Special Ambulance Transport Service Ltd

Special Ambulance Transport Service

Quality Report

AJP Business Centre
152-154 Coles Green Road
London
NW2 7HD
Tel:0203 375 6012
Website:www.sats.uk.com

Date of inspection visit: 23 and 24 April 2019
Date of publication: 17/07/2019

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

Ratings

Overall rating for this ambulance location	Requires improvement
Emergency and urgent care services	Requires improvement
Patient transport services (PTS)	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Special Ambulance Transfer Service is operated by Special Ambulance Transfer Service Limited . The service provides emergency and urgent care and a patient transport service.

Special Ambulance Transfer Service (SATS) was founded in 2006 and is an independent ambulance service providing a range of different patient transport services based in north west London. This includes the transfer of high dependency and critical care patients, non-emergency transfers, repatriations and event medical cover such as sporting events. The service has contracted work with both NHS and independent hospitals. Journeys are made to various locations within London and longer journeys occur on a regular basis. The service also occasionally transfers patients from international European locations back to the UK. The service has vehicles operated by emergency care assistants, emergency medical technicians and nurses

The service provides patient transport services (PTS) and emergency and urgent care (EUC) services. EUC patient transfers are between hospitals. The provider is registered for the regulated activities: transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury.

SATS operates as a main contractor to an NHS trust in north London, an independent hospital and another ambulance service. SATS also operates as a subcontractor to main contractors (identified as commissioners in this report). A small part of its work is private and for this work the service liaises directly with the private hospitals or private organisations.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 23 and 24 April 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We last inspected this service in July 2016 but at the time we did not have the legal duty to rate independent ambulance services. However, following this inspection we rated the service Requires Improvement for both core services.

The main service provided by this service was EUC. Where our findings on EUC – for example, management arrangements – also apply to other PTS, we do not repeat the information but cross-refer to the EUC core service.

We rated it as **Requires improvement** overall because:

- We found poor medicines management within the service. This included prescribing, ordering, storing and administrating of medicines. For example, the service had no management system in place which recorded what medicines were stored in the service. The service also stored medicines that required a prescriber or patient group directives (PGDs) to be in place, which there were not.
- We found poor management of medical gases within the service. For example, medical gases were not signed in and out to vehicles and were left on vehicles when they were out for servicing.
- We found an example of patient record forms (PRFs) being left on vehicles for extended periods of time that contained patient sensitive information.
- The service had not improved the safety testing and servicing of certain equipment which could leave patients at risk if it failed.
- The provider had not improved their processes for Disclosure and Barring Services (DBS) checks to ensure it was safe for staff to work with patients.

Summary of findings

- We found some staff members' driving licences had not been re-checked to ensure they were authorised to drive the vehicles.
- Staff knowledge around the Mental Capacity Act was good. However, staff knowledge about Gillick competency was poor.
- The provider did not have access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with patients.
- There were no regular staff meetings as part of the service's governance arrangements.
- The provider did not have systems and processes to ensure that ambulance staff declared working arrangements outside of the service. This was not monitored to make to ensure staff were not working excessive hours.
- Whilst risk management had improved since the last inspection. However, there were a number of risks we identified which were not on the risk register with mitigations in place.
- There were clinical governance meetings to discuss and monitor the services risks, issues and performance. However, these were not on a regular basis. We found there had been one meeting in 2018.

However, we found the following good practices within the service;

- The provider had systems, processes, and practices to keep people safe and safeguard them from abuse. Staff were aware of and knowledgeable about these processes. This had improved since the last inspection. However, this was with the exemption of DBS checks.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had introduced national early warning scores (NEWS) assessments as part of their mandatory training and patient transfers.
- Since the last inspection the service had improved the way they reported, monitored and learnt from incidents.
- We observed effective multidisciplinary working between SATS staff and staff at the various hospitals they worked with.
- Staff treated patients and relatives with compassion, kindness, dignity and respect. We observed staff acting in a professional and courteous manner at all times.Patient feedback was positive.
- The service had improved the way they recorded and learned from complaints. All complaints were now documented and any learning was shared with staff via the staff portal.
- The service had a good audit programme in place which fed into staff appraisals and performance management on a regular basis.
- Staff reported a positive working culture within the service and found leadership supportive and caring. There were recognition awards in place to reward staff for good work.

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

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	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 	The main service was Emergency and Urgent Care (EUC) which made up 84% of the provider's work. The provider had 13 ambulances used for both EUC and Patient Transport Services (PTS). The arrangements for PTS and EUC were the same. Therefore, we have reported most of our findings for PTS in the relevant EUC sections of the report We rated EUC as requires improvement overall because there was poor management of medicines including medical gases and issues with equipment maintenance. Clinical governance arrangements were in place; however, these were not regular. Therefore risk, issues and performance were not discussed on a regular basis and challenged to improve the service. Risk management had improved but there were a number of risks within the service which had not been assessed and mitigated at the time of the inspection.
Patient transport services (PTS)	Requires improvement 	PTS services made up 16% of the work they carried out by the provider. Arrangements for PTS and EUC were mostly the same. Therefore, we have reported most of our findings in relation to this core service in the relevant sections of the EUC section of the report. We rated the PTS service requires improvement overall for the same reasons set out in the EUC summary of findings above.

Requires improvement

Special Ambulance Transport Service

Detailed findings

Services we looked at
Emergency and urgent care; Patient transport services (PTS)

Detailed findings

Contents

Background to Special Ambulance Transport Service

Special Ambulance Transfer Service (SATS) was founded in 2006 and is an independent ambulance service providing a range of different patient transport services based in north west London. This includes the transfer of high dependency and critical care patients, non-emergency transfers, repatriations and event medical cover such as sporting events.

The service has contracted work with both NHS and independent hospitals. Journeys are made to various locations within London and longer journeys occur on a regular basis. The service also occasionally transfers patients from international European locations back to the UK. The service has vehicles operated by emergency care assistants, emergency medical technicians and nurses.

The service has 13 vehicles. Nine are used for Emergency and Urgent care (EUC) services and four are used for patient transport services (PTS). The majority of SATS work is EUC (84%). The majority of PTS work are private bookings or booked on behalf of patients from private hospitals. Since March 2018 the service had provided 1026 PTS journeys which accounted for 16% of their work.

SATS registered with the Care Quality Commission on 1st April 2011. The service has had a registered manager in post since it opened in 2011.

When we inspected the service in July 2016 we did not have the statutory power to rate independent ambulance services. However, in 2016 we told the service that it must make improvements in relation to the safeguarding and governance including management of medicines, incident reporting, and infection control auditing. We issued requirement notices in relation to those areas of concern. Following the 2016 inspection the provider made improvements and provided an action plan to address our concerns.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and two specialist advisors with expertise in working in private and NHS ambulance services. The inspection team was overseen by Terri Salt, interim Head of Hospital Inspection.

Detailed findings

How we carried out this inspection

During the inspection, we visited the service's base in north west London. We spoke with 10 staff including emergency ambulance crews, management and office staff. We spoke with two patients and one relative. We also spoke with numerous staff working at the hospital locations where SATS provided patient transport services (PTS) and emergency and urgent care (EUC) services. We also reviewed patient feedback forms which patients had completed after using the service and reviewed data sent to us by the provider prior to the inspection.

Facts and data about Special Ambulance Transport Service

The service is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice in the past and the most recent inspection took place in July 2016.

Activity (March 2018 and April 2019)

- There were 1026 Patient Transport Service (PTS) journeys undertaken
- There were 5251 emergency and urgent care (EUC) journeys undertaken.

Staff

- 17 emergency ambulance crew staff worked at the service. The service also had a bank of temporary staff that it could use.

Track record on safety (February 2018 to January 2019)

- There were no Never Events.
- 64 incidents.
- No serious injuries.
- 17 complaints.

Our ratings for this service

Our ratings for this service are:

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

Emergency and urgent care services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The main service provided by this ambulance service was Urgent and Emergency Care (UEC) Where our findings on UEC– for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the UEC section.

Summary of findings

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

- We found deficiencies in medicines management within the service and we were not assured medicines were appropriately and safely managed within the service
- We found deficiencies in management of medical gases within the service. For example, we found medical gases had been left on a vehicle when it was out for servicing.
- We found an example of patient record forms (PRFs) being left on vehicles for extended periods of time that contained patient sensitive information.
- The service had not improved the safety testing and servicing of certain equipment which could leave patients at risk if it failed.
- We also had concerns that should a patient deteriorate there was not access to appropriate medicines to reduce risk. For example, there was poor access to pain relief should a patient require this during a journey.
- The provider had not improved their processes for Disclosure and Barring Services (DBS) checks to ensure it was safe for staff to work with patients.

Emergency and urgent care services

- We found some staff members' driving licences had not been re-checked to ensure they were authorised to drive the vehicles.
- Staff knowledge around the Mental Capacity Act was good. However, staff knowledge about Gillick competency was poor.
- The provider did not have access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with patients.
- There were no regular staff meetings as part of the service's governance arrangements.
- The provider did not have systems and processes to ensure that ambulance staff declared working arrangements outside of the service and monitor this to make sure staff were not working excessive hours that may adversely impact on the care being provided.
- Whilst risk management had improved since the last inspection there were still a number of risks within the service that we identified which were not being mitigated at the time of the inspection. Some risks identified when we previously inspected the service were ongoing risks.
- There were clinical governance meetings to discuss and monitor the services risks, issues and performance. However, these were not on a regular basis. We found there had been one meeting in 2018.

However, we found the following areas of good practice:

- The provider had systems, processes, and practices to keep people safe and safeguard them from abuse. Staff were aware of and knowledgeable about these processes. This had improved since the last inspection. However, this is with the exception of DBS checks.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had introduced national early warning scores (NEWS) assessments as part of their mandatory training and patient transfers.
- Since the last inspection the service had improved the way they reported, monitored and learnt from incidents.
- We observed effective multidisciplinary working between SATS staff and staff at the various hospitals they worked with.
- Staff treated patients and relatives with compassion, kindness, dignity and respect. We observed staff acting in a professional and courteous manner at all times. Patient feedback was positive.
- The service had improved the way they recorded and learned from complaints. All complaints were now documented and any learning was shared with staff via the staff portal.
- The service had a good audit programme in place which fed into staff appraisals and performance management on a regular basis.
- Staff reported a positive working culture within the service and found leadership supportive and caring. There were recognition awards in place to reward staff for good work.

Emergency and urgent care services

Are emergency and urgent care services safe?

Requires improvement

We rated it as **requires improvement**.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received training in safety systems, processes, and practices. This was delivered as part of the service's mandatory training of staff. There were processes to monitor training compliance by staff.
- Training was delivered as a mixture of face to face training and online completion by staff. Staff were sent reminders when mandatory training was due via the staff portal.
- Emergency Care Assistants (ECA) were required to complete Emergency First Aid at Work (EFAW), Basic Life Support (BLS), blue light driving (desirable), National Early Warning Scores (NEWS) and Medical gases training. Compliance for BLS and EFAW was 86.3%, NEWS was 90.9% and blue light driver training was 54.5%. All ECAs had completed Emergency First Aid at Work or equivalent.
- Emergency Medical Technicians (EMT) were required to complete Intermediate Life Support (ILS), NEWS and Medical gases training. Compliance was 90% for ILS and 90% for NEWS. All EMTs had completed the Institute of Healthcare (ICHD) EMT course of equivalent.
- Registered nurses were required to complete Intermediate Life Support (ILS), NEWS and Medical gases training. Compliance was 75% for ILS and 100% for NEWS. All registered nurses were required to have a current Nursing and Midwifery Council (NMC) registration. We found the service had completed checks one week prior to our inspection and all nurses were up to date.
- E-learning training modules included whistleblowing, infection control, hand hygiene and waste management, moving and handling, fire safety, records management, health and safety, dementia, equality and diversity, accident and incident reporting, privacy and dignity, information governance, customer care, COSHH, consent, bullying and harassment, basic life support, complaints, office safety and being honest.
- Compliance with the E-learning mandatory modules as of December 2018 was 96%. Mandatory training was monitored on a monthly basis as part of a new initiative the service had introduced since the last inspection. Every staff member was scored as a percentage each month for mandatory training. If performance dropped then this would trigger management to intervene to improve performance. Individual scores were then combined to an overall team score and this was displayed each month. This helped management monitor mandatory training performance effectively.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, disclosure and barring service checks were not always completed to ensure staff were safe to work with patients.**
- During our last inspection we identified issues with Disclosure and Barring Service (DBS) checks. DBS checks help employers make sure they recruit suitable people to work with vulnerable groups including children. Our concerns during the last inspection were that SATS was not always conducting DBS checks themselves. For some staff they were using pre-existing checks which meant they could not be assured staff were suitable to work with vulnerable people. During this inspection we found this was still the case and this was not on the services risk register.
- Similar to our previous inspection all crews were required to obtain a handover prior to transporting a patient. This enabled the staff to ascertain important information about the patient including any safeguarding issues. Crews were still required to inform control of any issues that might affect the safe transfer of a patient. In the event of uncertainty, a registered nurse from the hospital should be requested to accompany the crew and handover appropriately at the receiving hospital.

- The service's safeguarding procedure set out what actions staff had to follow on identifying a safeguarding concern. Staff were to contact the police where a person was at risk of immediate threat or danger or liaise with the control room in all other instances. According to the procedure the manager would then need to complete a safeguarding referral to the relevant local authority.
- There was a section on the Patient Record Form (PRF) for staff to complete which documented whether there were any safeguarding alerts. The PRF informed staff whether a safeguarding referral form needed to be completed.
- Since the last inspection the safeguarding policy had been updated to include up to date relevant national guidance. The policy included information on Female Genital Mutilation (FGM) and Child Sexual Exploitation (CSE). Staff were aware of the policy and how to access it.
- At the last inspection we found staff were not trained to the appropriate level of safeguarding training as per the Intercollegiate Document for Healthcare Staff (2014) recommendations. At this inspection we found this had improved. Staff were trained to safeguarding adults level two (100%) and safeguarding children level one, two and three (100%).
- The operations manager and clinical lead had completed safeguarding for managers and leads training.
- When we previously inspected we found staff understanding of safeguarding processes and procedures was variable. This had also improved and staff were able to describe what would constitute a safeguarding concern and how this should be reported.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.**
- There were bins on vehicles available for clinical waste.
- Crews still relied on disposing of clinical waste at hospitals throughout the day. We were not assured staff placed tags around the clinical waste bags. Tags are used to tie clinical waste bags and provide an effective audit trail, so the bag can be traced back to the hospital or service if need be.
- We inspected eight of the provider's 13 vehicles and found they were visibly clean and tidy.
- Compliance for infection control training was 100% for staff. Staff had a good understanding of their roles with regards to infection control.
- Since the last inspection the service had introduced a Vehicle Cleaning Audit which was completed each shift by crews. The audit ensured crews checked the whole ambulance to check it was clean and well maintained. Any issues were noted down on the forms.
- Crews still completed Vehicle Daily Inspection (VDI) forms at the start of their shift. This included checking for appropriate cleaning supplies and promoted staff to clean the ambulance and equipment. The service had created individualised VDIs for different ambulances so they appropriately reflected what equipment was on board.
- Additional deep cleaning was completed by staff as and when required.
- The Patient Record Forms (PRF) also promoted infection control with staff and crews were required to record any risks of infection, whether hands were washed, use of gloves and aprons, if equipment was cleaned and whether a deep clean was completed.
- Management had an action log in place regarding infection prevention and control. The log recorded any issues including ensuring crews were bare below the elbows, updating infection control policies and replacing mattresses with tears. The action log recorded what remedial actions the service had taken and any changes in practice.
- Hand hygiene and Personal Protective Equipment (PPE) audits were completed on a monthly basis. Each crew member received a score based on performance and this was added to their overall monthly performance score. If a crew members score was declining this triggered a report from the administrator which then flagged to management. Management would then speak to crew members about performance in order to improve it. The service also added the scores together to get a monthly team score which was displayed in the office.
- The manager told us they had conducted an ultra violet audit of vehicles. This is where an ultra violet light is

used to check levels of cleanliness. We were told the service had pre-programmed in all the different vehicles and selected the relevant areas to be tested. For example, bedframe, bed rails, sharps bin, suction unit. The services plan was to identify areas that are missed during cleaning and provide staff with training on how to improve this.

- We observed crews following infection control procedures, including washing their hands of using alcohol gel after patient contact. Crews adhered to the principle of 'bare below the elbows' as a way of minimising the spread of hospital-acquired infection.
- Crews had access to personal protective equipment (PPE) such as gloves and aprons. However, staff did not have access to goggles which could put them at risk if patients were sick or being suctioned. Following the inspection, the manager told us this had been added to the services risk register and an order had been placed.
- We saw there were mops, cleaning products and wipes available for vehicles.
- Sharps bins were closed, signed and not overfull.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well. However, not all equipment was appropriately maintained as per recommended guidance.**
- At the last inspection we found suction units and stretchers received preventative maintenance only. This could pose a risk to patients if equipment failed during use. At this inspection, we found similar issues in relation to the routine servicing of stretchers and lifting equipment. The service only carried out reactive maintenance in response to problems with equipment. There is a requirement under work equipment and machinery (PUWER) legislation that requires comprehensive maintenance on a regular basis, often annually in line with manufacturers advice. The service was still not doing this and this was not on the services risk register at the time of the inspection.
- At the last inspection the service did not provide high visibility jackets for staff. We found the same issue at this inspection. This was a risk because staff wore dark uniforms and collected patients during the dark. Following the inspection, the manager informed us that these had now been ordered.
- We found two oxygen regulators for paediatric patients which were graduated in 0.1 litre steps had not been serviced since February 2014. We raised this with the services manager and these were removed from service.
- There were three different types of vehicles used for the ambulance service. The oldest vehicle in the fleet was 2012 and the newest was purchased in 2019. We were told vehicles were replaced for a number of reasons including too many mechanical issues, complaints or specific clauses in contracts regarding the age of vehicles.
- The service had set up a calendar account for the fleet and MOTs were documented within this. There were two-week reminders set up from the date of the last MOT. The service also conducted a fleet audit which ensured MOTs were checked on a monthly basis.
- Vehicle servicing occurred at regular mileage intervals or on an annual basis. There were daily and weekly vehicle checks as well as fleet incident reporting which allowed the management to monitor the servicing of the vehicles.
- All vehicles within the fleet were B vehicles (weighing up to 3500kg). All re- licences were checked to ensure staff were licenced to drive this class of vehicle. Driving licences were checked via the Driver and Vehicle Licensing Agency (DVLA) at six monthly intervals. Drivers were requested to send an authorisation code which allowed managers to view their driving licence in detail including recent convictions. However, we found some staff licence re-checks were not completed at the time of the inspection as per company policy. This could leave patients at risk if staff were not safe to drive vehicles.
- The fleet manager conducted weekly checks on vehicles. These checks included checking tyre pressure, tyre tread/wear, fluid levels and bulb checks.
- Similar to the last inspection staff were required to complete Vehicle Daily Inspection (VDI) checks on

vehicles where equipment should be checked and tested. The VDI checks covered a range of things that needed to be checked in the vehicle, such as cleanliness and oxygen levels.

- The service used lap belt restraints on stretchers and wheelchair restraints to ensure patients were safe during transit.
- 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.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.**
- The manager told us that commissioners informed the service if patients had any pre-existing conditions or risks at the time a job (patient journey) was dispatched to the service. The Control office staff recorded any key information on the journeys dispatch log which was handed over to the crews.
- The service had introduced the use of National Early Warning Scores (NEWS) since the last inspection. NEWS enabled the early identification of deteriorating patients. All staff had received training on NEWS scoring as this was part of their mandatory training.
- When bookings were made control staff asked hospitals to provide the NEWS score for each patient and this was recorded as part of the dispatch log record.
- Crews were required to assess the patients and obtain a NEWS score prior to transfer.
- With regards to children and young people, the service only transported these patients with a medical or nursing escort provided by the hospital. Staff told us the service only use the short PRF form which recorded minimum patient details including name and hospital number as well as response times etc. These records did not require or have space for clinical observations to be completed.
- Staff told us in the rare event that the child was stable enough for an EMT crew (sometimes discussed when the ward is short staffed and clinical advice/dynamic risk assessment had been obtained), the technician would document as per their JRCALC guidelines. Under no circumstance would a Nurse or ECA escort a child or neonate without an escorting hospital nurse, unless they were trained.
- We asked staff how they assessed and responded to deteriorating patients when there was no clinician on the patient journey and found that they knew how to respond to a deteriorating patient and escalate their concerns. Staff were able to describe the actions they would take including monitoring blood pressure, heart rate, and blood sugar depending on the nature of the patient's condition. Observations were recorded on the patient report form. Staff responded to deteriorating patients by providing first aid, calling for the emergency services or diverting to the nearest accident and emergency unit.
- The service had critical care nurses and the clinical lead had a clinical background and was an additional source of information if staff required clinical advice.
- We saw there had been a clinical incident where a patient with cerebral palsy was allocated an ECA crew and had deteriorated during transport. This patient was escorted by a nurse from the hospital who held clinical responsibility.However, we noted that on the booking form the patient was reported to be stable with no Intravenous Therapy (IV) in place. The ECA crew noted that they saw variable oxygen saturation of the patient. We had concerns that a patient with variable oxygen saturation could be considered to be unstable and at risk. This risk might have been mitigated if the allocated crew were clinically trained. The ECA crew did not seek medical advice regarding the varying levels of oxygen saturation. However, the service told us this was mitigated by the fact the patient had a nurse form the hospital with them.
- SATS did not transport patients detained under the Mental Health Act 1983. Patients experiencing a mental health crisis were accompanied by a member of staff from the transferring hospital.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment**.

Emergency and urgent care services

- The service employed 17 permanent staff made up of five management and office staff, two nurses, one emergency medical technician and nine emergency care assistants. Additionally, they had 27 members of bank staff which they used as and when required. Office staff included the managing director, control staff and the clinical lead.
- SATS had control of the work they accepted from commissioners and only accepted jobs they had capacity for. This meant that they avoided having to deal with unfilled shifts. They would also subcontract work out to other ambulance services if they did not have the capacity.
- Since the last inspection the service had created a fixed set of shifts for each day and night of the week. The service had based these shift patterns on the number of calls received throughout the day. The service had designed a set three-month rota pattern for ECA's which ensured staff were fairly allocated to the different shifts. The rota also allowed management to know exactly how many full time ECA positions were available to recruit into.
- Shifts were created electronically and colour coded in red. Contracted shifts were allocated and highlighted dark green and any remaining bank shifts were coloured light green. Colour coordinating helped control and senior staff to see a snapshot of staffing levels for each day. It helped management to control the number of shifts per staff member, as well as monitor sickness levels. Any specific notes for each shift were added in the event of an incident.
- A monthly audit was completed identifying number of available shifts vs number of filled shifts. Between December 2017 and December 2018 there was an average of 16% of shifts per month that were not filled.
- Staff reported that they generally managed to get a break during work hours. They were entitled to three breaks per shift. The service conducted a meal break audit to ensure staff were taking their breaks. In the month prior to our inspection 90% of the time staff had their allocated breaks.

Records

- **Staff kept records of patients care and treatment but these were not always safe and confidential.**
- Completed Patient Record Forms (PRF) were kept in ambulances before being transferred for storage in the office. PRFs were scanned into the system and then kept in the office for up to 12 months. Following this they were moved to archives.
- We saw patient information and PRFs were kept within plastic folders to ensure they were not visible within vehicles. There had been an incident where a PRF had been blown out of a vehicle which had resulted in folders being used to keep them secure.
- During the inspection, we inspected one vehicle and found six PRFs within the vehicle that should have been removed and taken to the office. One of the PRFs had been in the vehicle since June 2018. This was a risk because the vehicle had been out to the garage for its MOT since then with the PRFs left inside it with patient identifiable information. We raised this issue with the service manager and the PRFs were removed from the vehicle. Following the inspection, the service manager told us the staff members involved were repeating their GDPR training and a portal message was sent to all staff to remind them of the procedure around PRFs.
- A PRF audit was completed each month to ensure staff were completing them properly. We reviewed audit data and found between December 2017and November 2018 compliance varied between 80% and 90%.
- Since the last inspection the service had put in place a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy. This provided crews with guidance on the procedure to follow when patients had a DNACPR in place. Crews were required to check DNACPR paperwork prior to transporting patients. Any issues regarding DNACPR needed to be escalated to control. Crews we spoke had a good understanding of this process.
- Crews now also completed training around information governance which was not the case when we inspected last.

Medicines

- **The service did not always follow best practice with regards to medicines management**
- The service had a medicines management policy in place for staff to adhere to. This provided information on

the procedures to be followed when prescribing, ordering, storing and administrating medicines. The clinical lead was responsible for identifying trends relating to medicines incidents.

- The clinical lead was responsible for ordering and receiving medicines, stock maintenance and resolving discrepancies. The service had a clinical advisor who prescribed medicines for the service.
- The service did not have clear oversight of medicines usage. There was no medicines stocklist and no records of when medicines were used or when medicines were taken for medication packs for the ambulances. We raised this concern with the service and following the inspection the service created a stock check list.
- Staff kept records when medication packs were signed out to ambulances. Systems were in place for checking medication packs on ambulances. Packs were sealed with tamper evident seals and the numbers were recorded. If a medicine was used, staff were required to record this as part of daily checks and replace with a new seal and update records.
- However, when we asked the service how many times medicines had been used they were unable to tell us this at the time of the inspection.
- We reviewed the record for a medication pack on one vehicle. We were told by crew that the pack was complete and therefore ready to use, but the checks identified one medicine was missing. Although the record did reflect this, the highlighted omission was not noticed by the crew. This is a risk because should the patient have required this medicine, then treatment would have been delayed with potential for harm.
- The service conducted a medicines storage audit of medicines bags, which commenced in May 2018. This looked at temperature, storage, expiry dates and disposal. We saw that there were recorded actions when gaps in the audit had been identified. However, there were no audits of overall stock within the service.
- The service had no nurse prescribers or use Patient Group Directives (PGDs).
- Patient Group Directions (PGDs) are defined by the Human Medicines Regulations (HMR) 2012 as a 'written direction that relates to the sale, supply and administration of a description or class of medicinal product'. A PGD enables named, authorised, registered health professionals (including paramedics and nurses) to administer a parenteral medicine for which there is not another exemption to a pre-defined group of patients. Paramedics are covered by two Schedules (Schedule 17 and Schedule 19) of the HMR.
- We found three Prescription Only Medicines (POM) on the service's medicines list which are not included in either Schedule 17 or Schedule 19. These require a prescription or a PGD whether a paramedic or a nurse. The service should not be stocking these medicines. We saw no PGDs in place for the ordering of these medicines.
- During the inspection we spoke to nursing staff. Nurses told us they were reluctant to open and use medicine bags due to the lack of PGDs in place. The lack of PGDs could put patients at risk. For example, if a patient deteriorated during transfer the nurses may not have access to the medicines required to treat the patient with the potential to harm. This was not on the service's risk register.
- The service did not prescribe, order, dispense or store controlled drugs.We were told that in the event a patient required a controlled drug these would be written up on the ward prior to a transfer. If patients were required to travel with controlled drugs then these were either locked in syringe drivers or infusion pumps. At no time did staff take responsibility for controlled drugs.
- At the last inspection we found medicines were stored in an unlocked cupboard. Since then the service had moved medicines into a locked cupboard within the control room. During the inspection we found this cupboard was locked at all times.
- We found the shelf life of a medicine when the product was out of refrigerated storage had expired. If administered to a patient this may not be as effective and could cause harm. This was raised with the services management who removed this from the medicines bags. New stock had been ordered.
- There was no medicines administrations protocol on the safe use of nitrous oxide with oxygen and no detail in the medicines management policy around the safe and effective use of medical gases. On the second day of the inspection a policy was finalised and sent out to staff via the staff portal.

Emergency and urgent care services

- We found one vehicle had been sent for servicing with nitrous oxide with oxygen till stored on the vehicle. We found there was no process in place for the signing in and signing out of nitrous oxide with oxygen. Following the inspection, we were told the service had introduced a new process whereby nitrous oxide with oxygen cylinders were tagged and signed in and out daily. A notification had been sent out to all staff regarding the new procedure. We were told this would prevent them being on vehicles when they were out for servicing.
- Following the inspection, the manager told us the service had taken the following steps. The service reviewed the medical gases policy and added this to the servicing checklist. The service planned to use wristbands with serial numbers. This was currently waiting for approval from the Finance Director. This would mean the service could label and locate nitrous oxide with oxygen cylinders to avoid misuse and losing cylinders.
- The service had improved their storage of oxygen canisters since the last inspection. Oxygen was stored in a secure area and stored as per national guidance. Oxygen cylinders were appropriately secured on the vehicles. The service had audits in place to ensure medical gases were stored in line with national guidance and could prevent a safety risk in the event of a fire. The service had also had external visits from the London Fire Brigade and BOC.

Incidents

- **The service managed patient safety incidents well.**
- At the last inspection staff were unable to tell us the incident reporting procedure and show us how to access incident reporting forms as per the services policy.
- There was now an incident and near miss reporting policy in place. This provided staff with information on the types of incidents they should be reporting and why it was important to manage risk and for service development. The policy explained what a near miss was and encouraged staff to report low level incidents and near miss. Staffs knowledge of how and when to report incidents was good. However, the policy did not explain what a never event was.
- When we inspected the service in July 2016 we also found there was underreporting of low-level incidents and near misses. There was also no evidence of learning from incidents or actions plans to bring about change.
- During this inspection we found the service had improved their incident reporting culture. The service manager had focused on improving incident reporting since the last inspection. All types of incidents were now reported and recorded on the incident reporting log. This allowed the service to monitor trends and use this to inform service development. Learning from incidents and actions were shared with staff via the staff portal. For example, there was an incident where a PRF had been blown out of a vehicle and had to be found by staff. The service had introduced folders to ensure PRFs were not stored loosely in vehicles and a notification had been sent to staff.
- Between January 2018 and December 2018 there has been 64 clinical incidents. Of these 57 (89%) were no harm, four (6%) were low harm, one (2%) was moderate harm and two (3%) had not been allocated a level of harm.
- 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. The service had introduced DoC champions since the last inspection.
- Staff had completed Being Open training to encourage and were clear on their responsibilities in relation to Duty of Candour.

Are emergency and urgent care services effective?

Requires improvement

We rated it as **requires improvement.**

Evidence-based care and treatment

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

- The Clinical Lead communicated new and improved clinical guidelines with all staff. The team of Nurses who specialised in different areas were responsible for keeping up to date with new guidance and sharing knowledge amongst the team.
- We reviewed the provider's policies and found them to be detailed, clear and in date. Policies referenced guidance from the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- Staff provided care in line with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). A copy of JRCALC was available in the staff room where staff could easily access it. The service also paid for staff to have copies of the JRCALC app on their mobile phones. This ensured staff had immediate access to the most up to date guidelines.
- There were policies and protocols in relation to children, however the Mental Capacity Policy did not include information regarding Fraser and Gillick Competency. This did also not form part of the training around the Mental Capacity Act 2005.
- Policies and procedures were kept on the staff portal which was accessible to all staff and staff knew how to access them.
- Staff told us if a patient had a stroke or heart attack, they would be diverted to the nearest accident and emergency department.
- On the first day of the inspection we found there was no policy or protocol in place for the use of medical gases. On the second day of the inspection the clinical lead published this policy.

Pain relief

- **The service did not provide timely and effective access to pain relief.**
- There was no access to pain relief other than nitrous oxide with oxygen on vehicles due to there being no prescriber or patient group directives (PGDs) within the service.
- Staff told us pain relief was included in medicines bags but they had concerns opening these.
- However, the service told us they managed this by ensuring patients had pain relief assessed within the hospital prior to transfer. Any pain relief would be prescribed on the patients drug chart.
- Patients had their pain needs assessed as part of their National Early Warning Scores (NEWS) assessment. However, the service was unable to address patients pain needs unless this medication was already prescribed by the hospital prior to transport.
- If patients had communication issues there were no alternate methods to assess pain in these patients.

Response times

- **The service monitored response times and key performance indicators**
- The service had one Key Performance Indicator (KPI) around response times which was on the scene arrival time. This KPI was monitored for their contracted work with commissioners.
- The service monitored this for their three main contracts (one NHS trust, one independent hospital service and one patient transfer service).
- Between December 2017 and November 2018 performance varied between 83% and 92% for the services NHS contract. This meant the service was not always meeting the agreed target of 95%. The service held regular meetings with the trust to discuss performance including discussions on what the service needed to do to improve performance. These meetings also provided the trust with feedback around patient experience questionnaire feedback, incidents and complaints.
- For the independent hospital performance varied between 76% and 99%. The service had provided the hospital with a review of performance in September 2018. This included information regarding performance against the KPI, incidents and complaints. It also discussed any service improvements.
- Between December 2017 and November 2018 performance for transfers provided for the patient transfer service varied between 80% and 95%.
- Staff told us if they were running late they would call control, who would then inform the hospital.

- Standards and expectations of the service were outlined in the Service Level Agreement (SLA).

Patient outcomes

- **The service and its commissioners monitored key performance indicators**
- The only outcomes measured by the provider related to response times starting with the time they were notified of a patient journey by a commissioner. Office and ambulance staff recorded journey start and finish times and this enabled them to monitor their own response times.
- SATS provided commissioners with information regarding performance in relation to KPIs on a regular basis.
- The service asked for feedback from patients regarding their experience of using the service. This was recorded within a database to monitor positive and negative feedback.

Competent staff

- **The service made sure staff were competent for their roles. However, we found re- licence re-checks were not always completed for staff.**
- New employees were provided with a staff handbook which provided them with key information around company human resources policies and procedures.
- New employees had a period of supervision where they shadowed more experienced staff on vehicles. All new staff were required to complete an induction checklist.
- The service asked new or prospective staff to provide evidence of qualifications. We reviewed staff files and found evidence of staff competencies and qualifications in the form of various training certificates.
- The service asked new or prospective staff to provide evidence of qualifications, for example, nurses needed to be registered with the nursing and midwifery council (NMC). We reviewed staff files and saw evidence of staff qualifications in the form of various certificates.
- Staff were required to complete the '#PLEDGED' agreement as part of their role. This involved staff agreeing to adhering to 17 standards of care. This included a range of things such as arriving on time, wearing the correct uniform, completing VDI checks, being professional, courteous and respectful, data protection, incident reporting and learning and development. The 17 standards were displayed in the control room and staff received a '#PLEDGED' badge to show they had agreed to meet these standards.
- The service had introduced a new training called Critical Care Transfer Course. This was around safety transporting very ill patients safely across London. This was open to registered nurses and had been completed by 75% of staff.
- The service provided staff with annual appraisals. Compliance was 100% for registered nurses, 92% for Emergency Medical Technicians (EMT) and 92% for Emergency Care Assistants (ECA).
- The service did not provide staff with blue light training. Any staff with blue light training had this before joining the service. This was not a requirement for the service.
- At the time of the inspection there were no driving assessments in place. Following the inspection, we were told the service was introducing a driving assessment as part of the PRF which allowed staff to rate their colleagues driving.The plan was for this to form part of the staff appraisal process.
- The service did not routinely transport patients detained under the Mental Health Act 1983 or patients experiencing a mental health crisis. However, staff told us if they had to transport a patient experiencing a mental health crisis, a member of staff from the hospital would accompany that patient in the ambulance.
- Senior leaders told us that driving licence checks were conducted six monthly as per the company policy. However, during the inspection we checked 11 staff members and found four of these had not had their checks completed. There was clear evidence the staff had submitted their codes which enabled SATS to check the licence. However, there was no evidence that these had actually been checked.

Multi-disciplinary working

- **Staff of different disciplines worked together as a team to benefit patients.**

Emergency and urgent care services

- We observed effective handovers between SATS staff and staff at the various hospitals they served. SATS staff made sure all documentation was present and correct and went through it in detail with hospital staff paying attention to allergies and the condition of the patient.
- We observed staff completing patient details on patient report forms (PRFs) on assignment of the patient journey. A copy of the form was given to hospital staff or other staff on the receiving end.
- Where SATS were made aware that a patient had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR), they liaised with staff at the locations they picked the patient up from to ensure they received a copy of the DNACPR prior to transporting the patient.
- SATS engaged with two critical care networks regarding their work and performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**
- The compliance rate for Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training for staff was 100%. Deprivation of Liberty means taking someone's freedom away.
- 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 told us they would seek advice from senior leaders if anyone was refusing treatment.
- However, Staff were not aware Gillick competency and this did not form part of their training. The Capacity to Consent policy did not have any information regarding Gillick competency. Following the inspection, the operations manager provided us with evidence that Gillick was discussed in the safeguarding policy. However, when we spoke to staff they did not know what this was.

Are emergency and urgent care services caring?

Good

We rated caring as **good.**

Compassionate care

- **Staff cared for patients with compassion.**
- Staff cared for patients with compassion, kindness dignity and respect. We spoke with four patients and four relatives who all spoke positively about the staff. They told us staff treated them well and with kindness.
- We travelled with staff on some of the ambulances and observed patient transfers during the inspection. Staff maintained the privacy and dignity of patients including using blankets to protect patients from the cold.
- Ambulance staff spoke with patients and relatives in a caring and polite manner throughout the journeys.
- We heard ambulance staff speak to patients in a supportive manner whilst moving them on and off vehicles. Staff clearly explained what was going to happen.
- We spoke with staff at hospitals (discharging and receiving patients) and they were complimentary about staff at SATS. They said the crews were friendly and professional.
- The service had its own patient feedback questionnaire which asked patients or carers about the quality of the service and additional comments they would like to make. Comments about the service were mainly positive and included statements such as; "They were lovely people", "A brilliant crew, made me very comfortable and confident in their treatment", "They were great, I was frightened and they made me feel safe and "Very professional, caring and considerate".

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- We observed staff talking reassuringly to patients who were anxious about their transfers.
- Staff showed a genuine interest in the welfare of patients they were transporting. Staff would intermittently talk to patients to check how they were doing during the transfer.

Emergency and urgent care services

- Staff said they had not had a patient die in while being transported but were able to articulate the service's procedure for dealing with such a scenario.
- There were still no formal debriefs for staff following any distressing patient transfers.

Understanding and involvement of patients and those close to them

- **Staff communicated effectively with patients around their care during the journey.**
- Staff showed respect to relatives, welcomed them to join the patient on the ambulance and treated them as important partners in the delivery of the patient's care.
- We observed crews engaged with patients during the handover process.
- We observed crews ensured that patients were empowered and supported to move independently when transferring to ambulances.

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

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of the various locations they served.**
- The service tracked the locations of its ambulances which helped identify who had finished jobs and was nearest for the next pickup.
- The control desk in the office had a permanent member of staff which meant bookings could be responded to quickly. Each booking would come via telephone followed by an online booking form submission. If the control desk did not answer then calls were diverted to one of the services mobile phones to ensure calls were not missed.
- The service audited response times to telephone calls. Between May 2018 and April 2019 71% of calls were answered within 5 seconds. This met the services target.
- The service still took a mixture of advance and on the day bookings and workloads were planned around this. The service planned and provided services in partnership with its commissioners through formal contractual arrangements.
- Special Ambulance Transfer Service (SATS) transported patients across the whole of London which meant they did not only serve the local population.
- The service had responded to a possible major incident at a local hospital due to a loss of water supply. The service had responded by providing some vehicles on standby in case there was a need for patient transfers.

Meeting people's individual needs

- **The service tried to take account of patients' individual needs.**
- Booking forms still requested various patient information to ensure individual needs could be met. For example, weight, mobility and areas for special alerts such as DNACPR.
- Some of the vehicles had built in satellite navigation system to enable them to travel efficiently between their destinations. All crews had phones which had access to maps.
- SATS had no access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with the patient. Staff also relied on communicating via hand gestures and mobile phone translation applications which is not good practice.
- Information posters on the vehicles such as how to make a complaint were only available in English. However, the service transported a large population and it would be difficult to have every language included on the poster. Instead the service had opted to use pictures and large text to help patients understand.
- We were told staff would be completing Makaton training to help improve their understanding and ability to communicate with patients with learning disabilities.
- Equipment in ambulances was suitable for the transportation of bariatric patients. Staff also told us that where bariatric patients were to be transferred they used a four-person crew instead of the standard two-person crew.

- Although the service did not routinely transport patients experiencing a mental health episode, they had a member of staff from the hospital in the ambulance with them in the instances where they have had to transport such patients.
- There was a cultural and religion policy to guide staff on what they should do in order to meet patients cultural and religion preferences.
- During the inspection, we saw a crew member asking a female patient whether they were happy to be moved by a male member of crew.

Access and flow

- **People could access the service when they needed it.**
- The service only accepted work from their commissioners if they had enough staff and ambulances to provide transfer services. If the crews were too busy they would subcontract work out to other ambulance services they had service level agreements with.
- The operations manager and other control staff allocated patient journeys to staff considering the type of journey required and staff skills. They also made sure staff were where they needed to be at the required time.
- There was communication between ambulance staff and office staff in relation to any delays. Control staff kept the commissioners updated on any delays in the service.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously and investigated them and there was evidence of learning from complaints.**
- The complaints policy provided information on what processes were in place to resolve complaints. The service had an up to date complaints policy. There was a clear process between SATS and its commissioners on handling complaints. Complaints received directly by the commissioner were sent to SATS for investigation and comment. These were then sent back to the commissioners for completion and conclusions.
- Compliments and Complaints posters were displayed in the rear cab of the vehicles with contact details of how to make a complaint. The service encouraged and welcomed feedback. Complaints forms were available within the vehicles and accounted for on the vehicle daily checks to ensure they were available.
- It was the duty of the complaints manager/operations manager to manage the complaint and respond to the complainant acknowledging the complaint. The complaint was then investigated and passed to the relevant department lead / senior staff member for review and response. The investigation was summarised on the complaints spreadsheet and all emails/letters/ statements and investigatory documents stored in a dedicated folder. The Operations Manager checked the response and signed it off.
- The service's target was to acknowledge complaints within 3 working days of receipt in writing or verbally over the telephone. In the 12 months preceding our inspection, 100% complaints received were managed within this time frame.
- There had been 15 complaints between January 2018 and December 2018 which were documented on the complaints log. These complaints had been investigated with staff and actions put in place as a result. The service now documented informal as well as formal complaints which they did not do when we last inspected.
- The operations manager monitored complaints and fed information back to all staff via 'The Huddle' or as a single memo on the Staff Portal. The Huddle enabled the whole team to focus on recent events. The Huddle was recently updated to include 'What's wrong with me?' which is a picture of poor practice which may help to avoid a complaint being made.
- The service had made changes as a result of complaints and internal incidents. One such change was the introduction of "#PLEDGED" which was a staff engagement exercise in which all staff 'pledged' to acknowledge and adhere to 17 fundamental principles to ensure teamwork, efficiency and responsibility within a 12-hour shift.

Are emergency and urgent care services well-led?

Emergency and urgent care services

Requires improvement

We rated it as **requires improvement.**

Leadership of service

- **Leaders did not always understand the challenges to quality and sustainability within the service. did not have the right skills and abilities to run a service providing high-quality sustainable care.**
- The operations manager (also the registered manager) and clinical lead were responsible for overseeing the day to day management of the service.
- We were told the organisation's financial director was also responsible for running the service. However, when we spoke to the financial director they informed us this was the operations manager's responsibility and they did not have much involvement other than an informal catch up phone call. Following the inspection, we were told the financial director attended the clinical governance meetings. Information provided showed there had only been one meeting in 2018 and one so far in 2019.
- The operations manager was responsible for coordinating the day to day running and delivery of the service including managing staff. They were also responsible for the service's audit and quality processes.
- We found a number of issues regarding the leadership of the service. This included 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.
- Staff were able to identify to us who the leadership of the organisation were and their responsibilities within the organisation.
- Staff told us they saw the senior leadership team on a regular basis. Staff spoke positively about the management team.

Vision and strategy for this service

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- The service's vision had changed since the last inspection. The new vision was 'To provide and uphold high level care governed by specialist nurses throughout ambulance transfer to or from medical facilities'.
- All staff were provided with the vision, mission statement and values during the induction process. Staff were required to sign that they read and understood the statement. The vision was displayed within the control room however staff were not always aware of what the vision was when asked.
- At the last inspection there was no formal strategy in place for the service. During this inspection we were shown a strategy spreadsheet.
- The strategy spreadsheet listed what strategy needed to be in place in order to successfully meet the mission statement. This included things such as having appropriately trained crews, incident reporting culture, audits and meeting Key Performance Indicators (KPIs). The service employed staff of the appropriate grade and trained and appraised staff on a quarterly basis.
- The service also produced a mission statement which was 'to be committed to the continuation of care and wellbeing for each and every patient entrusted to our care'. The service wanted to increase recognition of specialist transfer services across the UK and Europe and promote a higher level of patient care and safety.
- The service had lined up its values with the five core values of the Care Quality Commission (CQC). These were for the service to be safe, effective, caring, responsive and well led. Staffs knowledge of the services values was varied.

Culture within the service

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff described a positive working culture where they were valued and supported. Staff also consistently spoke positively about the flexibility the work allowed them and how proud they were to work for the service.
- The service encouraged staff to raise any issues or concerns with management. Staff were made aware of

the whistleblowing policy via the staff handbook. Staff were encouraged to follow the whistleblowing procedure if they had any concerns about wrong doing within the service.

- Staff spoke of a culture where they were encouraged to report incidents. They also said they could raise concerns without fear of retribution.
- There was evidence that management acted to address behaviour and performance that that was inconsistent with the vision and values of the organisation.

Governance

- **The service did not always systematically improve service quality or safeguard high standards of care by creating an environment for excellent clinical care to flourish.**
- Since the last inspection the service had put a clinical governance policy in place. The policy stated three key attributes to clinical governance. These were; recognisably high standards of care; transparent responsibility and accountability of these standards; and an ethos of continuous improvement.
- We found the governance structure was not robust. There was no clear oversight of the service and its performance from a director level. Therefore, no assurance performance measures were reported and monitored. Whilst the service told us they scheduled in 3 monthly meetings to discuss performance. On review we found only one meeting had taken place in 2018.
- There was confusion over responsibilities of the service leaders. We spoke to the operations manager who told us that the director maintained oversight of the service. However, when we spoke to the director they said oversight of the service was the responsibility of the operations manager. The director told us their only involvement in the service was to finance it.
- Following the inspection, the service told us the financial director has overall oversight of the service. The operations manager has oversight of the daily running of the service.
- The senior manager told us that him and the director held phone calls to discuss how the service was performing. However, there was no evidence of this.
- There were clinical governance meetings to discuss and monitor the services risks, issues and performance. However, these were not on a regular basis. We found there had been one meeting in 2018. We were told these were meant to take place every three months. However, due to how busy the service was this could not always happen.
- There were no effective arrangements in place to ensure that information used to monitor, manage and report on quality and performance were accurate, valid, reliable, timely and relevant.
- The service had some systems to monitor the quality and safety of the service. For example, they used audits of daily vehicle and equipment checks, infection control, and record completion to improve quality. They also monitored their performance against their contracts with commissioners and had regular reviews of policies to ensure that staff delivered a service that was safe and effective.
- The service recruitment process ensured staff were appropriately qualified to deliver good quality care. However, we found not all staff had had appropriate checks prior to working for the company. For example, some driving licences had not been re-checked.
- We also found processes for disclosure and barring services (DBS) were poor. Our concerns during the last inspection were that SATS was not always conducting DBS checks themselves. For some staff they were using pre-existing checks which meant they could not be assured staff were suitable to work with vulnerable people. During this inspection we found this was still the case and this was not on the services risk register. The service had not taken any action to reduce this risk since the last inspection.
- The service did not have regular staff meetings as part of its governance arrangements. This limited the provider's ability to use these meetings to improve service quality or safeguard high standards of care. However, the service highlighted that getting staff into one place was difficult due to the nature of ambulance work. The service had therefore introduced a range of methods to communicate with staff. These included the staff portal, 'the huddle' update and team communication groups.
- The provider did not have systems or processes to ensure that ambulance staff declared working

arrangements outside of the service and monitor this to make sure staff are not working excessive hours that may adversely impact on the care being provided. Issues around Working Time Directives (WTDs) were highlighted at the last inspection and no improvements had been made with regards to the monitoring of this.

- Since the last inspection the medical director had left the service.
- There was poor governance in relation to medicines management within the service.
- There was no occupation health service for employees in place, However, this was on the risk register and we were told the service was hoping to have this in place in the future.

Management of risk, issues and performance

- **The service had improved systems to identify risks. However, not all risks identified within the service were on the services risk register and there were no plans to eliminate or reduce them.**
- We reviewed the services risk register and found risk reporting had improved since the last inspection. However, the lack of regular clinical governance meetings meant risks were not reviewed at a senior level.
- There were 21 risks on the risk register which included things such as staffing levels and recruitment, lack of occupational health, vehicle breakdown and equipment failure. We found the service had put mitigations in place to lower the risks.
- For example, senior management identified recruitment as one of the challenges the service was facing. The service had made a number of changes to improve the recruitment process and recruit more staff. This included having posts advertised continuously and grouping interviews together in order to process applicants together and more efficiently. Applicants were reminded to bring key documents to interview so these could be processed on the day.
- However, we identified some risks within the service that were not on the services risk register. For example, issues around medicines medication and stock. There was also the risk of critically ill patients deteriorating without access to appropriate medicines due to the lack of PGD's within the service.
- A number of issues that we identified during our last inspection were still present at this inspection. For example, equipment servicing, management of working time directives and Disclosure and Barring Service (DBS) checks. These were not on the services risk register and we were not assured the service had taken any steps to mitigate the risks associated with these issues.
- The service had improved clinical audit activity since the last inspection. This now included regulate infection prevention and control audits including hand hygiene.
- There was a lone working policy in place to ensure the safety and welfare of staff.

Information Management

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However, we found one example of poor information management.**
- The service ensured the accuracy of data by keeping complete and accurate records of patients record forms (PRFs). It ensured further accuracy by auditing staff completion of the PRFs. We saw reminders of staff being asked to complete PRFs fully following an audit.
- During the inspection, we found six completed PRFs had been left inside one of the ambulances. This included a PRF from June 2018 which contained confidential patient information such as names and addresses. Following the inspection, we were told staff had been told to redo their General Data Protection Regulation (GDPR) training and a message had been sent out to all staff on the staff portal.
- We also found evidence of engagement between the service and its commissioners where performance against targets was discussed.
- Staff had work mobile phones where they received information on the journeys to be undertaken. Phones were kept in control overnight. Details of jobs sent to the

work phones were deleted at the end of each shift. Staff were aware of this policy and were able to consistently tell us how they managed information received on the work telephone.

- The service had invested in software that allowed phones to be accessed, tracked and wiped remotely from control. This helped protect patient information and helped locate crews should the main tracking system fail.

Public and staff engagement

- **The service engaged well with staff and patients.**
- The manager highlighted staff engagement as one of the challenges the service faced. This was due to shift times making it difficult to get all staff in the same place at the same time. However, management had regular contact with staff during shifts when they visited the base. The service also had a suggestion box for staff in the office for staff to make any suggestions regarding service development.
- There was a 'staff huddle' posted monthly to update staff by portal message on relevant information including business development, incident feedback and feedback on compliments and complaints. However, this huddle was not a meeting where all staff attended.
- There was an employee of the month award which was shared with all staff via the staff portal to praise good word and recognise good practice.
- The service had introduced the SATS Improvement, Recognition and Effort Nomination (SIREN) awards in November 2018.
- The service had set up a group chat on mobile phones to encourage staff to engage and communicate with each other. The group was called "#TeamSATS".
- The Vehicle Daily Inspection (VDI) form which was completed by staff at the start of each shift now contained a 'rate your day' section. Management said this allowed them to monitor staff morale and identify any difficult days for crews.
- Patient satisfaction was recorded, monitored and audited. Patient questionnaires were sent out randomly asking for feedback and comments regarding their experience with the service. The services manager monitored feedback for any issues and trends which were then used to help improve the service. Any very positive feedback was highlighted to staff and staff were nominated for employee of the month.
- The patient satisfaction questionnaire asked things such as 'were you satisfied with how the call was managed'; 'did you find the crew friendly and 'did you find the crew professional'. Between December 2017 and November 2018, performance varied overall between 95% and 100% patient satisfaction.

Innovation, improvement and sustainability

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- We found that the managing director was committed to continuous learning and improvement. There was evidence of the management continually exploring and considering new ways of working. For example, by engaging various external organisations around infection control processes
- At the last inspection in July 2016 the management discussed plans to find a new office space. The service had been unable to find suitable premises large enough for all ambulances and staff vehicles. Similar to the last inspection the service was hoping to find a space that included areas to clean vehicles and equipment.
- The service had introduced a monthly performance score for all staff. All staff were scored for several different things such as hand hygiene, on time attendance, complaints, HR entries, Patient Record Form (PRF) audit, sick days, appraisals and mandatory training. Staff were rated a percentage for each of these items and received an overall score out of 100. Each score was colour coded depending on performance (green, amber or red). When performance decreased this would trigger a response from management in order to speak with the staff member and improve performance. All scores were then added to the overall teams score and displayed on the door in the office so staff could see performance for the month. This system was also used to identify good performance.
- The manager told us they had conducted an ultra violet audit of vehicles. We were told the service had pre-programmed in all the different vehicles and

selected the relevant areas to be tested. For example, bedframe, bed rails, sharps bin, suction unit. The services plan was to identify areas that were missed during cleaning and provide staff with training on how to improve this.

Patient transport services (PTS)

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The main service provided by this ambulance service is Emergency and Urgent care (EUC) making up 84% of the work the service undertakes. Patient Transport Services (PTS) is a small part (16%) of the work the service undertakes.

Moat of our findings for PTS including some arrangements for safety, effectiveness, responsiveness, caring and well led also apply to EUC and because of this we do not repeat the information but cross-refer to the EUC section.

Summary of findings

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

- We found an example of patient record forms (PRFs) being left on vehicles for extended periods of time that contained patient sensitive information.
- The service had not improved the safety testing and servicing of certain equipment which could leave patients at risk if it failed.
- The provider had not improved their processes for Disclosure and Barring Services (DBS) checks to ensure it was safe for staff to work with patients.
- We found some staffs driving licenses had not been re-checked to ensure they were safe to drive the vehicles.
- The provider did not have access to translation services which meant they relied on staff or relatives who spoke the same language to communicate with patients.
- There were no regular staff meetings as part of the service's governance arrangements. However, the service communicated with staff in a range of ways to counteract this.
- The provider did not have systems and processes to ensure that ambulance staff declared working

arrangements outside of the service and monitor this to make sure staff were not working excessive hours that may adversely impact on the care being provided.

- Whilst risk management had improved since the last inspection there were still a number of risks within the service that we identified that were not being mitigated at the time of the inspection. Some risks identified when we previously inspected were still risks within the service.
- There were clinical governance meetings to discuss and monitor the services risks, issues and performance. However, these were not on a regular basis. We found there had been one meeting in 2018.

However, we found the following areas of good practice:

- The provider had systems, processes, and practices to keep people safe and safeguard them from abuse. Staff were aware of and knowledgeable about these processes. This had improved since the last inspection. This was with the exception of DBS checks.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Since the last inspection the service had improved the way they reported, monitored and learnt from incidents.
- We observed effective multidisciplinary working between SATS staff and staff at the various hospitals they worked with.
- Staff treated patients and relatives with compassion, kindness, dignity and respect. We observed staff acting in a professional and courteous manner at all times. Patient feedback was positive.
- The service had improved the way they recorded and learn from complaints. All complaints were now documented and any learning was shared with staff via the staff portal.
- The service had a good audit programme in place which fed into staff appraisals and performance management on a regular basis.
- Staff reported a positive working culture within the service and found leadership supportive and caring. There were recognition awards in place to reward staff for good work.

Patient transport services (PTS)

Are patient transport services safe?

Good

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 training in safety systems, processes, and practices. This was delivered as part of the service's mandatory training of staff. There were processes to monitor training compliance by staff.
- Training was delivered as a mixture of face to face training and online completion by staff.
- Training modules included infection prevention and control, manual handling, fire safety and information governance.
- At the time of the inspection, all staff were up to date with their mandatory training.
- 100% of emergency care assistants were trained in Emergency First Aid at Work or equivalent.

Safeguarding

See the Emergency and Urgent Care (EUC) section for main findings.

Cleanliness, infection control and hygiene

See the Emergency and Urgent Care (EUC) section for main findings.

Environment and equipment

- There were four vehicles that were used for patient transport services (PTS).
- The service had conducted 250 airport journeys since May 2018. Staff did not have access to high visibility jackets to use whilst completing airport transfers. This was identified as a risk at the last inspection because staff wore dark uniforms and collected patients during the dark at airports. This was still the case. Following the inspection, we were told by the operations manager that high visibility jackets had now been ordered.
- See the Emergency and Urgent Care (EUC) section for main findings.

Assessing and responding to patient risk

See the Emergency and Urgent Care (EUC) section for main findings.

Staffing

See the Emergency and Urgent Care (EUC) section for main findings.

Records

See the Emergency and Urgent Care (EUC) section for main findings.

Medicines

The PTS service did not use medicines.

Incidents

See the Emergency and Urgent Care (EUC) section for main findings.

Are patient transport services effective?

Requires improvement

We rated it as **requires improvement.**

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- The Clinical Lead communicated new and improved clinical guidelines with all staff. The team of Nurses who specialised in different areas were responsible for keeping up to date with new guidance and sharing knowledge amongst the team.
- Policies referred to the National Institute for Health and Care Excellence ().

Nutrition and hydration

- **Staff gave patients opportunities to obtain food and drink during patient journeys.**
- Staff sometimes undertook long distance journeys, for example transporting a patient from Portugal. They told us they informed patients they could make as many stops as they needed to obtain food or drink.

Patient transport services (PTS)

- On shorter journeys patients were also given the option to stop for food or drink if required.

Response times / Patient outcomes

- **The service did not routinely monitor response times and key performance indicators (KPIs) for PTS journeys only.**
- There was no formal contract in place for PTS work and this only accounted for 16% of all patient journeys.
- There were no specific contracts for PTS work. However, the service did PTS journeys as part of their service level agreement with commissioners. These were usually patient discharges and admissions.
- As part of their work with an independent hospital the service did PTS journeys. The service did not routinely monitor PTS journeys separately from their EUC work. We asked the service to provide a sample month looking at figures for PTS work only for this commissioner. We saw there had been 94 PTS journeys in January 2019, of these 87% were on time and 97% were within 30 minutes of their appointment time. The service provided updates with the commissioner on a regular basis regarding performance as part of their EUC work.
- Performance for private patient journey bookings were not monitored because this work was only taken on if the service had capacity.

Competent staff

See the Emergency and Urgent Care (EUC) section for main findings.

Multi-disciplinary working

See the Emergency and Urgent Care (EUC) section for main findings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

See the Emergency and Urgent Care (EUC) section for main findings.

Are patient transport services caring?

Good

We rated it as **good.**

Compassionate care

See the Emergency and Urgent Care (EUC) section for main findings.

Emotional support

See the Emergency and Urgent Care (EUC) section for main findings.

Understanding and involvement of patients and those close to them

See the Emergency and Urgent Care (EUC) section for main findings.

Are patient transport services responsive to people's needs?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

See the Emergency and Urgent Care (EUC) section for main findings.

Meeting people's individual needs

See the Emergency and Urgent Care (EUC) section for main findings.

Access and flow

- **People could access the service when they needed it.**
- The service only accepted work from their commissioners if they had enough staff and ambulances to provide PTS services.
- The operations manager and other control staff allocated patient journeys to staff considering the type of journey required and staff skills. They also made sure staff were where they needed to be at the required time.

Patient transport services (PTS)

- There was communication between ambulance staff and office staff in relation to any delays. Control staff kept the commissioners updated on any delays in the service.
- Private patient PTS journeys were only booked if the service had capacity.
- The service could subcontract PTS journeys to other PTS services with whom they had service level agreements (SLAs) with.

Learning from complaints and concerns

See the Emergency and Urgent Care (EUC) section for main findings.

Are patient transport services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership of service

See the Emergency and Urgent Care (EUC) section for main findings.

Vision and strategy for this service

See the Emergency and Urgent Care (EUC) section for main findings.

Culture within the service

See the Emergency and Urgent Care (EUC) section for main findings.

Governance

- The service monitored Emergency and Urgent Care (EUC) and Patient Transport Services (PTS) as one whole service. All journeys were monitored to ensure standards of care were met. However, some on scene times were not monitored for PTS journeys.

See the Emergency and Urgent Care (EUC) section for main findings.

Management of risk, issues and performance

See the Emergency and Urgent Care (EUC) section for main findings.

Information Management

See the Emergency and Urgent Care (EUC) section for main findings.

Public and staff engagement

See the Emergency and Urgent Care (EUC) section for main findings.

Innovation, improvement and sustainability

See the Emergency and Urgent Care (EUC) section for main findings.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Review and improve the management of medicines within the service. Including prescribing, ordering, storing and administrating of medicines.
- Ensure patient information is securely stored to ensure patient confidentiality is protected at all times.
- Ensure suitable checks are carried out on staff to make sure they are suitable and safe to work for the service. Such as driving license and disclosure and barring service (DBS) checks.
- Improve clinical governance within the service to ensure risks and safety are suitable monitored on a regular basis.

Action the hospital SHOULD take to improve

- Have systems and processes to ensure that clinical ambulance staff declare working arrangements outside of the service and monitor this to make sure staff are not working excessive hours that may adversely impact on the care being provided.
- Have systems in place regarding the management of medical gases within the service.
- Staff should remove patient identifiable information from vehicles at the end of each shift.
- Improve pain management within the service to ensure patient needs are met.
- Continue to review its recruitment processes to ensure that in relation to Disclosure and Barring Service (DBS) checks are carried out.
- Have systems and processes in place to ensure equipment is suitably maintained and safe for use.
- Engage and involve staff so they are aware of the services vision, strategy and values. The provider should have systems and processes to measure how operational staff deliver a service aligned to the service's vision and values.
- Improve risk management within the service to ensure risks are identified, mitigated and monitored at a senior level.
- The provider should have regular clinical governance meetings as part of its governance arrangements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of the Health and Social Care Act 2008** **(Regulated Activities) Regulations 2014** **Safe care and Treatment – the proper and safe management of medicines.** The regulation was not met because: There was a lack of oversight of where medical gases were. One vehicle had been sent out for servicing with a medical gas still on board. There was no stock check for medicines and therefore the service did not know stock levels for medicines they stored in the storage room. The service stocked some prescription only medicines and medicines which required patient group directives (PGDs) for usage but did not have these in place. There was no monitoring of medicines usage within the service. We found medicines that had reduced shelf life if stored outside a fridge within the medicines bags. The service was not aware of this and that the medicines were out of date and could be a risk if they were used.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance

The regulation was not because:

Systems and processes were not established to ensure the service assessed, monitored and improved the quality and safety of the service. Formal clinical governance meetings were not regular and therefore the service could not evidence performance was checked and challenged at regular intervals from a director level

Risk management was not robust and there were a number of risks identified previously and during this inspection which were not being mitigated.

There was poor medicines management within the service.

Some equipment was not safety checked inline with manufactures guidance. This could leave patients at risk should it fail during use.

We found some driving licenses had not been re-checked in line with the services policy to ensure staff were safe to drive the vehicles.

Disclosure and Barring Service (DBS) checks were still not completed for all staff by the service themselves. The service was relying on DBS checks from other employers.

The provider did not have systems and processes in place to ensure that ambulance staff declared working arrangements outside of the service and monitor this to make sure staff were not working excessive hours.