St. John Ambulance

St John Ambulance North Region

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

The service had not been rated before. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However

- Several ambulance vehicles were outside of their servicing interval at the time of inspection.
- In some instances the organisational risk register lacked required detail about mitigation that should be taken or who was responsible for implementing such.
- The service did not have documented processes for performing the duty of candour, nor detail of any staff members who had responsibilities for such.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Patient transport services

Good 

This service has not previously been rated. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. The service met agreed response times. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Patient transport service is a small proportion of the service activity. The main service was urgent and emergency care. Where arrangements were the same, we have reported findings in the urgent and emergency care section.
We rated this service as good because it was safe, effective, caring, responsive and well led

Summary of findings

Contents

Summary of this inspection

Background to St John Ambulance North Region

St John Ambulance North Region is an independent ambulance service with a regional headquarters based in Stockport, Manchester and has ambulance operations bases across the North of England including Carlisle, Gateshead, Hull, Liverpool, Ossett, Preston and Warrington with 290 clinical staff.

We inspected this service using our comprehensive inspection methodology. We have inspected St John Ambulance previously, however not as it is currently registered with us. Therefore, this is the first time we have inspected St John Ambulance North Region.

St John Ambulance North Region provides adult, paediatric and neonatal patient transport, and emergency response services for NHS ambulance and hospital trusts across the North of England.

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

How we carried out this inspection

We inspected two core services during this inspection; emergency and urgent care and patient transport service.

The team that inspected the emergency and urgent care service comprised of a lead CQC inspector, an assistant inspector and a paramedic specialist advisor.

The patient transport service was inspected by a lead CQC inspector and a team CQC inspector. The inspection teams were overseen by an inspection manager.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service had taken feedback from patients, which resulted in blacked out windows within the ambulance vehicles, being covered in colourful art murals, which depicted local culture and landmarks.
- Vehicles for patients traveling at the end of their life contained murals inside of calming and peaceful landscapes of local landmarks which patients could see rather than a blacked out window and white wall. This meant helped reduce anxiety and made the patients final journey as pleasant as possible.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Urgent and Emergency Care

- The service should ensure that all ambulance vehicles are serviced within designated intervals. Regulation 15 Premises and Equipment.
- The service should ensure that service's risk register contains all relevant information and updates, which the provider stipulates is required within it. Regulation 17 Good Governance.
- The service should consider implementing written documentation for staff, which details the process for performing the duty of candour and described which staff members have responsibilities, for such.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Good	Good	Good	Good	Good
Patient transport services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Emergency and urgent care

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

Are Emergency and urgent care safe?

Good

We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff.

We noted that there were 18 modules of mandatory training to complete, including modules of essential education. This meant that staff could have a good level of knowledge and information about the provider's policies, procedures and role essential learning.

Managers monitored mandatory training and made sure all staff completed it.

Overall mandatory training figures for the service was 96%. This meant that training had been completed by a high proportion of staff.

During our inspection we spoke with staff who told us about their mandatory training, which they received during induction and at refresher intervals. Staff felt the training was of a good level and equipped them with the skills and knowledge they needed to carry out their role.

We also spoke with managers within the service. They described to us the process of ensuring that staff kept up to date with their training. Managers would receive electronic notifications about training expiry dates for staff. This meant that managers could follow up with individual staff members if their training had not been completed.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. We reviewed information which evidenced staff completed both adult and children safeguarding training.

The level of training undertaken, corresponded with their role. For example, leaders and managers had completed safeguarding training at level 3.

Safeguarding training compliance rates for the service for both adult and child safeguarding were; 99% for safeguarding level 1 and 95% for safeguarding level 2. An adult safeguarding lead was in place within the organisation and had attained the qualification of safeguarding adults and children level 4. In addition, the service had access to advisors outside of the organisation who were trained to level 5 safeguarding.

Staff were aware of the different types of abuse that patients could be at risk of. This included being sighted on the risk signs of both; female genital mutilation and radicalisation.

Service managers told us they were acutely aware of specific cultural and geographical considerations, when considering where risks of this type of abuse would be higher.

Staff knew how to identify adults at risk of, or suffering, significant harm and knew how to make a safeguarding referral and who to inform if they had concerns.

Staff gave us examples of where adult safeguarding alerts had been raised and how this would happen. We observed that staff demonstrated an appropriate professional curiosity when asking questions to ascertain if patients may be at risk of harm.

Staff explained to us the process for reporting safeguarding alerts. In the first instance this was reported to the contracting NHS ambulance trust, who would then coordinate an alert to the relevant body, in line with their procedures.

The alert would then also be notified internally within the provider's processes and systems, which allowed development and learning opportunities around safeguarding practice to be shared within the organisation.

Cleanliness, infection control and hygiene

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

We observed that ambulance station areas had suitable furnishings which were clean and well-maintained. The areas were not cluttered. We observed that ambulance stations had designated cleaning preparation and storage areas, which promoted good levels of cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE). We noted that face masks, gloves and aprons were used where appropriate, at times of patent contact. All PPE was stored in line with national guidance. We observed that hand sanitising gel was present in appropriate areas.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed a sample of Infection Prevention and Control (IPC) audits which demonstrated a comprehensive record of checks and a high level of compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed that ambulance vehicles were clean and well maintained. All ambulances that we observed were within a designated 'deep clean cycle' time period.

Good

Emergency and urgent care

Environment and equipment

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

The design of the environment followed national guidance. We observed that stock room access was appropriately controlled. This ensured that only authorised members of staff accessed these areas. All relevant equipment was stored appropriately, for example medical gasses.

Each designated area had visible posters or information, to remind staff about the requirements and legal obligations of using them.

We observed that all ambulance vehicles had suitable equipment for caring for adults and children including for example, specialist child secure harnesses.

Staff carried out daily safety checks of specialist equipment. We observed that equipment was properly labelled and sign out sheets were in use and correctly filled in. This meant that there was a record of equipment used and who by.

The service had enough suitable equipment to help them to safely care for patients. We reviewed a sample of all equipment and perishables, which were within expiry dates.

We reviewed information about the ambulance fleet used by the service including MOT and services records. All were within MOT date where applicable, however we did note that 13 were outside of their servicing interval at the time of inspection

We also reviewed a sample of a vehicle safety inspection checklist compiled by a local vehicle technician. This comprehensively evidenced that the vehicle was in good working order and free from any faults.

We noted that staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed life support training as part of the providers essential education modules. In addition, the service supplied us with information which detailed that staff and volunteers completed both first aid and emergency first aid at induction and every three years thereafter.

We noted that ambulance crew adhered to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines in assessing a patient's clinical presentation. The JRCALC guidelines are a nationally recognised body which produces clinical guidelines for ambulance professionals.

Staff and management told us that crew members would be dispatched to an emergency call via a direct notification to the ambulance vehicle from the contracting NHS ambulance trust. This notification was received by an electronic console which was fixed within the ambulance.

Good

Emergency and urgent care

The ambulance and crew from the service could be dispatched by the contracting NHS ambulance trust, to any category of emergency response. Ambulance emergency responses are categorised from one through four. Category one is the most urgent and category four is the least.

Where an ambulance crew would attend any emergency response, patients were clinically assessed within relevant guidelines and if escalation was required, a suitably qualified paramedic, from contracting NHS ambulance trust would also attend the scene. This was in line with both national industry standards and best practice.

We reviewed patient record forms, which detailed a section for a patient's National Early Warning Score (NEWS2) to be recorded. NEWS2 is the latest version of a system to standardise the assessment and response to acute illness.

Staffing

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

We reviewed staffing establishment for the service which exceeded planned numbers. Staff members also told us, that the levels of staffing felt enough to keep patients safe. This meant that the service always maintained safe levels of staffing.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with required skill set and knowledge. Management told us that a rota of staff, for the following day, would be received by them from the main control base. This was then reviewed to ensure that the correct level of qualified staff, were deployed on to a shift.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We observed that the service benefitted from a high degree of employed staff and volunteers. Management told us that there was no differentiation between employed staff and volunteers, in that; both received the same levels of training, induction and development.

Due to the nature and reputation of the service, a high level of ambulance crew volunteers which were utilised by the service, were qualified medical professionals such as junior doctors or paramedics.

Management explained to us however that; for the purposes of any volunteer deployment as crew, this was only within the services designated ambulance crew roles, which volunteers had received specific training for.

Records

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

Patient notes were comprehensive and all staff could access them easily. Staff told us that following an emergency response call, ambulance crew completed a patient report form (PRF).

We reviewed a sample of completed patient report forms and noted that the document contained sections to document all relevant and appropriate patient details.

Good

Emergency and urgent care

During inspection we observed a sample of two emergency response PRF's. Following our inspection, we requested and received a further ten emergency response PRF's. We noted that crew notes were written in a clear, legible and verbatim manner. However, we did note that the PRF's observed during inspection lacked some details. For example, in one PRF there was a lack of completed crew details and within another, there were no full clinical observation written.

Records were stored securely. Upon completion of an emergency response shift, ambulance crew would collate the PRF's within a sealed and signed envelope, and deposit these within secure storage within the ambulance station. Management advised us that the PRF's were collected on a twice weekly basis by a dedicated courier service and transported to a central hub.

The PRF's were then scanned int to a secure electronic system and a copy was provided to the contracting NHS ambulance trust. Electronic copies of scanned in PRF's were available for management review, if required by being requested from a central records hub.

The provider advised that a move toward electronic patient record forms was underway, however at the time of our inspection had not been implemented.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We observed that there were sign out sheets for medicine packs. This ensured an audit trail was in place for the use of medicines and by who.

Staff completed medicines records accurately and kept them up-to-date. Full and unopened medicines packs were colour tagged. If ambulance crew did open and use any medicines, a full count and record of contents was noted after.

Staff stored and managed all medicines and prescribing documents safely. We noted that the service had developed a specific process for ambulance crew to administer designated medicines to patients, in certain circumstances. The process developed was similar in structure to a patient group directive. Patient group directions (PGDs) are written instructions to administer medicines to patients. Only ambulance crew who had undertaken specific training, could provide any medicines under this process.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised.

Staff knew what incidents to report and how to report them. Staff explained to us that in the first instance, the incident would be raised to the contracting NHS ambulance trust, for escalation under their processes and procedures.

Staff were clear however, about the need and requirement for the incident to be reported within the service's own internal policies and procedures, which was raised with the relevant station locality manager. Staff told us about the online incident reporting form that they would use.

Good

Emergency and urgent care

Managers told us about the how any incidents reported would be investigated. Upon an incident being reported, the relevant locality manager would ascertain a copy of the patient record form. Following this, one to one meetings would be arranged with the ambulance crew on duty at the time of the incident and statements would be taken. The outcome of the investigation would be reported to both; provider management and the contracting NHS ambulance trust.

The service had reported 373 incidents between June 2021 and June 2022. It reported collectively under ambulance ops (urgent and emergency care and patient transport service) therefore it could not be determined how many of these incidents related to patient transport services. Of the 373 incidents 370 had been resolved and closed and three were in the fact-finding stage.

Posters were displayed at each location to demonstrate the number of incidents and near misses reported within 24 hours, this was 75% in July 2022 meaning the service was focused on the timely reporting and response to incidents.

We noted that the service had no never events or serious incidents reported within the previous 12 months. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

During our inspection we requested a copy of the service's duty of candour policy. The information provided was part of a larger clinical legal framework document. The information did provide a description of what the duty of candour is, what it means and the regulation that enshrines this.

We did note however that the section within the document was relatively brief and provided no process for performing the duty of candour, nor detail of any staff members who had responsibilities for such.

Staff received feedback from investigation of incidents, both internal and external to the service. Management told us that feedback and learning from incidents were used as examples in team meetings and in staff one to ones. During team meetings, staff were encouraged to share their experiences and with other team members to promote learning and opportunities to improve practice.

Are Emergency and urgent care effective?

Good

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We found that the JRCALC guidelines were available to all staff as well as specific learning and training for medicines.

We reviewed training modules which were part of the services 'essential education', which aligned to; best practice and both National Institute for Health and Care Excellence (NICE) and JRCALC guidelines.

Good

Emergency and urgent care

Staff told us that they were equipped with local geographical knowledge, which ensured that patients were taken to the nearest and most appropriate NHS trust's emergency department.

Staff understood the issues of attendances to patients who were subject to the Mental Health Act. The service did not carry out any mental health patient transports, however both management and staff were aware that crew could be dispatched to a patient who may be detained under the Act.

Staff told us that if any patient has a level of need which would mean a higher level of transport risk, then a member of staff from the care home or mental health unit is asked to accompany and support the patient, during any transport to an emergency department.

We were advised that if the patient's support staff are unavailable to accompany, then contact with contracting the NHS trust would be made for either; further advice or paramedic attendance.

We reviewed the service's safeguarding level two module content, which included detailed sections on mental health knowledge and training. We noted that compliance was 95%. This meant that a high level of staff, had the necessary skills and knowledge to support patients with any mental health need.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff told us they assessed patients to ascertain a 'pain score' and noted this within the PRF. We reviewed a sample of patient PRF's and saw this was recorded appropriately.

Staff prescribed, administered and recorded pain relief accurately. The service had PGD's in place for any volunteers that were health care professionals. For staff or volunteers who did not have the designation of a health care professional, the service had developed a specific protocol in consultation with the Medicines and Healthcare products Regulatory Agency, to allow medicines to be administered in a way which maximised patient outcomes.

Response times

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

We noted that the service was subcontracted by NHS ambulance trusts to provide emergency responses to patients. As part of this service level agreement, an ambulance and crew on shift were allocated and dispatched to responses by the contracting NHS ambulance trusts control headquarters.

The dispatches were automatically delivered to an on-board electronic control unit within the providers ambulances. During inspection, management told us that the timings relating to a response were collated by the NHS contracting trust from the electronic control unit within the ambulance.

If any response time issues were identified, then this was raised and discussed by the provider during regular meetings and inspection and/or audit.

Good

Emergency and urgent care

Patient outcomes

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

The service participated in relevant national clinical audits. Managers told us that they submitted care bundle data to the Association of Ambulance Chief Executives (AACE). The 'care bundle' is a list of ten measures which aim to capture what matters clinically to patients and reduce the risk of spreading COVID-19.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Due to the nature of the service, the overall adherence to national standards, was with the contracting NHS ambulance trusts. The service was however subject to regular auditing by the contracting NHS ambulance trusts, where issues such as performance and outcome indicators were discussed.

Following our inspection, we were provided with a template example of a contracting NHS ambulance trust's compliance review form. This form had detailed sections to complete and could result in action being required for the provider to take. We were not provided with any copies of completed compliance review forms.

Managers and staff carried out a daily programme of audit to check standards were met. Managers told us that a regular sample of PRF's were undertaken, usually daily, to ensure that correct and complete information was being compiled about patient care.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service gave all new staff a full induction tailored to their role before they started work.

We reviewed mandatory training materials, which evidenced that staff would undertake role specific training, to ensure they had key skills and knowledge. This included topics such as basic life support for patients of all ages and could take the form of practical exercises.

This meant that staff would have both; the theoretical understanding of any learning, as well as experience of putting the learning into practice. Staff told us their induction and training provided them with the knowledge and skills to carry out their role in a confident manner.

We observed initial employment checks which included competency assessments. We noted that all relevant employee checks had been carried out including checking staff; disclosure and barring service (DBS) status and driving licence qualifications.

Managers supported staff to develop through, constructive appraisals of their work. Staff told us that they have a one to one with their manager every three months and commented that they felt well supported.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers told us that regular team meeting were held virtually. The virtual meetings had been in response to the COVID-19 pandemic.

Managers told us that this had worked well, as the setting had allowed colleagues to feel more confident in speaking up about issues that were affecting them, or where improvements could be made.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. During our inspection managers told us about an updated 'blue light' driving qualification. The service had recognised that this was an area for staff development and promoted and encouraged staff to undertake the newest qualification.

During our inspection we reviewed examples of employee training, which documented completion of 'blue light' driving training, for both the older and newer qualifications.

Managers recruited, trained and supported volunteers to support patients in the service. The service benefited from several volunteers who were professionally registered health and social care workers such as doctors, nurses and paramedics. Managers of the service advised us that all volunteers, completed the same training and induction as their employed counterparts. Managers were very strong in their conviction that aside from pay arrangements, there was no differentiation between volunteers and employed staff within the service.

Multidisciplinary working

Staff communicated effectively with other agencies.

Staff worked across health care disciplines and with other agencies when required to care for patients. We observed that crew provided an appropriate patient handover to emergency department staff. This handover was comprehensive and accurate. Crew members demonstrated that they could share knowledge of any clinical concerns and other matters, for example safeguarding.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We spoke with staff who told us what and how they would work with patient who did not give consent or lacked capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us that if a patient did not give consent for any action or intervention, they would consider the person's decision-making capacity. Staff told us that they were aware of the 'presumption of capacity' and a person could only lack capacity after being properly assessed as such. We observed that there was a clear section within the patient record form for documenting consent.

During our inspection we requested a copy of the services consent policy. The information provided was part of a larger clinical legal framework document. The information provided however referenced consent on two occasions and only within the context of how it would be audited as part of wider effectiveness of clinical care outcomes.

Good

Emergency and urgent care

When patients could not give consent, staff made decisions in their best interest. Due to the nature of the service and potential patient presentation, there would be times where the Mental Capacity Act processes would not be applied, for example in emergency interventions. Where appropriate and applicable, staff could tell us about the process of best interest decisions under the Mental Capacity Act 2005.

Staff understood Gillick Competence. We reviewed training materials which included a specific section about Gillick Competence and Fraser Guidelines, which gave a description of the legal principles and the circumstances behind the case law. This meant that staff could better understand the context of the case and why the law had developed as it had.

Gillick competence means that children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment.

Are Emergency and urgent care caring?

Good

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We travelled with and observed crews providing Urgent and Emergency Care Services. Staff interacted in a kind and respectful manner when supporting patients

Patients said staff treated them well and with kindness. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff provided examples of formal and informal patient feedback. Patients felt staff provided a caring service and displayed compassion and empathy. Patients felt staff were quick to respond and efficient with a positive and helpful attitude.

Staff followed policy to keep patient care and treatment confidential. We observed all handover of patient information to be discreet and confidential. All patient information was handled and stored safely and securely.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us about their experience supporting patients with mental health needs in a respectful manner. Staff provided examples of professional curiosity for vulnerable patients in need of safeguarding.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us about reasonable adjustments they made to care and treatment for personal, cultural and religious reasons. This included providing gender specific crews by request and involving relatives or carers in transport and care.

Good

Emergency and urgent care

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff regularly reassured patients at all stages of transport. Staff used a kind and respectful tone when speaking with patients and relatives.

Staff provided physical support and reassurance through hand holding. When patients became distressed staff used verbal reassurance and physical touch to effectively support them to calm.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff speaking with patients in a clear and direct manner. Staff clearly explained to patients what to expect at each stage of care and transport. Staff kept relatives and carers informed.

Staff supported patients who had made advanced decisions about their care. Staff ensured patients travelled with their completed DNACPR document, where applicable. Staff advocated for full completion of these documents when not provided at the time of handover.

Are Emergency and urgent care responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

The service contracted with NHS ambulance trusts to provide care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. The service held contracts with NHS ambulance trusts in the north of England. The service would provide a number of ambulance vehicles and crew, in line with the service level agreements applicable.

At the start of a shift, the ambulance and crew would log onto the contracting NHS ambulance trust's system and would be dispatched and deployed by the trust's control room.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. During our inspection we were informed about how ambulance crew accessed support for any issue.

Good

Emergency and urgent care

Managers told us that whilst working under a service level agreement, emergency response, staff had access to the on-duty resources that the contracting NHS ambulance trust's staff had. This meant that timely advice for a wide range of presenting issues could be sought by the crew, if needed.

The service had systems to help care for patients in need of additional support or specialist intervention. Ambulance crews were trained to recognise situations and incidents where a paramedic from the contracting NHS ambulance trust would be required. This meant patients with specialist or significantly higher needs, were cared for by the most relevant clinical professional.

We also reviewed copies of the service's internal monthly newsletter to staff. This specifically included a section with a list of contact details for clinical and other advice. This was available to staff on a 24-hour basis.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us they undertake training for supporting patients with mental health, learning disabilities, and dementia. Staff provided examples of reasonable adjustments for these patients included reduced calm lighting while travelling in ambulances and fidget items for distraction and reassurance.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff made use of and referred to these documents to inform their care, when made available by the patient or their carers or care staff.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw that all ambulances were equipped with communication books for patients with a disability, sensory loss, or where English was their second language. These books featured easy read language and visuals, BSL and English alphabet boards, simple communication cards, and multiple language translations of regularly used phrases. Staff told us they made regular use of these books when communicating with patients, and that their use improved interactions and quality of care with patients.

Staff had access to communication aids to help patients become partners in their care and treatment. We noted the services' feedback leaflet was colourful and both easy to read and understand. It promoted good communication needs, by having a series of smiley faces and colours to align with a statement. For example, strongly agree was accompanied by a very smiley face in green, whereas strongly disagree was accompanied by a very sad face in red.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives and carers knew how to complain or raise concerns. We reviewed a copy of the feedback leaflet that could be given to patients during or after their transport to an emergency department. The leaflet could either be filled in and free posted to the provider, or a QR code could be scanned to fill in the survey online.

Good

Emergency and urgent care

Managers investigated complaints and identified themes. Managers told us that complaints could be raised to the service in two ways. The main route of complaints was via the contracting NHS ambulance trusts. For example, a complaint would be made to them, which would then be forwarded on to the provider. Managers explained to us the process of investigating a complaint and providing a response to the contracting NHS ambulance trust.

If a complaint was received directly by the provider, the process would be the same as described above, however the response would be directed toward the complainant.

Managers shared feedback from complaints with staff and learning was used to improve the service. During our inspection we were told that managers used complaint examples in team meetings and also in staff one to one meetings, to encourage reflection and improve practice.

We reviewed copies of the provider monthly newsletter. This included a standing content entitled 'Learn and Grow'. This section detailed an incident or complaint that had been noted, what the outcome was and how the provider had learned from this.

Staff could give examples of how they used patient feedback to improve daily practice. Managers told us about feedback from a patient, who commented that the blacked-out windows of the ambulance, had contributed to feeling travel sick.

Following this staff developed a program, whereby a member of staff would create art murals of local landmarks or cultural references, to be placed on the windows. The provider financed this by providing an opportunity for people or staff to 'sponsor' a mural, which in turn would have their or their loved one's name within the art.

Are Emergency and urgent care well-led?

Good

We rated it as good.

Leadership

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

We reviewed the personal files of senior leaders against fit and proper person criteria. We noted that senior leaders underwent a comprehensive and competency-based appointment process. This included validation of professional registrations, qualifications and DBS checks.

Senior leaders articulated the top challenges the service faced and how to meet them. For example, the provider's focus was sighted on the skills, knowledge and experience of relevant directors, to grow and improve the service.

Staffing challenges, for example recruitment and retainment affecting the wider health economy, were also recognised at senior level.

The provider had a recognition that leadership training at more junior levels was required to be further developed. To do this, the provider had developed a 'Leaders with HEART program'.

Vision and Strategy

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

The vision of the service had been created with reference to a specific set of values, which were well implemented in staff training and development. As an example of this, we noted that the values were displayed within ambulance stations in a clear way.

We also reviewed the service's three-year vision and strategy. The provider had a clear and unequivocal goal to become, what they described as, the nation's 'auxiliary ambulance'. This included an ambitious target of being regarded as such formally, within the scope of the Civil Contingencies Act 2004.

To support this further the provider aimed to have closer integration of relevant voluntary sector organisations such as St John Ambulance in national emergency preparedness, resilience and response planning structures and exercises.

We received the provider's long-term strategy which demonstrated clear goals, by clear timescales. For example, this included; increasing paediatric and neonatal offering nationally, the provision of bariatric transport and, the embedding of volunteer ambulance crews within all crew bases.

We reviewed senior team meeting notes that demonstrated an awareness of expansion of the service being within sustainable financial means.

Culture

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

We spoke with staff that told us they were confident in raising issues with their manager and that managers were both; fair an approachable.

Senior leaders told us that a staff survey has been developed and carried out. Following feedback about this, an example of improvement made was in relation to freedom to speak up (FTSU) work. From this the service appointed both FTSU advocates and a FTSU guardian. This means that staff can feel supported and encouraged to raise any issues without fear of reprisal.

The service also implemented access to a wellbeing chaplaincy service, where staff could discuss any of their issues in a confidential environment.

Senior leaders told us that staff turnover was of an acceptable level and the service was accepting and indeed proud of; if staff do leave it is to join the NHS.

We reviewed the services whistleblowing policy, which demonstrated key processes, action and accountabilities of staff.

Good

Emergency and urgent care

Governance

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

We reviewed the structure of the organisation, which demonstrated a clear line of management from front line crew to the Director of Health and Volunteer Operations. We noted that a medical director and quality and safety director were also in post.

We noted that in policies we did review, these were structured in a way which clearly defined which members of staff were responsible for which actions.

We requested copies of the provider's service level agreements that were in place with partner organisations, during our inspection. This demonstrated a clear legal framework with stated responsibilities and terms, for the provider and the contracting NHS ambulance trusts.

During the inspection we spoke with the registered manager. They told us about an aspect of the governance structure of the service, which was a clinical committee. The purpose of this committee was to review any national evidence-based practice aspects, which would then filter into organisational policies and procedures.

We reviewed minutes from the July 2022 North locality management meeting demonstrated that staff absence, training compliance, appraisals, vehicle audits, incident and complaints were discussed.

Quarterly team meetings were held for all staff members. Minutes from a team meeting held in July 2022 demonstrated that training, wellbeing, complaints, feedback and regulations were discussed. The meetings were repeated over three days so that as many staff could attend. A frequently asked question sheet was produced following the meeting each quarter with managers answering any questions from the meetings.

Minutes were accessible to all staff on an electronic platform as well as printed and posted onto a noticeboard in the staff areas. This meant staff who were not able to attend could still be kept up to date with important information.

Performance dashboards were available to monitor performance and meant that senior managers could quickly and easily see any gaps in performance or challenges to the service. Dashboards included sickness absence training, fleet vehicle deep cleaning, feedback and incidents.

The governance framework was centred on patient care and safety. Thresholds and trends for risks and incidents were monitored by a specialist insight team and a feedback and complaints dashboard was benchmarked against activity. This was monitored through the monthly business meeting.

An on-call escalation telephone number was in place for all staff which supported staff in undertaking their roles. This telephone number provided updates about safeguarding, logistics, operational management and clinical management.

The patient care services operated two contracts at the time of inspection. Both had service level agreements in place. These were in date and set out key areas of accountability.

Good

Emergency and urgent care

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues, however did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

We reviewed the provider's risk register. We noted that it contained a description of the risk and was allocated a score. This score was then colour coded and categorised as either tolerable, action required or unacceptable.

Within the risk register there were a number of tabs which included details about what score the risk should be i.e. tolerable and also what further action should be taken and who by. However, we noted that for 5 of the 11 entries detailed, where there was a score which indicated action should be taken, there were no action details or who was responsible for implementing such. This could mean that some risks lacked both; any action plans to improve and who had ownership of the risk.

Managers told us about the plan for any contingencies. This included designated back up locations. In the event of the need for a contingency, staff were aware that they would have to contact relevant management and the facilities department.

During our inspection we requested a copy of the services business continuity plan. Upon review, we noted that the policy did demonstrate the roles and responsibilities of key persons and that there was a business continuity plan pro forma to be completed for hubs or sites.

We observed a sample of a business continuity plan for one of the hubs that the provider operated.

Information Management

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

Data was collected and processed through an electronic system. This included training compliance, staff absence, staffing rotas and also feedback from staff members and patients. This allowed managers to be able to make real time decisions about operational capability.

Documentation was processed electronically. If any paper documents were completed, these were collated within the ambulance station and then sent to a central location to be uploaded.

The electronic system used was password protected. Staff were able to access the electronic system with their own username and password and could see system information relevant to their role and seniority.

We noted that all staff were required to complete data security awareness as part of mandatory training. The service had a dedicated Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Staff told us they were aware of the service leads who would be responsible for making alerts and notifications and what to do if they were not contactable. This was reinforced in monthly newsletters and policies we viewed, which clearly provided required contact numbers.

Good

Emergency and urgent care

Engagement

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

Senior leaders told us that a technology driven way had been devised to promote receiving patient feedback. For example, QR codes were displayed within ambulance vehicles. A QR code is a scannable logo which, in this case, linked to an online patient feedback survey.

Managers went on to tell us that the services connected with local Healthwatch groups as there was a recognition within emergency response calls, circumstances may not be appropriate to seek feedback from patient, at the time.

The service developed a celebrating community's network, which aligned and was involved with different events or organisations. For example, the service had recently shown affiliation with a prominent and national LGBT event.

Recently the service had relaunched a staff forum, with the remit being to hear issues or problems and take suggestions or solutions from colleagues. Senior leaders told us that a key aim of this forum was to have at least one representative from each ambulance station or hub. This would ensure staff voice was heard from all locations of the service.

Equality, diversity and inclusion training was in place for staff as part of annual mandatory training and was reflected in the planning and delivery of services and shaping of culture within the service. This included protected characteristics as well as additional characteristics such as those with caring responsibilities, low socio-economic backgrounds and volunteers. An equality, diversity and inclusion impact assessment was completed for each policy, practice, function or programme (project) within the service and considered both positive and negative impacts.

An equity, diversity and inclusion steering group comprising of people networks included disability accessibility, family and carers, pride, women's and multi-cultural networks. The networks were championed by the chief executive. The steering group contributed to the equality, diversity and inclusion 2022-2023 strategy. This showed the service was committed to promoting equality, diversity and inclusion in all areas.

Learning, continuous improvement and innovation

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

The service placed an importance on learning and development. This was reflected within part of the provider's overarching activity of being a nationally recognised trainer.

The service had implemented what was described as a 'learn and grow model'. This meant that at the conclusion of any incident a template document could be completed, by managers. The learn and grow document was then reviewed for inclusion to the wider service, to promote best practice, learning and staff reflection.

We noted that the service did undertake innovative projects, for example senior leaders told us that volunteers and staff had been offered the opportunity to come together as a collective and help design key aspects and layout of a new fleet of ambulances to be purchased.

Good

Patient transport services

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

Are Patient transport services safe?

Good

This service has not previously been rated. We rated it as good.

Mandatory training

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

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers monitored and updated a dashboard monthly. This meant they were able to track which staff needed to complete mandatory training modules.

The service did not distinguish between staff working on the patient transport and urgent and emergency vehicles and therefore could not breakdown the mandatory training figures to patient transport level. Managers told us that staff rotated between emergency and urgent care and patient transport services.

Mandatory training for the service had been completed by 96% of the 290 staff members. This included modules such as data protection, emergency first aid which included basic life support, equality and diversity and health and safety awareness.

Please see Urgent and emergency care core service.

Safeguarding

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

There was 95% of staff who had received training in adults and children level two safeguarding training on how to recognise and report abuse.

Safeguarding referrals were made using a dedicated team. A safeguarding lead trained to level four was available 24 hours a day to offer support and guidance to staff if required.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding referrals were made electronically by smart phones in the vehicles which contained a secure application. In addition, a safeguarding policy was available for all staff on this device meaning that staff could easily access information they needed to make a referral of concern.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable contents which were clean and well-maintained in line with national guidance. Cleaning areas were available on all stations. Cleaning equipment such as disinfectant and spill kits were stored on each vehicle in the event of the vehicle needing cleaning when away from its base.

Vehicles were deep cleaned every six weeks and managers monitored this on a performance dashboard to ensure the vehicle deep cleaning schedule was maintained. This allowed for the vehicles cleaning to be flexed and still meet the national guidance for frequency of cleaning. For example, if a vehicle was heavily soiled and needed to be deep cleaned ahead of its six week schedule.

Pre and post deep cleaning swab tests were taken in the vehicles in areas such as door and cupboard handles and steering wheels. This information was analysed monthly and used to advice crews on which areas to focus on when undertaking their daily cleaning. A poster with this information was displayed on each station.

Staff followed infection control principles including the use of personal protective equipment (PPE) which included gloves, masks and aprons in line with national COVID-19 guidance.

Environment and equipment

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

A building audit was completed quarterly this meant the service could identify issues which needed addressing quickly.

A fleet checking electronic application was available on each vehicle phone where any vehicle defects could be reported including daily checks such as tyre pressures. Information such as vehicle insurance details and what to do in the event of the vehicle being involved in an accident or a windscreen breaking were also available on this devise meaning that staff could quickly and easily access the information they needed.

The service used disposable one use linen; A dedicated procurement team ensured that disposable supplies and reusable equipment were easily available meaning vehicles could remain in operation with less time of unavailability.

A monthly operational group was attended by the head of fleet for the service so that any themes in vehicles off the road could be identified and quickly addressed.

A service and MOT log was held by the service which clearly set out each vehicle by fleet number, registration, make, model and location. This spreadsheet contained details of when the service and MOT checks were due and meant that the service could be assured each vehicle was road worthy and met legal requirements.

Good

Patient transport services

An external company provided the mechanical cover for when vehicles were defective. This meant that they could be assessed and repaired in a timely manner regardless of location. The service reviewed the responsiveness of the external company to ensure it was not impacting upon vehicle down time unnecessarily.

Staff had completed training on the use of specific items of equipment such as the track chair and stretcher meaning they could safely and efficiently use them.

Clinical waste was disposed of regularly from a secure bin stored on each station.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration

The service did not have a deteriorating patient policy. However, it had subscribed to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). This published national guidelines for the assessment and management of patients with various conditions, illness or injuries including heart attacks and strokes. This application was available on each vehicle phone and meant that staff could access support in the event they needed it whilst waiting for additional help via the 999 emergency call system.

Staff were trained in basic and intermediate life support and emergency first aid which included choking.

Staff shared key information to keep patients safe when handing over their care to others including when patients were transferred from hospital to nursing and residential care facilities.

Please refer to urgent and emergency core service for further details.

Staffing

Staff working for the service worked across both urgent and emergency and patient transport services and therefore were included within the establishment figures for the larger core service. - please refer to this section in the urgent and emergency core service.

Records

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

Patient transport logs were recorded for each patient undertaking non-emergency transportation. This was less detailed that a patient report form however noted the patient details and any actions or incidents undertaken during the journey. These logs were kept in an envelope during the shift and then posted into a secure box on each station. They were then collected twice weekly and uploaded onto a cloud based system. Paper copies were then destroyed.

Medicines

Please see urgent and emergency core service.

Incidents

The service managed patient safety incidents. Managers investigated incidents and when things went wrong, staff apologised and gave patients honest information and suitable support.

Good

Patient transport services

The service had one serious incident relating to patient transport services in May 2022. This was related to the administration of a patient's personal medicine. At the time of inspection this was being investigated in line with the serious incident policy. This policy was in date and set out responsibilities and accountabilities for incident investigations. Duty of candour had been applied and the service had worked closely with the NHS trust for which it was carrying out the patient journey.

Learning and changes to practice were shared with staff following incidents. For example, operational instructions relating to a bracket holding a piece of equipment were shared with all staff following an incident. This meant that staff had consistent information and guidance following an incident and that learning, and actions were identified and undertaken.

Please refer to urgent and emergency core service for further details.

Are Patient transport services effective?

Good

The service has not been rated previously. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance for example updates such as COVID-19 best practice guidance and the National Institute for Health and Care Excellence. The quality statements were reviewed at a clinical committee before being shared with staff and updates to policies and procedures made. Information was shared using an electronic application system, by email, newsletter and face to face.

Please refer to urgent and emergency core service for further details.

Response times

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

The service monitored agreed response times which were built into the contracts for the service. For example, a 20 minute mobilisation time for the renal patient transport service. These times were reviewed and monitored through a demand and capacity dashboard by a data and insight team. The information was shared with managers who could review and flex the capacity of the staff and vehicles where required.

Competent staff

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

Staff within the service completed a single emergency qualification as they worked on both patient transport services and urgent and emergency care. This meant that staff had the right skills and knowledge to meet the needs of the patient. Training included mental health awareness.

An essential education programme within the service was determined annually based on incident analysis, so for example by looking at themes and trends. The 2023 essential education programme was being finalised at the time of the inspection and included modules of mentorship and supporting newly qualified members of staff as well as intoxication from alcohol and/or drug use.

An electronic dashboard notified managers and staff that training was due to expire in 90, 60 and 30 days. Managers could monitor completion of essential training and support staff to complete the training in advance of the training expiring.

Initial pre-employment checks including references and employment history were carried out by a central human resource team of the service. All relevant employee checks had been carried out including disclosure and barring service (DBS) status.

There was 90% of staff who had completed an annual appraisal within the service. This figure incorporated both patient transport services and urgent and emergency care services. In addition to an annual appraisal staff also participated in bimonthly one to one discussion; meaning performance issues and training needs could be quickly identified and addressed. Staff confirmed one to one discussions took place and were useful.

The service promoted mental health awareness in the form of a book review within its June 2022 newsletter to all staff. The book was about mental health and focused on decision making, considerations and challenges to staff working in a pre-hospital environment. A discount code for the purchase of the book had been shared with staff. This meant the service was working to deliver staff development and improve their knowledge of mental health conditions.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked closely with colleagues from other organisations to secure the best outcome for patients. For example, a manager met with an end of life care manager at the patient's home to assess the access and egress in supporting the patient to return home to die. This meant the transfer could be undertaken as quickly and safely as possible and staff knew in advance the potential challenges where a stretcher could not pass.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Training for staff included information about transient capacity and staff could tell us about the process of best interest decisions under the Mental Capacity Act 2005. Gillick competence awareness was contained within the mental health awareness training provided by the service.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes and if staff needed support in doing this, they could access a 24 hour telephone line where support in decision making could be given.

Good

Patient transport services

Please refer to urgent and emergency service report.

Are Patient transport services caring?

Good

The service has not previously been rated. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff caring for patients compassionately such as holding hands and speaking to them with dignity and kindness. When moving and handling patients staff did this carefully and gently so not to cause pain or distress.

Staff followed policy to keep patient care and treatment confidential which included discreet handover at hospital and care locations. This further reinforced staff treating patients with dignity and respect.

During the inspection we were told of many examples where staff had gone above and beyond to care for patients. Compliment letters demonstrated that staff provided care to patients in a way they would want a relative to be cared for example, one patient had been discharged but had no bed linen at home. The crews stayed with the patient and sourced the linen themselves so the patient could remain in their home. This demonstrated that staff were compassionately working for the best outcome for patients and that they were modelling the values of the service.

Emotional support

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

Staff handled information sensitively for example when ensuring do not attempt cardio pulmonary resuscitation (DNACPR) orders were transported with patients on their final journey. Staff were unhurried and would wait to ensure to paperwork was available so the patient could be transported to their destination of choice.

Staff comforted patients that were distressed and held patients' hands which is thought to be a powerful non-verbal cue in caring for distressed and anxious patients.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them and worked hard to communicate effectively with both patients and their loved ones.

Understanding and involvement of patients and those close to them

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

Good

Patient transport services

Staff made sure patients and those close to them understood their care and treatment and staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were provided with information about the most suitable terminology to use when talking to patients and relatives.

Patients gave positive feedback about the service. Feedback cards and QR codes were given to patients at the end of their transport journey. It was not possible to distinguish between comments from urgent and emergency care and patient transport services however the comments were consistently positive and included "going above and beyond, kind, brilliant and amazing".

Are Patient transport services responsive?

Good

The service has not previously been rated. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services with NHS commissioners, so they met the changing needs of the local population, for example, adapting service provision for renal patient transportation in North East England and end of life transport.

Facilities and premises were appropriate for the services being delivered. Vehicles for patients travelling at the end of their life contained murals inside of calming and peaceful landscapes of local landmarks which patients could see rather than a blacked out window and white wall. This helped reduce anxiety and made the patients final journey as pleasant as possible.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. This was through a 24 hour support help line. Staff liaised with a clinician who could support with assessing the immediate needs of the patient and then seek any necessary referral or support.

The service had systems to help care for patients in need of additional support or specialist intervention. This included bariatric equipment, specialist seat belt harnesses for children and secure safety attachments for wheelchairs.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. This included small dementia friendly crocheted object for patients to hold. This was known to distract patients and reduce anxiety.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Communication books were available on each vehicle. These books supported non-verbal communication using pictures. The content of the books were part of staff training.

Good

Patient transport services

The service had information booklets available in different languages and a telephone translation service could be contacted 24 hours a day.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives and carers knew how to complain or raise concerns. Information was easily available and clearly displayed in vehicles and on the service internet website.

Managers investigated complaints and identified themes and shared feedback from complaints with staff. Five complaints from ambulance operations were reviewed these included clear timescales for investigation, actions and feedback letters from managers to complainants.

Please see urgent and emergency core service for further details.

Are Patient transport services well-led?

Good

The service has not previously been rated. We rated it as good.

Leadership

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

Leaders had the skills, knowledge and experience to support the running of the service. Locality level leadership was introduced in 2019, the patient transport line manager reported to a locality manager whom oversaw both urgent and emergency care and patient transport services meaning that the service had oversight of both services. A leadership and development team had been created to support junior leadership roles, an accredited first line management training course had been scheduled as part of a programme of leadership continual professional development. Managers told us this had been delayed during the COVID-19 pandemic but had been prioritised as part of the wider leadership programme.

The job role of lead crew had been created which supported succession planning and retention within the service. This role included a blended role of 80% patient facing and 20% supporting staff with areas such mentoring, following up incidents and supporting managers with audits.

Leaders were visible and approachable and offered an open door policy to staff.

Good

Patient transport services

Vision and Strategy

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

The service business strategy was focused on sustainability of the service and identified three key operational priorities. Build on success, wellbeing and getting the basics right. These priorities were underpinned by strategic goals and monitored regularly to ensure actions were completed in line with timescales.

An equality, diversity and inclusion 2022-2023 strategy set out strategic aims for the service that were underpinned by priorities which clearly set out actions, responsibilities and measures. This demonstrated the service was committed to promoting equality, diversity and inclusion in all areas which aligned to the strategic aim of well being.

Culture

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

Leaders understood the importance of staff being able to raise concerns without fear of retribution, and action was taken as a result of concerns raised. For example, the service commissioned external investigations into personnel disputes where appropriate.

The service had introduced Freedom to speak up. There was a whistle blowing policy in place which was easily accessible for all staff. The policy was in date and detailed how to raise a concern and accountabilities and responsibilities. Staff understood the policy and knew how to raise concerns.

A conflict resolution team was able to signpost staff when there was conflict to mediate without the need to enter formal procedures.

Staff could access an electronic well being app either from work or home. This application had well being strategies and included benefits to staff such as discounts, access to support mechanisms including counselling service, job roles and recognition of good work.

A quarterly pulse survey had been introduced within the service and meant that managers could sense check staff perceptions, thoughts and feelings and focus upon areas of strengths as well as areas for development.

Governance

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

Governance processes were in place within the service and staff understood their roles within the process.

Regular governance meetings were held including monthly operations business meetings which included patient safety as part of its standing agenda and monthly locality meetings.

Good

Patient transport services

Please see Urgent and emergency care core service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues, however did not always identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service understood and managed foreseeable risks such as disruption to staffing levels, adverse weather and loss of facilities or infrastructure. The staffing model created in terms of training for both urgent and emergency and patient transport services meant that staff could be utilised and flexed where the demand was required, and staffing resilience had been built into contracts. Estate and fleet management were a key part of the governance structure and contributed to key policies such as the winter plan and business continuity policies.

Managers knew the top three risks for the service. There was a risk register which detailed risks to ambulance and community response. Of the eleven risks sighted on the register none related to patient transport services. The risk register set out the impact and likelihood, it gave an overall risk appetite and set out what the legal implications were. There was a risk owner assigned and review dates were listed however actions were not always listed. Local risks scoring 20 or above were reviewed by the executive board through the board assurance framework. Please see the urgent and emergency core service for further information.

A business continuity policy was in place and set out incident management, triggers for escalation and post incident learning. The service had a business continuity manager who managed the process.

Information Management

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

Staff were able to access information easily and information technology was used to effectively monitor and improve quality of care such as the monitoring of feedback, training compliance and audit outcomes.

Notifications were consistently submitted to external organisations in line with statutory requirements through a dedicated team such as the patient safety team and safeguarding teams. Managers knew what information was to be reported and when. This demonstrated that the service was working collaboratively, open and transparently to improve patient care.

Information systems were secure password protected and in compliance with data security standards and GDPR requirements.

Staff received an electronic 'run sheet' at the beginning of their shift from the host organisation control centre. This meant that staff knew when and where to go in a timely way and could plan breaks and finish times effectively.

Good

Patient transport services

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. Equality, diversity and inclusion was a clear priority. The service collaborated with partner organisations to help improve services for patients.

The service worked closely with patients and their families to seek out and act on feedback. For example, the murals on the inside of the vehicles transporting patients on their last journey came from feedback provided by relatives of patients. Feedback leaflets were available on each vehicle for patients and their families, QR codes were also available and led to an online survey. A clinical team within the service received all feedback and reported the information quarterly at governance meetings.

External organisations such as NHS advocacy service had been consulted although this had stopped due to the COVID-19 pandemic. Managers told us they were planning on restarting patient forums via the advocacy service soon. This was not in place at the time of the inspection.

Learning, continuous improvement and innovation

The service took a proactive approach to seeking out new and more sustainable models of care. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was working hard to continually learn and improve the services for patients. For example, it had introduced a cloud-based procurement system to effectively manage equipment and medicines. The service was in the process of introducing electronic patient care records and were working with external auditors to develop software to monitor patient outcomes and care bundles more effectively. Please see urgent and emergency core service for more details.