

Special Ambulance Transfer Services Limited

Special Ambulance Transfer Services Ltd (SATS)

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?

Insufficient evidence to rate 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

Our rating of this service improved. We rated the service Good overall because:

- The service had made improvements in relation to the management of medical gases. There was an up to date medical gases policy and a process for the signing in and out and of oxygen cylinders so no cylinders could be left on vehicles when they went out for servicing. There was also more secure storage of oxygen cylinders in place at the base.
- Patient record forms were now being returned to the office after every shift and not left on vehicles for extended periods of time.
- The service had improved their processes around the safety testing and servicing of equipment. Equipment we checked was all in date and safety tested.
- The service used an electronic application for vehicle daily inspection checks where videos of equipment checks as well as pictures were uploaded and sent through to management allowing for full oversight of the vehicle checks.
- The provider had improved their processes for Disclosure and Barring Services (DBS) checks. All staff had up to date DBS checks and the service audited this to make sure processes were working effectively.
- The provider had improved their process around the re-checking of staff members' driving licenses. All staff had up to date driving license checks in place and these were now being regularly checked by management.
- The provider had now implemented a process to ensure that ambulance staff declared their working arrangements outside of the service. This ensured staff did not work excessive hours.
- Staff knowledge around the Gillick competency had improved. 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. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them.
- There were now regular clinical governance meetings where service risks, issues and performance were discussed. The meetings were minuted and included actions to take forward.
- The service had improved their risk register which reflected risks within the service and was updated and discussed regularly by the management team.
- The leadership team had significantly improved their governance processes since the last inspection and there were clear processes and systems in place which showed the service assessed, monitored and improved the quality and safety of the service.
- Staff reported a positive working culture and commented on a supportive leadership team who were friendly and approachable.
- Staff knowledge around infection, prevention and control was comprehensive and ambulances we inspected were visibly clean.
- The service's vehicles were bespoke to the services offered by the provider.

However:

- While staff we spoke with reported that the provider's main service was patient transport, the service's Scope of Practice Policy did not reflect the service's main service delivery offer of patient transport. It did not specify the new service provision for high dependency unit (HDU) transfers whereby transfers were non-time critical, and patients were always accompanied by their own medical teams from hospitals who would bring their own emergency

Summary of findings

equipment and medicines. The policy still went into detail about medicines administration by certain staff groups however the service no longer stored, prescribed or administered medicine. Information within the policy around medicines administration by certain staff groups was therefore no longer relevant and there was a risk that new staff could be confused about the service's scope of practice when they read the policy.

Nigel Acheson

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Patient transport services

Rating

Good



Summary of each main service

The main service was patient transport services (PTS) which made up 97% of the provider's work. The provider had 13 ambulances used for both PTS and emergency and urgent care (EUC). The arrangements for PTS and EUC were the same. Therefore, we have reported most of our findings for EUC in the relevant PTS sections of the report.

Emergency and urgent care

Good



Emergency and urgent care services (EUC) made up 3% of the work carried out by the provider. Arrangements for EUC and patient transport services (PTS) were mostly the same. Therefore, we have reported most of our findings in relation to this core service in the relevant sections of the PTS section of the report. We rated the EUC service good overall for the same reasons and using the same relevant evidence set out in the PTS summary.

Summary of findings

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Summary of this inspection

Background to Special Ambulance Transfer Services Ltd (SATS)

Special Ambulance Transfer Services is operated by Special Ambulance Transfer Services Limited. Special Ambulance Transfer Services (SATS) was founded in 2006 and is an independent ambulance service providing a range of patient transport services based in north west London.

The main service is patient transport services (PTS) and some emergency and urgent care (EUC) transfers. The EUC transfers the service undertakes are non-time critical and are between hospitals with hospitals' own medical teams on board SATS' dedicated high dependency unit (HDU) vehicles.

The service provides transport for both adults and children and young people. This includes the transfer of high dependency patients, paediatric and neonatal intensive care transfers, patients receiving Extracorporeal Membrane Oxygenation (ECMO), non-emergency patient transfers, repatriations and event medical cover such as for sporting events. ECMO is a form of life support that provides both cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life.

Journeys are made to various locations within London and longer journeys across the UK. In the last year, the service undertook 3273 journeys of which 3% were HDU journeys.

The service has vehicles operated by emergency care assistants, emergency medical technicians and nurses.

The provider is registered for the regulated activities:

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

The service performs contracted work with London NHS Trusts and independent hospitals. SATS also operates as a subcontractor to main contractors (identified as commissioners in this report).

At our last inspection, the main service provided was Emergency and Urgent Care (EUC) which made up 84% of the provider's work. Since our last inspection, the provider's activity had changed and the main service now provided by this ambulance service is Patient Transport Services (PTS). PTS makes up 97% of the work the service undertakes. Emergency and Urgent Care (EUC) takes up 3% of the work the service undertakes. Where our findings on Patient Transport Services (PTS) – for example, management arrangements – also apply to EUC, we do not repeat the information but cross-refer to the PTS section.

The service was last inspected in April 2019 and rated requires improvement overall. We carried out an unannounced inspection on 18 January 2022. We inspected this service using our comprehensive inspection methodology and we checked to see if the provider had complied with the Requirement Notice issued in July 2019. The provider had made improvements in relation to oversight of medical gases and they no longer stored, prescribed, or administered medicines.

Summary of this inspection

Systems and processes had been established to ensure the service assessed monitored and improved the quality and safety of the service. This included formal governance meetings, improved risk management processes, equipment safety checks in place. The provider also now conducted their own Disclosure and Barring Service (DBS) checks for staff, had put in processes for staff to declare working arrangements outside of the service, and were carrying out re-checks of staff members driving license to make sure they were safe to drive the vehicles.

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.

How we carried out this inspection

We carried out an unannounced comprehensive inspection on 18 January 2022 using our comprehensive methodology. The inspection team comprised a lead CQC inspector, a second CQC inspector and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

During this inspection, the inspection team spoke with the registered manager, management team, office staff and ambulance staff. We reviewed eight patient records and 16 staff records. Due to COVID-19 restrictions we were not able to observe care within ambulances but we were able to review patient feedback information.

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

Some staff were trained in British Sign Language and Makaton to improve their understanding and ability to communicate with patients with learning disabilities. The service also had an Assistance Dogs policy in place to ensure staff could support patients who travelled with assistance dogs.

Areas for improvement

Action the service **SHOULD** take to improve:

Patient Transport Services

- The provider should ensure their Scope of Practice Policy makes clear that the main service provision of the service is now patient transport services (PTS) and communicate this clearly to staff for journeys categorised as PTS.

Emergency and urgent care services

- The provider should ensure their Scope of Practice Policy reflects their new service provision for high dependency unit (HDU) transfers whereby patients are always accompanied by their own medical teams who care for and treat patients during the journey and communicate this clearly to staff for journeys categorised as HDU.

Our findings

Overview of ratings

Our ratings for this location are:

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

Patient transport services

Safe	Good 
Effective	Good 
Caring	Insufficient evidence to rate 
Responsive	Good 
Well-led	Good 

Are Patient transport services safe?

Good 

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. We viewed the mandatory training matrix during the inspection and saw that the overall mandatory training compliance rate was 96% in December 2021 which was above the service's target of 91%.

Training was delivered as a mixture of face to face and online modules on the service's e-learning training system.

Modules included basic life support, infection control, consent, dementia awareness, domestic violence awareness, learning disabilities awareness, mental capacity act, manual handling, safeguarding, fire safety, first aid and information governance.

100% of ambulance care assistants were trained in emergency first aid at work and nurses and emergency medical technicians (who undertook both HDU and patient transport journeys) had immediate life support training which was updated yearly. All staff had their driving skills assessed before being permitted to undertake any jobs.

Managers monitored mandatory training on a weekly basis and the e-learning training system sent automated emails to alert staff if they were required to update their training. The office manager also collated the information and sent reminders to staff who needed to update their mandatory training.

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.

Patient transport services

Staff received training on how to recognise and report abuse. Safeguarding children and adults level 2 and 3 formed part of the mandatory training programme for staff. At the time of our inspection training compliance was 94.6% for level 2 safeguarding adults and 100% for level 2 safeguarding children which exceeded the service's target of 91% compliance. Safeguarding children level 3 compliance was 89.2% where 34 of the 37 staff had completed the training. Reminders were sent to staff by email and training compliance was monitored weekly by the management team.

Two members of staff were designated safeguarding leads. They were trained to level 4 prior to the pandemic, however during the pandemic, were unable to enrol in face to face training and had completed training to maintain their competencies, which was not levelled. Following the inspection, the registered manager informed us that they had updated their risk register to reflect this and that the two staff members had now been enrolled in level 4 safeguarding training to take place in early February 2022.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We reviewed the service's safeguarding policy which was up to date and reflected current national guidance.

The service carried out a Disclosure and Barring Service (DBS) check on all newly appointed staff. All employed staff had a current DBS check recorded. At our last inspection, we had concerns that the provider was not completing their own DBS checks and relying on previous pre-existing checks. At this inspection we found improved processes and found the service was completing their own DBS checks. All staff had up to date DBS checks and the service audited this to make sure processes were working effectively. Audit results from the last three months, showed 100% compliance.

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.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff with PPE such as gloves, masks and aprons. Clinical areas within ambulances were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records we reviewed were up to date and demonstrated that all areas were cleaned regularly. All vehicles we checked were visibly clean including equipment such as slide sheets. Single use linen, hand sanitiser and decontamination wipes were also stored on board vehicles. We saw records that deep cleans had been undertaken by an external company on a monthly basis. The company undertook swab tests of certain areas of vehicles such as floor areas, grab rails and door handles pre and post deep clean and submitted this to the provider. This gave the provider additional oversight of areas that needed to be monitored.

Cleaning equipment reflected best practice and staff used appropriate antibacterial cleaning products to sanitise equipment at the end of each shift and between patients. Staff we spoke with were able to describe in full what products were used to clean equipment and what the process was. Staff were up to date with their infection prevention and control training which was part of their mandatory training.

The operations and compliance manager was the infection control lead for the service and completed infection prevention and control audits which looked at the correct use of personal protective equipment and hand hygiene compliance rates.

Patient transport services

The provider had started exception reporting to ensure they could focus on areas of non-compliance. If there was non-compliance or poor compliance, the operations and compliance manager would address staff members individually and this was recorded as an action within the audit.

Results from the audits had shown a sharp increase in hand hygiene non-compliance (83 times) in the month of October 2021. When this was analysed, managers found that this was because staff were using an old version of the IPC checklists on record forms where it was not clear where to record hand hygiene.

As a result, the service removed the old forms and ensured staff used updated forms to ensure hand hygiene compliance could clearly be recorded. Results in November and December 2021 were 10 and 6 staff members who were non-compliant which was a significant decrease in hand hygiene non-compliance.

The provider monitored government guidance in relation to COVID-19 and updated risk assessments and guidance for staff. Staff tested themselves for COVID-19 regularly and recorded their temperatures before the start of every shift. Managers checked these records on a weekly basis. We saw a record of this within the crew room alongside a board with information around the latest COVID-19 guidelines and protocols. The patient transport service did not convey patients who tested COVID-19 positive.

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 service had suitable facilities to meet the needs of patients. The service had 10 ambulances, three stretcher multi-purpose vehicle (MPV) and one wheelchair accessible vehicle (WAV) which were used for the regulated activities. The vehicles we observed were in a good state of repair and well presented. All fixtures and fittings in the ambulances were available for use and fully functional. Equipment available was appropriate for the activity of the service. All vehicles were kept on site and keys were stored securely in the office.

Vehicles were up to date with servicing and MOT which were checked monthly. Crews had access to up to date satellite navigation systems.

Staff used an electronic application on their crew phones to complete and submit vehicle daily inspection checklists. Checks included cleanliness of the vehicles, equipment such as stretchers and wheelchairs and oxygen levels. When a fault was found, staff could take a photograph using the application and the information would be sent immediately to the management team for action. Videos of checks were also taken using the electronic application which helped managers ensure that visual checks were being carried out correctly at the beginning and end of shifts. Vehicle daily inspection checklists were audited monthly.

The provider produced an exception report in order to better identify areas of non-compliance. Where there was an incomplete or unsubmitted vehicle daily inspection checklist, managers would follow this up with individuals who would be asked to provide reasons why this was the case. These reasons were then recorded within the vehicle daily inspection audits.

Patient transport services

The provider shared minutes from the last management meeting where it was discussed that staff members who were repeatedly not completing vehicle daily inspection checklists would have a meeting with their manager followed by training and an assessment. In December 2021 there were eight missing or incomplete vehicle daily checklists however in January 2022, this had improved to three missing or incomplete daily checklists. Managers monitored and discussed compliance rates weekly.

Staff knew how to use equipment safely. At the time of inspection all staff had completed moving and handling training.

Staff we spoke with were knowledgeable about how to handle and dispose of clinical waste in accordance with guidelines. Staff securely stored clinical waste whilst it was on the ambulance. On return to base, clinical waste was stored securely until it was collected by a third party. We viewed the clinical waste collection certificate and managers checked that clinical waste had been collected on a weekly basis.

At our last inspection we found issues in relation to the routine servicing of equipment such as stretchers as the service only carried out reactive maintenance in response to problems with equipment. At this inspection, the provider had a contract with an external company which serviced equipment annually in addition to when equipment broke or needed replacing.

The service now also had a stock of high visibility jackets for staff to keep staff safe when collecting patients in the dark.

Assessing and responding to patient risk

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

Staff identified and quickly acted upon patients at risk of deterioration. Appropriate procedures were in place to assess and respond to patient risk.

The service would gather information about the patients from the requesting service which included their name, age, where they were being transported to and if they had any specialist and mobility needs. This information was used to monitor the patients that the service transported.

Patients transported as part of the service were medically stable and not considered to be at risk of deterioration by the referring hospital or department.

Staff had a good awareness and understanding of how to manage a deteriorating patient, they explained they would call an NHS ambulance or transport a patient to an Emergency Department if they were nearby.

Managers told us that commissioners informed the service if patients had any pre-existing conditions or risks at the point of booking. Control office staff recorded any key information on the dispatch log which was then handed over to the crews. If crews arrived at a booking and felt the patient was not stable or suitable for the transfer, they would contact control to escalate this and 999 would be called to take the patient to hospital. All patient transport crew were trained in emergency first aid at work and basic life support. Nurses on board were trained in immediate life support. The clinical services manager had a clinical background and would be consulted if staff required clinical advice.

The service transported children and young people with a medical or nursing escort provided by the hospital.

Patient transport services

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 staff a full induction.

The service had enough staff to keep patients safe in line with transport agreements. The service had a total of 10 full time ambulance crew staff and 16 regular bank staff. Bank staff received a full induction. The service also had access to 12 regular bank paramedics for event medical cover jobs only. Office staff included the managing director, clinical services manager, operations and compliance manager, control staff and office manager. The service had adapted their systems to ensure that office staff could work securely from home during the pandemic.

There were no unfilled shifts as the service only accepted work from commissioners which they had capacity for.

The service had a set rota plan which was created at the end of each month. The rota was colour coordinated to help senior staff identify what shifts had and had not been filled. Online calendar invites would be sent to individual staff members so they could 'accept' a job which then was confirmed on the rota plan. Managers ensured staff members were not booked on for shifts after a long distance journey to give staff time to rest in between jobs.

Staff reported that they had regular breaks during work hours and were entitled to three breaks per shift. The service conducted a meal break audit to ensure staff were taking their breaks. The service produced an exception report for these audits and results showed that one person had not taken their meal break in December 2021, three people had not taken their meal break in November 2021 and four people had not taken their meal break in October 2021. The service's audit board indicated that if numbers exceeded five people, this would be reviewed and monitored by the management team

Records

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

Staff kept detailed records of patients' care and transfers. Records were clear, up-to-date and stored securely after use. At our last inspection we found an example of patient record forms being left on vehicles for extended periods of time and contained patient sensitive information. At this inspection we did not see any patient record forms that had been left within vehicles and saw that the forms had been stored securely in the office after the completion of a job.

Key information from the initial booking process was communicated to staff through their crew phones. These records included information on any specific needs relating to the patient including mobility needs.

Records handled by ambulance care assistants for the patient transport service related only to the safe transport of patients such as collection and drop-off times and notes relating to any events during the journey.

In our review of records we found that some jobs relating to patient transport services had a more in depth patient record form where a nurse on board had carried out a risk assessment and recorded more detailed observations of the patient. While these were still patient transport journeys, we were told that being a nurse-led service, the provider aimed to provide a higher level of care within their patient transport service and were able to deliver this with the competencies the staff held as the service had nurses and emergency medical technicians who undertook patient transport journeys.

Patient transport services

However, some of these records appeared to show that blue lights were being used for a patient transport journey. We later found that staff had mistakenly written notes in the section of the form to indicate blue lights were used. This made it harder to identify if an emergency and urgent care (HDU) journey or a patient transport journey was being carried out.

We highlighted this to the registered manager who acknowledged that the service did need to make their service provision clearer to staff to make sure they were aware of this difference in service provision and were aware of how to make this clear in patient record forms used to indicate what type of journey was being undertaken.

Patient record forms were audited to review the quality and effectiveness of the service and ensure key performance indicators KPIs were being met. Feedback was given to individual staff members and audits were monitored at monthly management meetings.

Staff had a good understanding of their requirement to check Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) paperwork prior to transporting patients and knew to check with control if there were any issues.

Medicines

The service did not store, prescribe, or administer medicines.

Patients were transported with their own medicines and these remained the responsibility of the individual and stayed on their person or in their bag.

Staff were trained in the administration of oxygen during journeys including connecting oxygen cylinders to face masks.

Oxygen cylinders were stored in a secure cage at the base and stored as per national guidance. Additional security measures had been put in place to ensure cylinders could not be tampered with when stored in the cage and the key to the cage was kept by the senior management team. Cylinders were signed in and out and a check of the oxygen cylinder on board vehicles was undertaken daily as part of the vehicle daily inspection checklist which included a video of the cylinder. We saw that oxygen cylinders were appropriately secured on the vehicles. We also viewed the service's medical gases policy which was up to date.

Incidents

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

The service used an incident reporting system and all staff we spoke with were familiar with the system. Staff said there was a good reporting culture and that they were encouraged to report near miss situations, which reflected a positive approach to learning.

Where incidents involved other services, staff and the registered manager worked with colleagues to investigate them.

The service reported that there were no never events in the previous 12 month reporting period. A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event reported type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Patient transport services

Incidents were reported and recorded on the incident reporting log and audited. Incidents were categorised into operational, fleet and equipment, health and safety, clinical, infection prevention and control and human resources. This allowed the service to monitor any trends and to ensure learning and actions were shared and embedded within the service. We saw that learning from incidents were disseminated at monthly staff huddles and also through the staff portal via bulletins.

In the last 12 months the service had 18 incidents. Of these, 17 were no harm and one was minor harm. We reviewed the service's incident log which showed learning from the incidents for example, after an incident where it was found that an oxygen cylinder did not have a hose properly attached, as part of the actions and learning following the incident, the provider had recorded that staff would be reminded at the next staff huddle of how to check the hose is properly attached. The service also added an additional oxygen hose check to the vehicle daily inspection checklist.

Duty of Candour (DoC) 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. SATS had a DoC and being open and honest policy and procedure. Staff we spoke with were clear on their responsibilities in relation to the Duty of Candour.

Are Patient transport services effective?

Good 

Our rating of effective improved. 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.

The service provided care and treatment based on national guidance and evidence-based practice. Staff followed national guidelines and evidence-based practice. The service kept a spreadsheet of policies which changed colour to indicate when a review was due. Managers monitored this on a weekly basis to ensure policies and procedures were up to date and referenced national guidance and legislation, for example National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC). We checked some of the service's policies including their lone working policy, deteriorating patient policy, incident reporting, infection prevention and control, medical gases, safe systems of work, and duty of candour and found them to be up to date with review dates and version controls in place.

Staff could access these policies through the service's dedicated staff portal where managers could also flag to staff any changes or updates to policies within bulletins on the portal. We viewed the portal and saw bulletins informing staff of what was discussed at the last clinical governance meeting, guidance around COVID-19 and vaccination requirements. We were told that whenever a bulletin was posted, all staff would be emailed to let them know there was a new post for them to read.

Managers reviewed staff understanding of best practices at supervision and appraisal. Staff requiring further support were provided with refresher training sessions. This ensured any gaps staff in knowledge was reviewed and updated.

Patient transport services

Staff received training regarding the Mental Health Act 1983. All staff were up to date with training at the time of inspection.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey. The service made adjustments for patients' religious, cultural and other needs.

Staff told us they gave patients opportunities to obtain food and drink during patient journeys.

Staff told us they would carry water bottles for patients on long journeys. They also told us that they would ensure that they took as many rest stops as the patient needed. Prior to a long journey, they would check that a patient had their own food or snacks to take with them.

If a patient required food for a journey for medical reasons, this would be recorded in the booking form and would be provided by the provider or carer who made the booking.

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.

Staff recorded response times as a part of their key performance indicators (KPIs). Response times were reviewed at monthly management meetings and were displayed on the audit board within the office. The management team also met weekly to discuss any urgent issues.

The service monitored whether ambulances arrived to pick up patients on time. This KPI was monitored monthly and compliance between October and December 2021 was 95% which exceeded the target of 91%.

The service had meetings with their commissioners. In these meetings they discussed their performance against the contract holder's key performance indicators.

Control teams had access to live traffic updates and could ensure routes could be planned taking traffic into account.

Pick up and drop off times were recorded and monitored by managers. If there were delays, crews would notify the control team who would inform the hospital awaiting the patient.

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 provided new staff with an induction programme that included logistics of daily operations, policies and procedures and an orientation of each vehicle in the fleet. New employees received supervision where they accompanied and shadowed experienced staff on vehicles. Staff received an employee handbook and employee policy declaration which they signed to confirm they had read the policies.

Patient transport services

The service undertook six monthly checks of driving license status and also checked this during the recruitment process. At our last inspection we found that some re-checks of staff driving licenses had not been completed as per company policy. Since the inspection, the service audited these checks and at the time of inspection, all re-checks had been completed.

At our last inspection there were no driving assessments in place. On the day of our inspection the service was undertaking a recruitment day where we saw managers undertaking the driving assessments for the potential candidates. If staff passed the driving assessment, they would then move on to the next stage of recruitment.

We reviewed personnel files and found evidence of staff competencies and qualifications in the form of various training certificates.

Managers supported staff to develop through constructive appraisals of their work. Managers identified poor staff performance promptly and supported staff to improve. They identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager. We spoke to a member of staff who had joined the service on an apprenticeship scheme and was supported to complete a management training course. They were then supported to develop to become a manager within the service.

Appraisal rates were at 83% and this was lower than the service's target of 91%. We were told that this was because the service had not been able to complete bank staff appraisals due to there not being enough shifts for bank staff during the pandemic. The service had completed a situation, background, assessment, recommendation and action analysis where managers had decided to assess bank staff if and when they were on shift and monitor bank staff's completion of patient record forms to ensure standards were being met. This would be done on a monthly basis until activity picked up and bank staff had more regular shifts whereby a full appraisal would be completed by managers and added to the staff member's personnel file.

Multidisciplinary working

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

Staff worked well together. We spoke with crew who said there was good team working with fellow crew members and control room staff. They commented on monthly huddles which were a good opportunity to feed back any issues and come together as a team.

The service had a comprehensive handover policy which explained how staff were required to get a full handover which should include details of patient history. If the crew felt the patient did not seem eligible for the patient transport journey booked, they would contact the control room and the journey would be cancelled.

Crew would notify the control team if there were any delays and the control team would inform the receiving hospital.

While we could not accompany crew on journeys due to the pandemic and the need to maintain social distancing, we saw copies of patient record forms which had been fully completed and showed detailed handover notes.

Patient transport services

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 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.

The compliance rate for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training for staff was 97%. We also viewed the service's Mental Capacity Act and DoLS policy which was comprehensive and in date. We spoke with staff about mental capacity and they were clear about their responsibilities in relation to obtaining patient consent. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. All records we reviewed showed that consent had been obtained.

At our last inspection staff were not aware of Gillick competency. At this inspection, staff we spoke with were able to describe Gillick competency. 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. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them.

The service did not transport patients detained under the Mental Health Act 1983 or patients experiencing a mental health crisis.

Are Patient transport services caring?

Insufficient evidence to rate 

Insufficient evidence to rate

We did not rate caring at this inspection as due to restrictions during the pandemic, we were unable to accompany staff on the ambulance to see care first-hand.

Compassionate care

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

We were provided with examples of patient feedback that demonstrated staff treated patients with compassion and kindness, respected individual needs and supported patients.

Comments from the past 12 months included: "I was very happy with the way the crew made sure I was safe inside my home," "I would like to take this opportunity to thank you for your care and attention," "...crew were very kind and helpful," "Booking a transfer was straight forward and well supported by staff," "The crew were very attentive and professional I felt safe with them at all times and it made what could have been a stressful time very relaxed", "I was grateful that everything was done to make the journey as comfortable as possible," "Fabulous service. Both crew members were polite and very competent and considerate, would recommend this service," "Amazing service, very polite, friendly, helpful crew. Keep up the excellent work!"

Patient transport services

Are Patient transport services responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

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

The main service provided was non-emergency patient transport for patients who were unable to use public or other means of transport due to their medical condition. Patient transport services were mostly provided to patients attending hospitals, diagnostic appointments and outpatient clinics and those being discharged from hospital wards. The service also provided repatriations from airports. The provider transported patients across London and further afield which meant they did not only serve the local population.

The service planned and provided services in partnership with its commissioners through formal contractual arrangements.

The service completed patient transport service transfers on a pre-planned, pre-booked basis for both private patients and commissioners. The booking system allocated vehicles and crew to transfers and ensured the service was not over booked.

The service was available seven days a week and there was always an on-call manager to support crew who needed advice throughout the day.

Ambulances could be tracked by control room staff to monitor their locations and to see if they were on time to pick-ups and to monitor if there were traffic delays.

Bookings would come in via telephone and the control room staff member would complete the booking process asking questions within the booking form to ensure the patient met the service's eligibility criteria.

The service audited response times for control team staff to answer the phone in a timely manner (within 5 seconds).

Any calls that weren't picked up would be diverted to the service's mobile phones held by managers. The compliance rate for December 2021 was 67% which was indicated as red and requiring review. We were told this was because if there was one person answering the telephone, they may miss or take longer to pick up other calls coming in which then impacted the audit. We saw in the December 2021 monthly management meeting minutes that this had been discussed and there was an action plan in place for the operations and compliance manager to monitor phone pick up times and review and identify any trends that were impacting the audit results. There was also discussion around exploring opportunities to divert calls to other phones during peak times. The service was also considering introducing another staff member to the control team as well as additional staff in order to improve timely answering of the phones but this was planned for when activity picked up.

Patient transport services

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.

The service took account of patients with individual needs at the point of booking. When a booking was made, the service collected information from the discharging service or hospital to ensure appropriate risk assessments had been conducted and that the patient was suitable for the patient transport service offered. This included whether there were communication needs such as the need for an interpreter. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Staff had access to communication aids to help patients become partners in their care and treatment.

The registered manager told us some staff were trained in British Sign Language and Makaton to improve their understanding and ability to communicate with patients with learning disabilities. We were also shown the service's Assistance Dogs policy although they had not yet transported patients requiring this.

At our last inspection, the service did not have access to a translation service and relied on staff and relatives to communicate with patients. At this inspection we were shown a translation application which had been downloaded onto all crew phones and used if a patient's first language was not English. Staff had been trained in the use of the application and we saw documentation to show this. A patient's language needs would also be checked at the point of booking to ensure crew were aware of this and to check if the patient was being accompanied by an interpreter.

Where possible, the same staff were allocated repeat patient journeys to ensure continuity of care.

We saw that equipment in ambulances was suitable for the transportation of bariatric patients. At the point of booking, a four person crew would be allocated to transport bariatric patients.

The service had a cultural and religion policy to ensure staff understood how to meet patients' cultural and religious preferences during journeys.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and the service's targets. The service only accepted work from their commissioners if they had enough staff and ambulances to provide transfer services.

The service was subcontracted by a main contractor and completed patient transfers for private hospitals. Managers monitored waiting times and control team staff would allocate patient journeys taking into account the type of journey and staff skills required. Crews reported delays to the control team who then informed the receiving hospital. This ensured good communication between stakeholders and rearrangements could be made where possible.

The service had not cancelled any journeys in the 12 months before our inspection.

Patient transport services

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 saw posters and cards within the ambulances with information on how to make a complaint. Staff understood the policy on complaints and knew how to handle them and managers investigated complaints and identified themes.

The service collected 50 patient feedback forms a month and audited this. Managers analysed patient feedback to see if there were any improvements that could be made to the service. They shared feedback from complaints with staff and learning was used to improve the service. Managers had created a spreadsheet with action columns to show how they had improved the service based on comments received.

We viewed the service's complaints policy and saw that it was up to date. There were clear processes between SATS and its commissioners on the handling of complaints. Complaints received from commissioners would be sent to SATS for investigation. Once completed, the investigation would go back to the commissioners for conclusion. Any learning would be shared among teams at SATS.

In the last year the service received three complaints. The service aimed to acknowledge complaints within three working days of receipt in writing or verbally over the telephone. In the 12 months preceding our inspection all three complaints were received and managed within this time and were all responded to within one day.

Learning from complaints was shared at monthly huddles with staff and put on the staff portal as a bulletin.

The provider gave us an example of how they learned from a complaint about miscommunication of pick up times. After receiving the complaint, the service took statements from crew, looked at their tracker to see the time of pick up where the miscommunication of the pick-up time was identified. They then worked with the commissioner to produce an operational policy to ensure both parties had a clear understanding of how crews needed to communicate with the commissioner and record pick up and drop off times. The provider told us that the policy was working well and they had not received any similar complaints since.

Are Patient transport services well-led?

Our rating of well-led improved. 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.

Patient transport services

The service was managed by the managing director who was the registered manager. The operations and compliance manager and clinical services manager were responsible for overseeing the day to day management of the service including managing staff. The operations and compliance manager was also the infection control lead who conducted audits and quality processes alongside the clinical services manager.

Leaders of the service understood and managed the priorities and issues the service faced.

Staff were able to identify to us who the leadership team were and their responsibilities within the service. They spoke highly of the managers of the service. They said managers were visible, friendly and approachable.

There were significant improvements to the leadership of the service since our last inspection. At our last inspection we found poor medicines management, incomplete checks to ensure staff were suitable to work with vulnerable patients, no senior oversight of the service and no clinical governance meetings to ensure safety was regularly discussed at a senior level.

At this inspection the service had ensured the medical gases policy was up to date and had strengthened processes around medical gases. The service had also completed checks to ensure staff were suitable to work with vulnerable patients and this was being audited. There was now senior oversight of the service in the form of monthly formal management meetings. These meetings which were minuted covered clinical governance, operational updates, audit results, incidents, complaints, risk register updates, discussion around recruitment and fleet and equipment. Meeting minutes were comprehensive with actions clearly indicated and leads allocated to the various actions. The management team also met weekly to discuss any issues and incidents and latest audits so that anything that needed addressing quickly, could be actioned and disseminated to the teams appropriately and in a timely manner.

However, while staff we spoke with reported that the provider's main service was patient transport, the service's Scope of Practice Policy did not reflect the service's main service delivery offer of patient transport. It did not specify the new service provision for high dependency unit (HDU) transfers whereby transfers were non-time critical, and patients were always accompanied by their own medical teams from hospitals who would bring their own emergency equipment and medicines.

The policy still went into detail about medicines administration by certain staff groups however the service no longer stored, prescribed or administered medicine. Information within the policy around medicines administration by certain staff groups was therefore no longer relevant and there was a risk that new staff could be confused about the service's scope of practice when they read the policy.

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.

Staff understood the vision and values of the service. The "17 fundamental principles" of the service were referred to as part of staff induction and also available to refer to on crew phones' messaging application.

The provider's vision was "To provide and uphold high level care governed by specialist nurses throughout ambulance transfer to or from medical facilities".

Patient transport services

All staff were provided with the vision and values of the service during the induction process and were required to sign that they had read and understood the statement.

The registered manager told us that the service planned to expand their patient transport service offer to other private hospitals and recruit more staff to support the expansion of the service. The managing director was focussed on growing the business while also ensuring that they delivered a high quality service for patients.

The service continued to keep and update a strategy spreadsheet which listed what strategy needed to be in place in order to successfully meet the service's vision. This included to continue to strengthen the senior team, to continue regular communications to review the service and identify areas needing improvement, to continue to identify and review risks within the service, to promote health and safety for staff and patients, to continue to encourage incident reporting, to share and promote learning, to investigate and introduce better safety standards, equipment and services and to continue monitoring national guidance for infection control procedures, ensuring PPE stock levels remain safe.

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.

Due to restrictions during the pandemic, we were unable to accompany staff on the ambulances and were therefore limited to how many staff we could speak with. The staff we were able to speak with before they started their shift reported that they felt supported by managers, felt able to escalate or raise concerns or incidents with the management team and felt the service was open and honest.

Staff commented that they were proud to work for the service and felt valued by management.

We also saw within management meeting minutes that the management acted to address behaviour and performance that was inconsistent with the values of the organisation.

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.

At our last inspection, we found that there were no systems and processes in place to ensure that ambulance staff declared working arrangements outside of the service. The provider now had a policy around declaring working arrangements outside of the service and staff were required to fill in a form which was signed off by managers. Managers monitored this to make sure staff were not working excessive hours that may adversely impact on the care being provided.

The service had strengthened its governance structure and service leaders were now clear about their individual responsibilities and roles. Monthly management meeting minutes we viewed showed a comprehensive discussion of the service's risks, issues and performance. The provider also displayed an audit board within their base office which could be seen by management and staff to see how the service was performing in all aspects of the service from infection control, records completion and, on scene key performance indicators, and vehicle daily inspection checklist completion. The board showed results from the last three months. These audits allowed the management team to monitor, manage and report on quality and performance in an accurate and timely manner.

Patient transport services

We saw that policies had been reviewed and updated with different leads allocated depending on whether they were clinical or operational policies.

The service had also improved its recruitment processes by building in driver assessments and doing their own disclosure and barring services (DBS) checks. The service was also now doing regular driving license re-checks. Driving license re-checks and DBS checks were also audited to monitor the effectiveness of the processes and results from the last three months showed 100% compliance.

Governance arrangements now included regular monthly staff meetings called huddles in conjunction with updates accessible on the staff portal and messaging applications for staff who were not able to attend the meetings.

At the last inspection we were told the medical director had left the service. At this inspection, there was a medical director in post. The medical director attended the quarterly board meetings and was available to provide additional clinical advice if needed.

At our last inspection, there was no occupational health service in place for employees to access.

At this inspection the registered manager confirmed that since July 2020, the provider had in place a service level agreement with a local NHS Trust's employee wellbeing service where staff could access occupational health services.

Management of risk, issues and performance

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

The service had a risk register that was reviewed monthly by the management team. The risk register reflected the main risks to the service which were voiced by staff we spoke with. All risks were clearly identified, had dates reviewed and when to next review them, with identified leads and control measures put in place to manage and mitigate them. We reviewed minutes from the last management meeting which showed discussion of the risk register and new risks that had been added. We saw that audits and performance were also discussed at the management meetings with action points to take forward allocated to members of the management team accordingly.

The service had an up-to-date business continuity plan. This covered what to do in the event of an incident occurring that would result in the disruption of the running of the service.

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.

Computer systems were password protected and staff locked computer screens when leaving their workstation. Staff knew their responsibilities regarding data protection and information governance was part of the mandatory training modules.

The data available on the service's computers was accurate, up to date and easy to access. The system contained a wide range of information from training completion rates, journey completion times and files for current employees.

Patient transport services

The application that staff used on crew phones to access booking information was password protected and information was automatically deleted at the end of each job.

Patient transport records were paper based and were stored securely in the main office after completion of staff shifts. They were scanned into the service's computer system and paper versions were kept for six months for audit purposes before being destroyed.

Engagement

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

The service engaged with potential clients and patients and had a website along with social media. Crews had patient feedback forms available on vehicles and gave these out to patients where appropriate.

The service engaged with staff members through regular monthly staff meetings and messages on the staff portal. Staff could also communicate with one another using an electronic messaging application.

The service had a staff survey called 'What Matters to You' which was done every year. However, the service had not done this survey in the last year due to pressures of the pandemic.

The service also had an Employee of the Month scheme where staff could nominate one of their colleagues for their contributions at work and positive feedback received. We saw examples of this on the staff portal.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff we spoke with were proud to work for the service. They commented on how they enjoyed working within a diversely skilled, nurse-led team and that the service was focused on delivering high quality care.

The service had sustained the good practice we had identified at our last inspection and was committed to further improving the service.

Patient feedback was monitored by the clinical services manager to look at areas to improve the service. The service held a spreadsheet which detailed the feedback and the actions taken by the relevant teams as a result. Within this, there were also actions showing how managers had provided additional support to staff after challenging transfers.

Emergency and urgent care

Safe	Good 
Effective	Good 
Caring	Insufficient evidence to rate 
Responsive	Good 
Well-led	Good 

Are Emergency and urgent care safe?

Good 

Our rating of safe improved. We rated it as good.

Mandatory training

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

See Patient Transport Services for main findings.

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.

See Patient Transport Services for main findings.

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.

See Patient Transport Services for main findings.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. HDU ambulances were used for Extracorporeal Membrane Oxygenation (ECMO) transfers. ECMO is a form of life support that provides both cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life. Some of these transfers would include the transfer of patients who were COVID-19 positive. The service checked with staff members first to make sure they were happy to do such a transfer. All staff who carried out transfers of COVID-19 positive patients had undertaken training to fit test face masks which is best practice to ensure maximum protection. Staff had access to the correct personal protective equipment such as FFP3 masks. Ambulances used to transfer COVID-19 positive patients were deep cleaned and disinfected with fogging machines.

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.

See Patient Transport Services for main findings.

For neonatal transfers, the service used incubators which were designed for the safe transfer of neonates. The incubators had safety crossover belts and a vacuum mattress and were safety checked.

For the majority of HDU journeys, medical teams from hospitals used their own equipment but at the point of booking, the control team would ask if specialist equipment was needed. Specialist equipment such as ventilators were stored at base in a room that was locked. The equipment was serviced regularly by an external company and we saw that this had been completed.

As the service began to focus on patient transport journeys and due to the low activity in HDU journeys, during the COVID-19 pandemic, the service donated some of their ventilators to Gibraltar where this equipment was needed.

Assessing and responding to patient risk

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

See Patient Transport Services for main findings.

The HDU transfers the service undertook were for stable patients only who were accompanied by their own medical teams who cared for and treated patients during the journey. This was made clear within contracts the service had with commissioners and checked at the point of booking. Only journeys that were non time critical and were non-emergency transfers would be booked.

For HDU transfers, the service used National Early Warning Scores (NEWS2). NEWS is a tool which enables the early identification of deteriorating patients. The use of NEWS2 had been in place since March 2019. At the point of booking, hospitals were also asked to provide the NEWS score for the patient to ensure they were stable and suitable for the journey and to check that medical teams were bringing their own equipment or if they needed additional equipment. All staff had received training on NEWS scoring. Crews who always consisted of a nurse, were required to assess the patients and obtain a NEWS score prior to transfer. NEWS scoring was audited monthly by the clinical services manager. In the last three months due to the low activity in HDU service provision, no audits could be undertaken. However senior leaders had made the decision that in these instances, all records would be analysed and anomalies would be picked up and discussed with individual staff members in order to maintain clinical excellence and a high standard of documentation.

Staff told us if a patient deteriorated during a journey, they would ask control for authorisation to use blue lights and drive to the nearest emergency department. Crews who undertook HDU transfers had blue light training.

Staffing

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

Emergency and urgent care

See Patient Transport Services for main findings.

As a nurse-led service, the provider always ensured there was a nurse on HDU journeys even though there would always be a medical team from the hospital on board. The clinical services manager told us that the nurse from SATS on board would assist the medical teams and monitor the patient but would not administer medicines or treat patients.

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.

See Patient Transport Services for main findings.

Patient record forms were audited to review the quality and effectiveness of the service and ensure key performance indicators (KPIs) were being met. Feedback was given to individual staff members and audits were monitored at monthly management meetings. A sample of five patient record forms were analysed monthly by the clinical services manager to audit the quality of the records.

Due to the low activity in HDU journeys in the last three months, the service was unable to audit patient record forms as there were not enough records to audit. The service had completed a situation, background, assessment, recommendation and action analysis and the management team had decided that when there were not enough samples of records, each patient record would be examined and anomalies would be picked up and discussed with individual staff members in order to maintain clinical excellence and a high standard of documentation. Following the low activity numbers in HDU journeys from October to December 2021, the management team had decided to undertake quarterly audits going forward in order to for a larger sample to be collected.

Medicines

The service did not store, prescribe, or administer medicines.

See Patient Transport Services for main findings.

Since our last inspection, the provider's service provision had changed whereby the main service provided was now patient transport services. The provider had therefore made the decision to no longer store, prescribe or administer medicines. Where patients were transported with medical teams from hospitals, it was the responsibility of the hospital medical teams to bring and administer medicines where necessary.

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 and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

See Patient Transport Services for main findings.

Are Emergency and urgent care effective?

Emergency and urgent care

Good 

Our rating of effective improved. 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.

See Patient Transport Services for main findings.

Pain relief

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

The service did not administer pain relief but now had a tool within the patient record form to assess and record patient's pain scores which could then be handed over to the receiving hospital.

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.

See Patient Transport Services for main findings.

Patient outcomes

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

The clinical services manager audited patient record forms to ensure compliance around assessments made by staff. If there were concerns, these would be addressed with individuals and additional training would be provided if required.

Due to the nature of services provided, patient outcome information was limited. Ambulance crews handed over the care of transported patients to the receiving hospital.

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.

See Patient Transport Services for main findings.

The service did not provide staff with blue light training. Staff within the service did have blue light training which they had received outside of the service.

Emergency and urgent care

Multidisciplinary working

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

See Patient Transport Services for main findings.

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.

See Patient Transport Services for main findings.

Are Emergency and urgent care caring?

Insufficient evidence to rate 

Insufficient evidence to rate

We did not rate caring at this inspection as due to restrictions during the pandemic, we were unable to accompany staff on the ambulance to see care first-hand.

See Patient Transport Services for main findings.

Are Emergency and urgent care responsive?

Good 

Our rating of responsive stayed the same. 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.

See Patient Transport Services for main findings.

The service did not undertake work deployed by NHS emergency services.

The service undertook non time critical transfers which were between hospitals with hospitals' own medical teams on board SATS' dedicated high dependency unit (HDU) vehicles.

Emergency and urgent care

In addition, the service undertook neonatal intensive care transfers and transfers of patients receiving Extracorporeal Membrane Oxygenation (ECMO). ECMO is a form of life support that provides both cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life. These types of journeys made up 3% of the provider's activity over the last 12 months.

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.

See Patient Transport Services for main findings.

Access and flow

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

See Patient Transport Services for main findings.

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.

See Patient Transport Services for main findings.

Are Emergency and urgent care well-led?

Our rating of well-led improved. 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.

See patient transport service section for main findings.

However, while staff we spoke with understood the service's provision, the provider's Scope of Practice Policy still reflected the service that was offered when the provider was doing mainly high dependency unit (HDU) transfers and did not make clear the new Scope of Practice whereby the provider's main service was now patient transport.

Information within the policy around medicines administration by certain staff groups was therefore no longer relevant and there was a risk that new staff could be confused about the service's scope of practice when they read the policy.

Emergency and urgent care

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.

See Patient Transport Services for main findings.

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.

See Patient Transport Services for main findings.

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.

See Patient Transport Services for main findings.

Management of risk, issues and performance

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

See Patient Transport Services for main findings.

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.

See Patient Transport Services for main findings.

Engagement

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

See Patient Transport Services for main findings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Emergency and urgent care

See Patient Transport Services for main findings.