SSG UK Specialist Ambulance Service Ltd

SSG UK Specialist Ambulance Service - South

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

SSG UK Specialist Ambulance Service – South is operated by SSG UK Specialist Ambulance Service Ltd. The service provides emergency and urgent care and some patient transport services. The services are predominately commissioned by NHS trusts.

We carried out an unannounced focused inspection of the service on 6 November 2018. This was to follow up on specific concerns we had identified at our inspection on 23 August 2018 and 4 September 2018 which were not covered in warning notices issued following those previous inspections.

We did not look at all the domains and key questions, instead we focused on specific areas of concern.

The service had 18 frontline emergency response ambulances, five patient transport vehicles and six secure vehicles all based at the Fareham station. The secure vehicles were used for the transport of mental health patients, these vehicles all had a secure area or cell.

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.

The main service provided by this service was emergency and urgent care.

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

- Absence of effective and safe medicines management process.
- No clear audits of controlled drugs (CDs). CD registers at station and held by paramedics not fit for purpose.
- No effective and safe process for the distribution, storage and return of CDs.
- An ineffective staff database which did not provide the service with clear information regarding staffing numbers, the skills of staff and their primary operational location.
- Lack of clear communication from senior leaders to operational staff.
- Lack of effective risk management within the organisation.

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

- Improved security at the station and medicines room.
- Improvements made to secure transfer documentation.
- Clear and consistent completion of patient care records by crews.
- Local leaders at the station had responded positively to verbal feedback provided at the previous inspection.

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

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South), 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		The main service for the provider is urgent and emergency care services. These were carried out under contract with NHS ambulance trusts. We have not rated the service as this was a focused follow up inspection. We did not go out on ambulances during this inspection and so were unable to observe care and speak to patients.

SSG UK Specialist Ambulance Service - South

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Background to SSG UK Specialist Ambulance Service - South

SSG UK Specialist Ambulance Service – South is operated by SSG UK Specialist Ambulance Service Ltd. The provider told us urgent and emergency care services was the largest proportion of their work.

The service was registered in 2017. It is an independent ambulance service in Fareham, Hampshire. The provider has two other locations with their headquarters situated in Rainham Essex. SSG UK Specialist Ambulance Service – South primarily serves the communities of the Hampshire, Southampton and Portsmouth areas.

The service has had a registered manager in post since August 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector,another CQC inspector, and a specialist advisor with expertise in emergency and non-emergency patient transport services. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection.

Facts and data about SSG UK Specialist Ambulance Service - South

The service is registered to provide the following regulated activities:

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

The service provided emergency transfers, patient transport and the secure transfer of mental health patients, both adults and children. During the inspection, we visited the provider's location in Fareham, Hampshire where the regulated activities were carried out.

Detailed findings

We spoke with seven staff including; managers, technicians, emergency care assistants, staff who undertook secure transfers of mental health patients and make ready staff who were responsible for ensuring the ambulances were stocked and ready for use.

We did not inspect any vehicles as they were not in the scope of this inspection. We did not speak with patients as we did not observe patients receiving care on the day of the inspection.

During our inspection, we reviewed 40 records which included staff personnel records, medicines registers, and emergency care patients' records.

The accountable lead officer for controlled drugs (CDs) was the registered manager.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by this service was emergency and urgent care.

The service provided, emergency and urgent transfers on behalf of NHS trusts. At the time of our inspection, the provider had four NHS contracts; and work at the Fareham station was being commissioned by two NHS ambulance trusts.

Summary of findings

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

- Absence of effective and safe medicines management process.
- No clear audits of controlled drugs (CDs). CD registers at station and held by paramedics not fit for purpose.
- No effective and safe process for the distribution, storage and return of CDs.
- An ineffective staff database which did not provide the service with clear information regarding staffing numbers, the skills of staff and their primary operational location.
- Lack of clear communication from senior leaders to operational staff.
- Lack of effective risk management with the organisation.

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

- Improved security at the station and medicines room.
- Improvements made to secure transfer documentation.
- Clear and consistent completion of patient care records by crews.
- Local leadership at the Fareham base who had responded well to initial inspection feedback.

Emergency and urgent care services

Are emergency and urgent care services safe?

Safe means the services protect you from abuse and avoidable harm.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- During the previous inspection the station was not secure. On arrival at the Fareham station it was noted that the station was now secure and could only be accessed via a lockable door.
- A new medicine room had been created since the time of the last inspection. The room was accessed via a lockable door and restricted to the two paramedics currently employed at this station and the two managers. The paramedics collected their controlled drugs (CDs) and the managers were responsible for adding prescription only medicines (POM) to any red tagged medicine bags carried on all urgent and emergency ambulances.
- The medicine room had two key safes, the codes were changed monthly, one key safe for the CD safe. The CD safe was only accessible by the paramedics and was used to store morphine. We noted all ampoules of morphine were in date and the balance matched that of the CD register which was stored on top of the CD safe. The POM's cupboard was accessed via a lock, the key was stored in a key safe.
- Temperature monitoring of medicines was not consistent and we could not be assured medicines were stored safely. The room had temperature monitoring which we saw was recorded but not daily only three times a week. Definitions of minimum and maximum temperatures were not recorded on the schedule and there was no guidance showing what action to be taken if temperatures were outside the expected ranges.
- Work on the medicine room was not complete at the time of our inspection and CCTV outside the room and work benches inside the room were yet to be installed. The local managers had not been informed of a date when this work would be completed.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had a Restrictive Intervention Policy that was in date and subject to annual review. The policy reflected national guidance and best practice and was available to staff who worked in the secure team.
- During this inspection we noted the secure team had responded to the verbal feedback provided at the last inspection and made improvements in their paperwork. On the booking form and central record, they had included a box to show when the cell or handcuffs were used and if the transfer was on blue lights. This additional information was added to the booking form, together with the verbal risk assessment which was routinely obtained the provider commissioning the transfer.
- We reviewed the new booking form. We noted from recent records of transfers carried out the reason for the cell being used was now being documented.
- We were told by two members of staff if an assault on a member of staff took place an incident form was completed. We were not given any specific examples but we were told information from incidents would be used to inform learning and change practice where appropriate.

Staffing

- We could not be assured the service had staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- We could not be assured the service was aware of the staff they had working for them and where they were located.
- Information provided by head office relating to staff who worked at Fareham station or who had undertaken work in the last 12 months did not accurately reflect staffing at the station.
- The information provided by head office did not match that held by the local manager. The local manager generated a list of paramedics who worked or who had worked from the Fareham station in the last 12 months. He provided detailed information of why the individuals were no longer active, such as out of date Disclosure

Barring Service (DBS) checks, their mandatory training was not up to date or lack of evidence of current driving licence and those who had never worked at the location and the date individuals had last worked.

- Corroboration of the evidence provided by head office prior to our inspection showed that of the 13 names listed as current paramedics at Fareham; two paramedics worked at the station, three had never worked at the station, eight had previously worked at the station, with three not doing so in the last 12 months.
- We were assured that the local manager could clearly describe the staffing at the station and was able to easily talk about individual staff and their skills. However, this did not correlate with the information provided by head office. Therefore, we were not assured that head office were aware of the location staff worked out of or had the ability to use the staffing data base to produce accurate up to date staff reports.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date.
- The patient care records (PCRs) we reviewed varied in the detail included but all boxes and a continuation sheet were completed, the writing was in black ink and legible. It was not clear if the provider had an expected standard of record keeping and if this standard had been communicated to all staff to ensure records were consistently completed to an agreed standard.
- We had concerns regarding the safe and secure storage of some records. We observed that in the medicines room there was a box of completed patient records relating to transfers undertaken for the local acute trusts. While in a locked room these were in a cardboard box and could be accessed by unauthorised members of staff.
- We saw that the PCRs relating to emergency attendances for the local commissioning trust were stored securely in a locked cabinet prior to being collated and delivered to the commissioning trust.

Medicines

- We were not assured the service followed best practice when prescribing, administering, recording and storing medicines.
- The current CD register located in the new medicine room was not fit for purpose. It did not include a record of any waste CDs or space for a witness signature.
- We were told, but did not observe the practice for disposal of CDs as there was no paramedic on duty. Any waste CDs were placed in a CD destruction kit and labelled with the computer aided dispatch (CAD) number. The kit should then be stored in the CD cupboard for 24 hours prior to being placed in the clinical waste bin. We noted the waste was not recorded in the CD register or in a waste medicine register and therefore not traceable.
- Prior to our inspection we were provided with details of all paramedics who had worked in the last 12 months and details of the CDs they had been issued with and any that had been returned. From this data we identified several individuals who had high usage of morphine and requested a sample of individual CD registers.
- The central records of CDs being issued to paramedics did not correspond with entries in individual CD registers. While the majority of transfers were included we noted additional supplies had been taken by paramedics but it was unclear who had signed these out.
- The provider told us, following our last inspection, that all CDs had been recalled from paramedics back to head office in Rainham. We were told this had been done as there had been no audits of the storage arrangements in paramedic's homes.
- Information provided by the provider as part of this inspection demonstrated that this was not the case. While audits of home storage arrangements had commenced these had not been undertaken for all paramedics who had been issued with personal issue CDs. Therefore, there was a risk that CDs may not always be stored in line with legislation.
- Individual paramedic CD registers were not consistently completed. When CDs were transferred into the paramedic's possession the registers did not include who had issued these or a time. The registers were not fit for purpose for example there was no column to record wasted CDs, the CAD number was presented in different ways, i.e. not always having the commissioning trust included and a running balance was not always recorded.

- CD usage could not always be tracked. Not all entries in individual CD registers could be linked to the CAD number provided. CD registers were not constantly completed to provide a clear audit trail of administration and wastage.
- Individual paramedic CD registers included self-audits. However, there was no independent or manager audit and therefore no independent validation of stock held by individual paramedics.
- We noted CDs were transferred between paramedics, for example we noted a paramedic had transferred his stock to another paramedic, no reason for this transfer was provided.
- We noted that a paramedic on duty at the time of our inspection had signed out two ampoules of morphine, this was not countersigned and no reason why this lack a second signature was recorded.
- We identified specific concerns relating to CDs based on a review of this data, these included;
- One paramedic who left the service and had last worked for the service on the 29 June 2018, had been issued with 20 ampoules of morphine prior to leaving. Despite leaving there was no record that the ampoules had been returned. We requested the CD register to confirm that the ampoules could be accounted for but as the individual was working overseas it was not possible to obtain this register or assurance that the CDs could be accounted for.
- One paramedic had last worked at Fareham in 2017 but was inactive, the reason provided for this was that his professional registration had lapsed. Records showed this individual was still being issued with CDs and was high user of morphine, on checking we found he was working at the Rainham station and for another independent ambulance provider. We have checked the HCPC register, these checks confirmed he currently has an active registration. Demonstrating that the provider's central records had not been updated to reflect the location this paramedic worked from and the period his professional registration had lapsed.
- We reviewed 36 patient care records (PCRs), which had been completed by ambulance crews in the two days prior to the inspection. This showed that medicines administered to the patients were in line with the service policy and did not include medicines in the patient group directions (PGD) medicines the provider had withdrawn following our last inspection.

Are emergency and urgent care services effective?

This section was not inspected.

Are emergency and urgent care services caring?

This section was not inspected.

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

This section was not inspected.

Are emergency and urgent care services well-led?

Well-led means that the leadership, management and governance of the organisation make sure it provides high-quality care based on your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Leadership of service

- There was evidence of strong local leadership supported by the operational manager who was on site regularly. However, there was evidence of a lack of information sharing from senior leaders to local managers and the operational manager. They described how this impacted their ability to address issues in a timely manner and ensure information submitted to the CQC was accurate and reflected the local service.

Management of risk, issues and performance

- We were not assured the provider had effective systems for identifying risks, planning to eliminate or reduce these, and coping with both the expected and unexpected risks.
- Known risks were not effectively managed. Despite PGD medicines being withdrawn following our last inspection, crews were dispatched to cardiac jobs which may require these medicines to be administered. We

were told by the manager that crews would call for back up from the commissioning NHS trust if a patient requires a PGD medicine that the crews do not have available following their removal.

- Crews were making on the scene decisions about if the backup would take longer to arrive than the journey to the cardiac centre. Managers and crew told us they would blue light the patient to the cardiac centre and not wait back up if they felt this was clinically appropriate and the journey time was shorter than the time it would take for the support crew to arrive on scene.
- Information relating to the number of times this occurred and the outcome for the patient was requested from the provider and local commissioning trusts. This information was collected by the commissioning trust but they were unable to provide this when requested. The provider and commissioning trusts could not state how many times a crew had requested back up as they could not meet the patients' needs due to not having PGD medicines available. The provider and commissioning trust were not able to confirm if this lack of medicines had an adverse effect on the patient's outcome.
- To manage the risks associated with mechanical restraint, all secure staff had annual mechanical restraint training updates. Records were maintained on a central log and this detailed when the secure cell and handcuffs were used. This information was collated by the secure team on a daily, weekly and monthly basis and reported to the senior management team.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Take prompt action to address concerns regarding the absence of effective and safe medicines management process.
- Take prompt action to address the lack of audits of controlled drugs (CDs) and to resolve issues concerning CD registers at station and those held by paramedics not being fit for purpose.
- Take prompt action to ensure effective and safe processes for the distribution, storage and return of CDs are implemented and audited.
- Take prompt action to address the ineffective staff database.
- Take prompt action to address concerns regarding the lack of effective risk management with the organisation.

Action the hospital SHOULD take to improve

- Address concerns regarding the lack of clear communication from senior leaders to operational staff.

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 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Care and treatment must be provided in a safe way for service users. The registered person must ensure that medicines are managed safely and securely at all times. This must include safe controlled drug management, audit and recording. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Governance. Systems or processes must be established and operated effectively to ensure compliance with the requirements. The provider must take prompt action to address concerns regarding the lack of effective risk management with the organisation. The provider must take prompt action to address the lack of corporate understanding regarding staffing numbers, the location of staff and an ineffective staff database with skills. Regulation 17(1)(2)(b) Regulation 17(1)(2)(d)(i)