equipment clearly indicating the next testing date.
- The service had introduced, in August 2016, an updated 'walk-around' building audit form to identify any risks such as building security and suitable storage for equipment. Staff sent the information to the regional assurance manager, who had overall responsibility for ensuring any actions were taken. We saw the audit report for Newark ambulance station for January 2017 which identified minor issues such as some first aid signage was missing. This had not been rectified at the time of our inspection. Security of the location was not highlighted as an issue on this audit report.
- Containers for the disposal of clinical waste and sharps were in place on each vehicle. There were suitable facilities at all premises for the disposal of clinical waste, at the end of a shift. However we observed staff not following the St John Ambulance 'Infection Prevention Control and the individual procedure' in regard to disposal of clinical waste. The policy required staff to clearly label clinical waste bags with the source of the waste prior to placing in the clinical waste bin at the ambulance station. We saw a bag of clinical waste at Newark station which was not labelled. We asked two members of staff to explain their responsibilities regarding the management of waste. They told us they did not label the waste as per the policy whilst working for ambulance operations; however they did follow the policy more closely when working on events. This practice was not in line with the requirements of Department of Health guidance 07-01: Safe management of healthcare waste. We escalated this to service leads during the inspection.
- Seats in the back of all vehicles had seatbelts. Patients conveyed on trolleys were strapped in using belts and trolleys were fitted with locking mechanisms to stop them moving during conveyance.
- Vehicles we inspected were equipped with paediatric transport harnesses, which staff told us were used in the event of transporting children aged one year and above. Children under this age could be transported using the parent's car seat if necessary.
- We saw that ambulances were equipped with trolleys that could safely accommodate bariatric (obese) patients with a safe working load of up to 60 stone in weight.
- Substantive staff told us, whilst they had enough uniform in general, they had been issued with reflective jackets that were unsuitable for cold and wet weather. One staff member showed us a thick waterproof high visibility jacket that they had purchased themselves in order to stay warm. However volunteers undertaking a similar role told us they had not been issued with this clothing. Paramedics working within FIRST had not been issued with any reflective jackets and had purchased their own. Following our inspection, we were told all staff working on ambulances (both for events and ambulance operations) or in the FIRST team had been issued with appropriate uniform in line with the organisation's Standards of Dress policy. The organisation accepted that staff had some leeway to supplement the standard issue uniform with similar items purchased themselves due to personal choice. There was a National Standards of Dress review group where the issue of high visibility jackets had been raised for further review. This had also been discussed at the national ambulance operations employee forum.
- Vehicles were fitted with radio systems so that staff could maintain contact with each other at events. In addition, staff working on the NHS ambulance service contract were provided with mobile phones and electronic systems (known as PDAs) on which they received information about the patient.

Medicines

- There was a medicines management policy (June 2015) and local operating procedures in place for staff to

follow for the order, receipt, storage, administration and disposal of medicines, including controlled drugs. Staff knew which medicines they could administer dependent on their role and scope of practice.

- The organisation had a Home Office Controlled Drug License. A home office drug license is issued in accordance with the Misuse of Drugs Act 1971 and meant the service could ensure stocks of certain controlled medication could be held for use by paramedics, nurses and doctors working on behalf of the company. There were effective system in place for the management of controlled drugs, this included receipt, transport, storage and regular stock checking.
- A central pharmacy supplied all of the medications used by this location, these were issued to the appropriate staff and monitored through a central contact at the location for expiry date and stock level.
- Paramedics carried personally issued medications. These were checked daily and in a sealed wipe clean carrier. A central electronics register monitored expiry dates and replenishment of drugs. When not in use the bags were stored in locked cabinets within the ambulance depot.
- Each ambulance had a small stock of general sales list medications (items available to buy over the counter such as paracetamol). These medications were stored on the ambulance at all times in a red pouch within one of the emergency equipment bags. Staff told us and we saw the medicines were checked against a stock list as part of the daily checks. Additional stock was ordered from the central store at Chesterfield when required, and securely transported to the staff at outlying stations.
- The organisation undertook a medicines management audit in January 2017. We reviewed a copy of the final report and saw the service was generally compliant in all areas and had produced an action plan for further improvements.
- Medical gases were stored securely on the vehicles. Staff told us and we observed these being checked daily on the vehicles by staff.
- We had concerns relating to the management and storage of medical gases within the ambulance stations. We saw medical gas cylinders including oxygen and pain relieving gas stored in a special area within the garage at Newark ambulance station. There was a separate cupboard for full and empty cylinders which meant staff would be able to easily identify which was which. However on our unannounced inspection we saw that there were padlocks for the cupboard, but they were left open which meant they were not secure. During our announced inspection at Derby ambulance station we saw there was not an effective stock control policy in place for medical gases and, at that time, there were no spare pain relieving gas cylinders at the station. This posed a risk of an ambulance crew being unable to replace an empty cylinder and being unable to provide this pain relief to a patient. We escalated our concerns to service leads following the inspection.

Records

- Ambulance crew completed patient report forms (PRF), which were based on the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) guidelines.
- Staff stored completed PRFs securely on vehicles in the cab area, which they kept locked when the vehicle was unattended. We saw there was a system for the collection of PRFs at the end of each shift. However St John Ambulance East Midlands Region did not have a robust secure transfer of PRF arrangement in place. PRFs were sent untracked through the royal mail postal system to an external provider who in turn scanned them onto a computer system for archive. There was no formalised or routine system in place to ensure this information had been either sent or received. There was no formal risk assessment in place for this process, nor did it feature on the organisation risk register. We could not see the provider had taken any action to mitigate the risk of this process. There was a risk that sensitive patient identifiable personal information could become lost. Following our inspection we were told action had been taken and we saw there was an action plan in place to add this risk to the risk register. Following our inspection we informed the information commissioner's office of our concerns.

- Staff within FIRST were not able to access the electronic patient records that other health care providers such as GPs in the area were using. This mean they did not have all available information on patients at risk of falls, and were required to contact GP surgeries to obtain information and make referrals for these patients. Staff in this team used paper diaries for recording planned appointments. When not in use these were stored in a locked cupboard and not left in the vehicle overnight.

- We observed staff completing PRFs for five patients and reviewed a further 10 completed PRFs, all were legible, complete accurate, dated and signed.

Safeguarding

- St John Ambulance had a national safeguarding directorate who had oversight of the activities of the regional safeguarding managers, district safeguarding officer and safeguarding team.
- St John Ambulance East Midlands had a regional safeguarding manager in post.
- Frontline staff could describe the signs of abuse, knew when to report a safeguarding incident, and knew how to do this. Service leads gave us examples of when safeguarding referrals had been made. We saw evidence there was an effective system to report safeguarding incidents.
- 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. This concern had been identified as an organisation-wide issue and we had requested at other inspections that St John Ambulance inform us of how they intended to address it. Following the concerns raised the organisation provided us with a plan which detailed the actions they had taken to address the concerns we raised.
- Safeguarding training compliance as of 8 March 2017 at this location was 74% for safeguarding level one with a trajectory that this would be 100% by 31 March 2017. For safeguarding level two compliance as of 8 March was 68% with a trajectory of 100% by June 2017. The organisation was on track to meet this target by June 2017.
- Staff had a pocket guide, which included local contact details for safeguarding referrals. The pocket guide included useful flow charts to support staff in decision making.

Mandatory training

- Staff completed mandatory training which was a mix of e-learning and practical assessed courses. Both employed and volunteer staff completed mandatory training.
- Mandatory training modules included equality and diversity, medicines management, information governance, conflict management and dementia. Staff took additional modules relevant to their role. Compliance rates as of 8 March 2017 varied between 68% and 100%. The organisation had very recently introduced a mandatory training target of 80% and we saw plans in place to ensure compliance. The mandatory training year ran from January to December.
- Staff working for the sub-contracting NHS Ambulance Trust were all up to date with the trust's mandatory training.
- St John Ambulance had a team of volunteer driver trainers for operational driver training, including response (blue light) training. These trainers had been approved by national headquarters and by the Royal Society for the Prevention of Accidents (RoSPA). Blue light training compliance as of 8 March 2017 was 100%.

Assessing and responding to patient risk

- All ambulance operations staff were issued with a current pocket guide of the Joint Royal Colleges Ambulance Liaison Committee protocols. This gave assurance that patients would be assessed against appropriate protocols.
- Staff completed structured patient assessments and clinical observations on patients, as part of their care and treatment to assess for early signs of deterioration. If a patient deteriorated, crews informed the receiving hospital's emergency department so hospital staff were aware before the patient arrived. The crews plotted observations on the patient record forms rather than using a tool. Staff had access to suitable equipment on the ambulance to enable them to monitor and assess patients. We observed staff carrying out full assessments including observations, blood sugar monitoring, ECG (a test of the heart function) and a mini mental test (a test used to check patients awareness and understanding). Service leads told us the pathfinder booklet was being updated which would incorporate an early warning score for use by the crews. (An early warning score allows staff to identify a seriously ill or deteriorating patient.)
- The organisation provided fully equipped ambulances and crews under contract to a local NHS ambulance trust. Most of the staff working within these crews were emergency transport assistants and were not qualified or competent to attend high priority calls. Call handlers at the NHS ambulance trust were aware of the clinical

limitations of the staff and allocated calls appropriately. Staff told us they were comfortable with the nature of calls they were sent to and the support they received from the NHS trust staff.

- We saw ambulance crews were able to access clinical advice from their team leaders and from the clinical advice team (CAT) at the local NHS ambulance trust. Staff told us and we saw they were not authorised to discharge the patient at the scene without first discussing details of the patient's condition and symptoms with CAT.
- Staff within FIRST followed a St John Ambulance falls risk assessment form when assessing the risk of falls. This followed the following risk factors; vision, mobility, transfers, behaviour and mental state, nutrition, continence and environmental factors.
- During our observations of direct care we saw appropriate manual handling techniques used for the transfer of all patients. This ensured that staff and patient safety was maintained and injuries avoided.

Staffing

- Team leaders and senior staff, regularly reviewed staffing levels and appropriate skill mix of staff to cover shifts through the contract with the local ambulance trusts and for planned event work.
- For contract work with the local NHS ambulance trusts, the service provided an agreed number of ambulances which was four (two from Newark and two from Derby) on each day of the week, with two appropriately qualified staff. Service delivery co-ordinators used an electronic rostering system to plan shifts. The organisation had both substantive and bank staff that were available to fill the shifts. The organisation monitored the number of emergency care ambulances deployed to the NHS ambulance trust. Data provided by the organisation for the period March 2016 to January 2017 showed the average daily deployment of ambulances was just over three which was lower than the target of four. This meant there were times when the full service contract could not be staffed.
- Substantive staff worked four shifts on followed by four rest days. The contracted shift times were from 10.00am to 8.00pm, and the crews were paid for an additional hour in order to check and clean vehicles before and after the shifts. Staff told us they were paid overtime if their shift overran.
- For event work, the service used an electronic planning system. The event organiser completed an online form; the information they submitted was used to produce a score indicating how many volunteers were needed at the event and the skill mix. This was dependent on the type of event, location and expected numbers. Event staff reviewed the suggested staffing numbers and discussed this with the customer before they asked volunteers to sign up for an event.
- The local event lead was responsible for ensuring the planned staffing numbers were met and that volunteers had the correct skills needed for the event, so people would receive safe care and treatment. Recruitment of volunteers to events was a national challenge for the organisation and included on the regional and national risk register. Staff completed an incident form when the staffing levels were not as planned. The ethos of St John Ambulance is not to deliver a service if there are insufficient personnel to deliver it safely.
- FIRST was commissioned by the local clinical commissioning group. There was one vacancy at the time of our inspection and staff worked in a larger area, and were supported by other permanent staff to cover the vacancy. This meant the service was not compromised. No agency or bank staff were used in FIRST.

Response to major incidents

- Emergency Preparedness, Resilience and Response (EPRR) policies were in place.
- The organisation had a current business continuity plan embedded across its services. The plan provided operational procedures to be followed to enable essential core business to continue during a period of disruption to regional resources. The plan covered disruption to personnel, buildings, communications and equipment. Specific action cards were included to allow staff to understand clearly actions they should take in the event of disruption to business.
- The service worked with contract providers to plan for foreseeable risk. For example, the service had deployed staff to an area of the country expected to be significantly affected by adverse weather conditions.
- Staff had received desktop exercise as part of their continuing professional development to rehearse the procedures to follow in the event of a major incident response.

Emergency and urgent care services

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

Evidence-based care and treatment

- We saw staff providing care and treatment to patients in line with the Joint Royal Colleges Ambulances Liaison committee (JRCALC) clinical practice guidelines.
- Staff told us they received a pocket sized version of the guidelines which they could keep with them at all times to refer to. In addition we saw there were full sized versions at the ambulance stations.
- Paramedics within the Falls Intermediate Response Support Team (FIRST) were compliant with National Institute for Health and Care Excellence (NICE) guidelines for example NICE 161 falls: assessment and prevention of falls in older people.
- We reviewed six policies and procedures on the organisations intranet. All were in date, included a review date and were in line with evidence base practice. For example they reference NICE and best practice guidance.
- In November 2016, the national organisation received a certificate of approval from the International Organisation of Standardisation (ISO) 9001:2008 for quality management system, which was applicable to commercial training services and ambulance operations. This included design, development of training courses in health and safety related subjects. This certification specifically included the East Midlands region.

Assessment and planning of care

- Staff within FIRST promoted holistic falls prevention by providing safe appropriate admission avoidance solutions, which promoted independent living with patient centred goals.
- Staff within FIRST worked in conjunction with other services to provide care in the most appropriate environment. We saw evidence of care handed over to a GP for follow up of medication after FIRST assessment.
- FIRST patient assessments included both physical and cognitive (process of knowing and remembering) tests.
- Staff assessed patients' level of pain as part of the overall assessment. We observed staff asking patients about the nature and level of their pain, which was then documented on the patient report from. We did not observe any patients receiving pain relief as part of the inspection; however staff told us they would administer pain relief appropriate to their level of training.
- Staff considered patient's nutrition and hydration when delivering care and treatment. In the interactions we observed, staff asked about the patients' food and drink intake. We saw there was bottled water on the ambulances and staff told us they would offer it to patients if needed and appropriate.
- Staff within FIRST prevented people attending emergency departments unnecessarily, therefore ensuring patients that needed to went directly to the appropriate location.
- Ambulance crews took patients to the nearest appropriate hospital for their treatment, as advised by the healthcare professional who had requested the hospital admission or transfer. For event first aid, staff told us they would take the patient to the nearest accident and emergency department, should it not be possible to care for them at the event.

Response times and patient outcomes

- The FIRST service was compliant with the NHS Outcomes Framework Domains and indicators one to five. For example domain one preventing people from dying prematurely and domain four ensuring people have a positive experience. The NHS Outcomes Framework (NHS OF) indicators provide national level accountability for the outcomes the NHS delivers; they drive transparency, quality improvement and outcome measurement throughout the NHS.
- The service regular met with the sub-contracted services to monitor service level agreements this provided the opportunity to monitor response times and clinical quality measures. No formal patient outcomes were collected by the service these were collected by the local ambulance NHS trust. We saw a plan in place for the service to record their own performance and clinical quality measure data to start from April 2017.
- The performance of the St John Ambulance East Midlands Region was included as part of a nationwide organisational key performance indicator (KPI) dashboard. KPIs reported included staffing, finance, number of patients transported and operational hours

and fleet details. The East Midlands Region did not necessarily provide the same service as other regions and therefore it was not possible to make direct comparisons.

- In addition to the national dashboard, we reviewed the St John Ambulance East Midlands Operational Report from June 2016 until January 2017. Data from the operation report showed staff from St John Ambulance East Midlands region attended 3,553 emergency and urgent care patient calls.
- Data provided by the organisation showed, between December 2016 and February 2017, the FIRST staff attended 190 calls. Admission to an acute trust was avoided in 184 of these attendances. Staff within FIRST reported never having to refuse attending a call although if necessary a St John Ambulance emergency ambulance would assist.

Competent staff

- All new staff were required to complete the 'Welcome Programme'. The induction period was completed when the staff member had been assessed to be fully trained, rather than a time limited period. Training requirements was role dependant. We saw these had been completed in all of the four files we reviewed
- There were arrangements in place for supporting and managing staff. We reviewed four files and could see that regular one to one meetings had taken place. Clinical supervision and revalidation was supported by line manager dependant on the staff member's role.
- In January 2017 St John Ambulance launched the national continuing professional development (CPD) Portfolio; this was a way for the organisation to plan CPD for staff. The portfolio allowed staff to manage and record all the CPD activities undertaken and ensured staff had up to date knowledge and skills to carry out their roles effectively. The organisation had set the 2017 CPD activities based on concerns raised by CQC at other St John Ambulance locations, for example dementia awareness training
- All staff completed an ambulance clinical competency assessment (CCA) each year, this covered areas such as basic life support and holistic care. The CCA was aligned with staff member's appraisal.
- Full appraisals were carried out on a yearly basis which included an interim review at six month. We saw evidence of this in the four staff files we reviewed. Volunteer staff were expected to keep a continuing professional development (CPD) folder, which was presented to their line manager each year.
- All available staff had received an appraisal at the time of our inspection. Volunteer staff also received an annual appraisal.
- St John Ambulance maintained a national driver and fleet register (NDFR) which is a system that records full details of all drivers including their qualifications, medical status and eyesight tests. Driving permits were issued to all drivers showing the category of vehicle each driver was permitted to drive. The NDFR system also issued reminders of pending license expiry to ensure all drivers had a valid licence. During the inspection, we checked the permits of staff and saw they were in date and displayed correct information.

Coordination with other providers

- There were agreed protocols and pathways for the FIRST team. They were able to refer patients to other providers such as GPs, integrated care community based teams which included occupational therapy and physiotherapy teams. These referrals were through a single point of access or GP services.
- We saw falls team staff planning care in care homes, GP practices, community hospitals and NHS hospitals.
- We viewed agreed care pathways the NHS ambulance provider expected St John Ambulance staff to follow, for example the major trauma and safeguarding pathways.
- There were suitable arrangements in place for escalating issues with the sub-contracting NHS Ambulance Trust. Staff raised incidents and safeguarding concerns directly to the ambulance trust through direct telephone contact numbers.

Multi-disciplinary working

- We observed good multidisciplinary team working between crews and other NHS staff when treating patients. We saw good co-ordinated care and transfer arrangements when handing the care over to NHS staff.
- Staff within FIRST completed handover sheets for GPs to inform and handover of care. We saw evidence of staff completing information following the situation background assessment recommendation (SBAR) model. Staff also had an understanding of handing over information following a medical format for the GPs.

- FIRST staff had a full understanding of services available and how to refer patients to other services.

Access to information

- Where appropriate FIRST staff had access to patient summaries from GP surgeries.
- 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 receive whatever information was known through the electronic (PDA) system. This might include details of any environmental hazards or special instructions such as advance care plans or 'do not attempt cardio-pulmonary resuscitation' orders (DNACPR) for the patient. We saw staff also communicating with the NHS ambulance trust staff by mobile phone to clarify information.
- Staff told us they would check with the patient to see if there was any care plans kept at home.
- We saw staff using satellite navigation systems to plan their journeys.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff received training in the Mental Capacity Act 2005 and Deprivation of Liberty (DoLS) safeguards as part of the St John Ambulance induction. Training records we reviewed confirmed this.
- Staff had a good understanding of their role in obtaining consent prior to entering a patient's home and providing care. We observed staff explaining treatment and procedures and providing patients with the opportunity to ask questions before gaining consent. Staff recorded consent for treatment in the patient records.
- 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 meant preserving life, preventing deterioration, maintaining dignity, and keeping the patient comfortable and pain free. This document also gave staff guidance in the treatment of patients for their mental illness under the Mental Health Act 1983. We observed staff provided care that was consistent with this guidance.
- We observed members of staff discussing a patient's capacity with other professionals. We also observed an elderly patient with capacity declining transportation to hospital following a fall. The crew member was able to clearly explain the assessment process and a patient's right to make an unwise decision.
- We reviewed the St John Ambulance national guidance 'Position statement on the transport of patients detained under the Mental Health Act'. This document outlines that St John Ambulance policy is not to transfer patients sectioned under the Mental Health Act unless working within an NHS contract. Staff within the East Midlands region told us they would transport such patients but only under the supervision of and accompanied by an appropriately qualified escort. None of the staff had been involved in the transportation of such patients and at the time of our inspection there was no such contract in place.
- Staff told us they would refer to the clinical advice team (CAT) at the NHS ambulance trust if they were asked to support a patient experiencing a mental health crisis.
- We reviewed the 'Resuscitation Decision Pathway' provided by the organisation as part of information request. This document included a flowchart to aid staff in decision making for commencing patient resuscitation and prompted staff to verify any advance decisions or DNACPR orders. We did not see any patients with a current DNACPR order during the course of this inspection. However staff understood their responsibilities in such circumstances.

Are emergency and urgent care services caring?

Compassionate care

- We observed staff to be respectful, friendly, kind and compassionate when providing treatment or care to patients. We observed staff introduced themselves and explaining who they were before undertaking any assessment or care.

- We saw that staff respected people's privacy and dignity, including during physical care. Staff demonstrated an awareness of how to maintain a patient's dignity whilst discussing potentially embarrassing situations. We saw staff explaining to a patient the benefits of a changing lifestyle and accepting help.
- Staff within FIRST (Falls Intermediate Response Support Team) demonstrated compassion in caring for patients living with dementia in a manner that caused the least amount of distress.
- We observed that staff treated relatives and carers with respect and with sensitivity when discussing a plan of care or referral to other services.

Understanding and involvement of patients and those close to them

- Staff gave clear verbal explanations to patients about the care and treatment they could provide.
- We observed patients being involved in decisions about their care and treatment. Staff checked with patients to ensure they understood the treatment offered, before they asked for consent.
- Where a patient did not require hospital treatment, we observed ambulance staff discussing this with the patient to ensure they were happy to remain at home and ensuring they knew what action to take in the event of further concerns.
- Relatives were included in plans of care. We saw staff discussing options and making a plan of care with a relative. This included ensuring the relative was satisfied with the plan prior to leaving the patient's home.

Emotional support

- During the inspection we heard FIRST staff reassuring a patient that a follow up visit would not mean an automatic transfer to hospital. We also heard a telephone discussion involving staff reassuring a patient that they would not be 'wasting the paramedic's time'.
- The service did not routinely transport deceased patients. However, all staff within ambulance operations received a mandatory training module which focused on looking after the deceased with care and dignity should they transport a deceased patient.
- Staff were aware of the need to support patients experiencing a mental health crisis. Frontline staff knew their responsibilities when transporting patients detained under the Mental Health Act.

Supporting people to manage their own health

- Staff supported patients to manage their own care and wellbeing and maximise their independence. For example, we observed the care of a patient who had fallen at home. We saw staff emphasising the importance of exercise to maintain independence, which was important to the patient.
- Service leads told us that during events, the majority of patients were not taken to hospital. They were signposted to prearranged primary care, such as GP services or pharmacy facilities, depending on the nature of their injury.
- The falls assessment and care plans aimed to encourage people to look at their own health and environment. The recent focus of falls prevention supported this.

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

(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The service had contracts with one NHS ambulance trust and one local clinical commissioning group. The NHS contract was due to come to an end in March 2017 but had been extended in February 2017 until September 2017.
- Regular meetings took place on a monthly and quarterly basis between St John Ambulance and sub-contracting NHS ambulance service to discuss demand and plan their service.
- Monthly and quarterly activity reporting took place which enabled the service to identify areas in which there was opportunity for improvement to better meet the needs of patients.
- At the time of our inspection the service was operating a Falls Intermediate Response Support Team (FIRST) commissioned by the local clinical commissioning group. FIRST aimed to reduce the inappropriate hospital admissions of falls patients. Staff within FIRST worked closely with local GPs and NHS ambulance providers to prevent hospital admission for patients. This increased their understanding of the needs of the local people. Regular visits by FIRST into local care homes increased the provision of support for those most in need.

- The events service had a number of contracts to provide event first aid, for local and national events within the area. Post event briefings were held with the organisers to review the service provision at these events. This included whether they had met people's needs and areas for improvement at future events, such as the location of the first aid unit at the event. However, some aspects of events activity is un-regulated, the CQC only regulates activity where patients need to be transported from an event for further medical treatment.

Meeting people's individual needs

- Staff had access to translation services for patients whose first language may not be English. The organisation provided clear guidance to staff to ensure that the service could meet the needs of the patient. We saw ambulances had copies of the NHS Confederation multilingual emergency phrasebook which meant staff could communicate basic information to a patient in an emergency.
- Staff completed Equality, Inclusion and Diversity training as part of the mandatory training programme.
- As part of the continuing professional development (CPD) of staff, one of the modules in the 2017 CPD was dementia awareness. As of 8 March 2017 42 % of staff had completed this module.
- St John Ambulance vehicles did not generally have bariatric equipment, although we did observe one ambulance that had a bariatric trolley. (Bariatric patients are those that are very overweight and require additional or modified equipment to accommodate them.) Service leads told us standard vehicles were not equipped for bariatric provision, there was a dedicated bariatric ambulance that had all suitable equipment. Service leads told us all staff had received bariatric training. The dedicated vehicle would be deployed if it was known in advance the patient required this equipment.Staff told us they would contact the NHS ambulance trust for additional support if they were not able to safely transfer a bariatric patient.

Learning from complaints and concerns

- The regional assurance manager had overall responsibility for ensuring the service responded to formal complaints within the agreed timeframe or keeping the complainant updated if there was a delay. The management of patient complaints framework and feedback policy 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.
- St John Ambulance East Midlands had low numbers of complaints (four in 2016) themes included service quality, behaviour of staff, service delivery failure and patient care and treatment.
- We reviewed four complaints and saw they had been managed appropriately and according to the organisation's policy. In all four complaints we saw where people were treated compassionately and supported with their complaint. Complaint investigations were carried out in an open and transparent manner by the assurance coordinator and all complaint responses offered an apology where appropriate. All four complaints demonstrated good practice in line with guidance for independent healthcare complaints.
- In the event of the complaint involving sub-contracting organisation such as the NHS ambulance trust there was a process for the joint investigation and learning.

Are emergency and urgent care services well-led?

Leadership of the service.

- There had been a review and reorganisation of the senior management and regional management structures within the organisation, this had led to the formation of four "super regions". This had led to a period of unsettlement amongst staff within this location, as some staff had been made redundant, moved into other posts or left.
- The management team for Ambulance Operations in this region consisted of a sector manager, who became the registered manager in July 2016, supported by a station manager, service delivery co-ordinator and two station team leaders. The sector manager reported to the national director of Ambulance Operations, the station manager and service delivery coordinator reported to the sector manager, while the two station team leaders reported to the station manager. For event services, the regional director was the interim caretaker

registered manager while his direct report, the operations manager pursued his application for registered manager. The operations manager was supported by an events manager.
- There were inconsistencies in terms of the way staff described the leadership of the service. Some staff were positive about the leadership of the service and told us leaders were accessible, visible and supportive, whilst other staff said leaders were not accessible, visible, and supportive.
- St John Ambulance undertook a pulse (staff) survey every two years. The next was scheduled for December 2017. In the 2015 pulse survey, 197 responses were received from the East Midland's staff and volunteers. Of those who responded, 56% said their manager gave them regular feedback on how they were doing.

Vision and strategy

- There was a national vision in place for the charity, "Everyone who needs it should receive first aid from those around them and no one should suffer for lack of trained first aiders." This was supported by five organisational values of humanity, excellence, accountability, responsiveness and teamwork (HEART).
- The organisation had a 2020 strategy to achieve the vision. The organisation had set out three main goals which were to raise awareness of the importance of first aid in the UK and encouraging everyone to promote and take positive action to be the difference, teach a significant number of the population first aid through work in schools, targeted communities and workplace training and building and mobilising a network of active first aiders and strengthening community resilience by providing out of hospital care through first aid treatment and transportation.
- The organisation through the 2020 strategy aimed to achieve five key outputs these were, advocate, equip, teach, treat and transport. In addition to the outputs the organisation described the three enablers of people, quality and finances would help them implement the strategy and deliver the vision over the next five years.
- Most staff were aware of the vision, values and strategy for the organisation and described how they would apply them in their role. St John Ambulance undertook a national 'pulse' staff survey, which was then broken down into regions. In the 2015 pulse survey 81% of respondents in the East Midlands Region said they understood the aims and objectives of the organisation and 79% said they understood how what they did in the organisation, helped to achieve its aims.
- Staff were observed to deliver care in line with the organisations values.

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

- There was a governance framework in place. Regular governance meetings were held locally, which were the fed into the national governance meetings. Content of the governance meeting was sufficient to ensure that the discussions held supported the delivery of good care. The service had undergone restructuring in 2016 and the new quality and standards directorate were just commencing in their new directorate. The service told us this directorate was focussing on consolidating and strengthening the activities of the health and safety, clinical and audit and assurance functions under one directorate, this would provide a stronger governance framework.
- There were risk registers in place for each specific directorate within St John Ambulance, these fed into the national St John Ambulance risk register when the risk was high. During inspection, we viewed the national and the regional risk register for ambulance operations. We did not review risk registers for each specific regional directorate or the events services. Both registers we reviewed were up to date and included actions assigned to staff members to mitigate the risks highlighted. Progress against the actions to mitigate risks was seen to be recorded and up to date. The regional assurance manager met regularly with the registered manager to review the risk register and ensure mitigating actions remained appropriate.
- We saw there was alignment between most of the recorded risks on the risk register and what leaders had identified as the challenges. However we found staff were posting patient report forms, which included patient identifiable sensitive information, through the Royal Mail postal system. There was no formal process for tracking they had arrived at an external scanning and archiving facility. This posed a risk to patient confidentiality. We raised this with the senior leaders at the time of our inspection, we requested a copy of a risk assessment for this process, and however one had not

been completed nor was this on the risk register. When we returned on our unannounced inspection seven days later, we found that this had not been addressed. Following our unannounced inspection we received documents from the organisation which showed following our unannounced inspection, discussions had taken place and that this risk would be added to the local and national risk register. Further discussions were scheduled to take place around this process.

- We had concerns about security at Newark ambulance station. The station and its facilities including store rooms and ambulances which were easily accessible to the public. We shared our concerns with service leads at the time of our inspection. When we returned seven days later for our unannounced inspection, we were able to access the station unchallenged, access an open key safe and take keys for an ambulance. We were also able to access the main office, medical gases cupboard and store rooms. We were concerned that action had not been taken to address this following our announced visit. We spoke with a staff member and asked them if they were aware of the concerns we had raised on our announced visit, who told us they were not aware. We were therefore not assured that information was being cascaded to appropriate staff members and that risks were not mitigated. Following our inspection we wrote to the organisation and asked for assurance that the concerns we raised at our inspection had been discussed and acted upon. We received a number of documents to show that discussions had taken place locally, and that actions had been taken and on-going action plan was in place. We were more assured that security at Newark ambulance station was being addressed following this information.
- There was a national quality dashboard for ambulance operations, which included information such as number of incidents, complaints and safeguarding referrals. This information was also provided at regional level for comparison and monthly trend analysis.
- In November 2016 the service was re certificated with ISO 9001: 2008. ISO 9001: 2008 is an international standard related to quality management system. ISO 9001:2008 is based on eight quality management principles. When fully adopted, these principles can help improve organisational performance for example facilitating the organisation to become customer-focused, ensuring sustained customer satisfaction by producing, delivering services and providing support functions that meet customer's needs and expectations. Increasing the effectiveness and efficiency of the organisation through continual improvement in systems and products /services quality.
- The maintenance contract for vehicles was managed through a strict set of key performance indicators (KPIs). KPIs are measurable and demonstrate how well an organisation is performing. KPIs were reviewed monthly and acted upon appropriately; extraordinary incidents were handled by the regional teams through a direct contact with the contract provider.
- Frontline ambulance operations staff were able to opt out of the working time directive (working time regulations that provide rights to employees). The service closely managed the working arrangements of staff to ensure that they did not work excessive hours, which in turn may have had an impact on the care and treatment they provided.

Culture of service

- We found the culture amongst staff within the location was mixed and there appeared to be a divide between volunteer and substantive staff, some staff described feeling respected and valued whilst other staff said they did not.
- Staff morale amongst substantive staff appeared low; the theme that came through during our discussions with staff was around communication, job security and career development. In the 2015 pulse survey 18% of respondents in the East Midlands Region said 'generally I'd say communication within St John Ambulance is effective'.
- In our interviews with the senior leaders, we were told that they had been working hard to address staff concerns in relation to job security and enhancing communication around career development.
- There were small pockets of staff within Ambulance operations who raised concerns about some management practices at some locations. Staff described a blame culture and fear of reprisal, although said that this was around personal issues rather than patient issues. Staff felt able to raise concerns around patient safety and were confident they would be supported in these matters.
- There was a culture that promoted the safety and wellbeing of staff. For example, if the service could not staff a vehicle with two suitable qualified staff the vehicle did not go out.

- An external employee assistance programme (EAP) was readily available to all staff. EAP are intended to help employees deal with personal problems that might adversely impact their work performance and well-being.
- The service had encouraged staff to register with the 'Blue Light Programme'. This programme provided mental health support for emergency services staff and volunteers such as ambulance service staff across England.
- Staff were very proud of the service they provided and felt they made a difference for people they saw.

Public and staff engagement

- There was a national newsletter sent to volunteers and employed staff, with further regional or operations specific newsletters. These contained information specific to each staff group, such as any changes to contracts, requests for cover at events and updates on clinical practice or training requirements.
- Staff were able to attend the monthly ambulance operations employee forum. Minutes we reviewed showed that there were a number of subject matters discussed. The meetings were employee led.
- We saw that the organisation had a people recognition procedure. There were a number of levels and methods of recognition these included immediate feedback and praise, acknowledging a contribution through mentions in newsletters, thank you letters, recognising service or achievement over a period of time ranging from a quarter of a year to a few years or for an achievement over a medium term period and recognising long-term service, typically over a substantial period of time, spent undertaking roles or activities for St John Ambulance.
- We saw examples of staff receiving nominations for volunteer of the year and regional directors commendation for individuals who went above and beyond their role or roles within the organisation
- We saw there was a volunteer strategy in place. The organisation set out to increase the impact that active volunteers made across a variety of roles. The organisation planned to increase the volunteer numbers across the service, including increasing the contribution that volunteers make.
- A local action plan was in place to drive improvements in staff and volunteer engagement. The plan was based around four main themes; Supporting and management of effectiveness, communications, involvement and recognition. The action plan was derived from the results of the national staff survey 2015. Actions that had been implemented at a regional level included but were not limited to; Staff and volunteers receiving regular one to one meetings with their manager, a focus on development opportunities available to staff and volunteers and improving internal communications.
- The organisations publicly accessible website contained information for the public in relation to what the service was able to offer.
- The organisation had a patient feedback framework this included how the organisation would engage with the public, in relation to concerns, compliments and complaints.
- Information relating to how a member of public could make a complaint was also available on the organisations website. In addition, an on-line patient experience survey could be accessed to enable users of the service to rate their experience and provide feedback. We did not see that this was available in other languages or formats.
- The assurance team produced monthly reports on feedback received through the on-line patient experience survey. Engagement levels were low. Plans to improve patient and customer feedback were being considered as part of a national review of the feedback policy.
- There was a robust whistleblowing policy for the organisation. The organisation encouraged paid staff and volunteers to raise their concerns, in order that they may be properly addressed.
- In the 12 months prior to our inspection the turnover rate for volunteer and permanent ambulance crew was 21% and for casual (bank) crew 56%.
- In the 12 months prior to our inspection the sickness absence ratio was 6.78 % which equated to a total days sickness absence of 374.43. Casual workers sickness was 100 hours in the same period.

Innovation, improvement and sustainability

- The organisation had employed four paramedics who were part of a commissioned falls service (FIRST). The team worked alongside the local NHS ambulance service and other professionals such as GPs.
- St John Ambulance was highly commended in the Marketing News 2016 Brand of the Year awards. In 2015 St John ambulance launched 'The Chokeables'

campaign, an educational campaign used to communicate the organisations First Aid vision. The Chokeables won an acclaimed Chartered Institute of PR (CIPR) Excellence Award in the healthcare category.

- The service had created an innovative national continuing professional development portfolio which was being rolled and used by all staff (volunteers and substantive).

Outstanding practice and areas for improvement

Outstanding practice

- The service had created an innovative national continuing professional development portfolio which was being rolled and used by all staff (volunteers and substantive).
- The organisation had employed four paramedics who were part of a commissioned falls service (FIRST). The team worked alongside the local NHS ambulance service and other professionals such as GPs and were able to demonstrate effective admissions avoidance.

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure all premises and equipment are secure at all times.
- The provider must ensure there are effective systems and processes in place to maintain security of patient records.

Action the hospital SHOULD take to improve

- The provider should ensure staff follow organisational policies with regards to the disposal of clinical waste.
- The provider should ensure there is a standard operating procedure in place to support staff making decisions as to whether an equipment or vehicle fault should result in a vehicle being taken off road.
- The provider should ensure that medical gases are securely stored at all times.
- The provider should ensure there is an effective stock control system in place for medical gases.
- The provider should consider investigating the causes of the culture identified within some ambulance stations including low morale, poor management practices and inconsistent leadership amongst, in relation to regulated activity.
- The provider should consider reviewing the poor lighting at Derby ambulance station

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met** Newark ambulance station was not secure at our announced and unannounced inspection. Regulation 15(1)(b)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** Staff were posting completed patient report forms, which included patient identifiable sensitive information, through the Royal Mail postal system. There was no local routine process for tracking they had arrived at an external scanning and archiving facility. Regulation 17(2) (d)