SSG UK Specialist Ambulance Service Ltd

SSG UK Specialist Ambulance Service - North

Quality Report

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Date of inspection visit: 30 April 2019
Date of publication: 16/08/2019

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
Patient transport services (PTS)	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

SSG UK Specialist Ambulance Service North is operated by SSG UK Specialist Ambulance Service Ltd (SSG) . The service provides a patient transport service for patients with mental ill health.

We inspected this service using our comprehensive inspection methodology. We made an unannounced visit to the service on 30 April 2019.

The service had been previously inspected in April 2018 but not rated.

Following that inspection, we told the provider that it must take three actions to comply with the regulations and that it should make six other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected Patient Transport.

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 patient transport.

We rated it as **requires improvement** overall.

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

- During the previous inspection the provider was given six should do actions to improve the service. During this inspection we found four of the six should do actions had not been completed.
- The provider did not have their own procedure for identifying high risk/infectious patients.
- During the inspection we found limited evidence the provider carried out effective audits to measure the quality and effectiveness of the service delivered. This was because the number of observations or gathering of audit information was so low; they were not a representative sample of the number of staff employed or the number of patient transports undertaken.
- The provider did not actively seek feedback about the quality of care and overall service provided.
- There was no evidence that dynamic risk assessments in relation to patients were recorded.
- There was not a system to record or measure the levels of staff adherence to local policies and procedures.
- There were very limited supervisory operational observations of staff carried out to identify either good or poor practice.
- During this inspection there was no evidence the PTS vehicles we inspected carried any information or leaflets which would explain to a patient, relative or carer how to make a complaint.
- During the inspection we did not see evidence of an effective system to actively seek feedback from patients, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.

However, we found the following areas of good practice:

- During this inspection we saw evidence the provider had acted to deal with the three must do actions, two of the six should do actions and the requirement notice issued following the previous inspection.
- There was evidence of a formal system for reporting and responding to incidents.

Summary of findings

- There were high levels of staff statutory and mandatory training.
- The station and working environment were visibly clean, safe and fit for purpose.
- There was evidence during this inspection that the five employed staff had a current appraisal.
- Staff observed during inspection displaying a caring, empathetic and supportive attitude.
- Staff were observed working well with hospital staff to calm a patient who was refusing to be transported.
- Patient transport journeys were planned to take account of patient risk.
- There was a shift system to manage access and flow covering 24 hours per day.
- There was evidence of a provider mission statement, values and strategic priorities for 2019.
- There was evidence of recent 1:1 staff employment consultation in relation to increasing the number employed staff in the company.

Following this inspection, we told the provider that it must take six actions to comply with the regulations and that it should make 12 other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected Patient Transport Services. Details are at the end of the report.

Ann Ford Deputy Chief Inspector of Hospitals (North), 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?
Patient transport services (PTS)	Requires improvement 	Patient transport services for patients with mental ill health was the regulated activity carried out. No other categories of patients were transported. In the reporting period April 2018 to March 2019 there were 4,014 patient transport journeys undertaken, of these 80 were children aged under 18 years. Safe was rated as requires improvement because there were no general waste bins or clinical waste bins on either vehicle inspected, not all incident forms had been reviewed by a manager and no personal protective equipment (PPE) audits had been carried out. Effective was rated as requires improvement because there was a lack of audit activity and some of the improvement actions resulting from the previous inspection had not been completed. The provider did not have a system to record or measure the levels of staff adherence to local policies and procedures. There were very limited supervisory operational observations of staff carried out to identify the levels of competence of staff or good or poor practice. Caring was rated as good because staff we observed displayed a caring, empathetic and supportive attitude toward the patient they were transporting. Responsive was rated as requires improvement because following the previous inspection the provider had been given some actions to improve the service during this inspection some of the actions had not been completed. There were no communication aids for staff to use with patients when English was not their first language in the vehicles we inspected. The PTS vehicles we inspected did not carry any information or leaflets which would explain to a patient, relative or carer how to make a complaint. Well Led was rated as requires improvement because there was not an effective system to

Summary of findings

actively seek feedback from patients, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies and there was limited evidence the provider carried out audits to improve the service.

Requires improvement

SSG UK Specialist Ambulance Service - North

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Detailed findings

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Background to SSG UK Specialist Ambulance Service - North

SSG UK Specialist Ambulance Service North is operated by SSG UK Specialist Ambulance Service Ltd (SSG) . The service commenced operating in July 2017. It is an independent ambulance service. The northern base is in Cramlington Northumberland.

In August 2013, the current SSG UK Specialist Ambulance Service North Regional Manager was asked to run the UK Specialist Ambulance Service Ltd North Division (UKSAS), with a view to building the company up in the North of England.

Initially this was done by providing a service for the transport of patients sectioned under the Mental Health Act. At this early stage the business operated from the Regional Manager`s home until such time that the volume of work warranted obtaining a business premises. This was achieved by November 2014, the company moving to the current premises in Cramlington.

The company continued to build up the business obtaining contracts with several clinical commissioning groups (CCGs). In July 2017, Servicios Socio-sanitarios Generales (Spain) purchased UK Specialist Ambulance Service Ltd SSG, creating the new company, SSG UK Specialist Ambulance Service Ltd.

SSG UKSAS nationally is a provider of urgent and emergency care, patient transport services and secure transportation services to numerous NHS Trusts around the country. SSG UKSAS had three main sites:

- Corporate HQ Rainham, Essex, serving two NHS ambulance service Trusts.
- SSG UKSAS South Fareham, Hampshire, serving one NHS ambulance service trust.
- SSG UKSAS North, Cramlington, Northumberland, serving CCG`s and Mental Health Trusts across the north.

The service has had a Registered Manager in post since 3 August 2017.The provider is registered to provide the following regulated activities at SSG UKSAS North;

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

The service also provides a patient repatriation service for insurance and air ambulance companies which fall outside the remit of CQC regulated activity and were not inspected. There were two PTS and two urgent and emergency care ambulances based at Cramlington.

Detailed findings

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in independent ambulances. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about SSG UK Specialist Ambulance Service - North

During the inspection we visited the SSG base at Admiral Business Park, Cramlington, Northumberland NE23 1WG.

The premise was a one storey privately leased building on an industrial estate. The building had an alarm and exterior security lighting. The industrial estate was also patrolled at night by a private security company. There were car parking spaces to the front of the building with ample room for the provider`s ambulances and private vehicles.

The ground floor of the building had a reception / office area used by the regional supervisor. There was a spare computer and desk which SSG staff could use. There was a large garage space to park ambulances which had a roller shutter door at the front of the building providing access to the exterior. There was a general storeroom where staff could leave broken or damaged equipment. There was an equipment store cupboard which was well laid out and stocked. There was a small cabinet on the rear wall of the garage which contain consumable stock items which staff could access to replace those that had been used. The garage also housed a large clinical waste bin.

There was a large meeting room adjacent to the ambulance crew room which had welfare facilities. There was a kitchen for staff to use and two single sex toilets. All areas of the building allowed disabled access.

During the inspection we spoke with nine staff including; the registered manager, regional manager, regional supervisor and six emergency care assistants. We were unable to speak to any patients or relatives.

During our inspection, we reviewed six sets of patients booking record forms.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in April 2018, which found that the service was not meeting all standards of quality and safety it was inspected against.

Activity (April 2018 to March 2019)

- In the reporting period April 2018 to March 2019 there were 4,014 patient transport journeys undertaken, of these 80 were children aged under 18 years.
- The service did not carry out any emergency, urgent care patient transports in the reporting period.

There were five employed staff; based at the Cramlington site who were, the regional manager, regional supervisor and three emergency care assistants, there was a bank of temporary staff that it could use. The Registered Manager was based at the SSG head office in Essex. At the time of the inspection there were 15 bank staff registered to work for the company. The accountable officer for controlled drugs (CDs) was the registered manager although no control drugs were stored on the station or on any of the vehicles.

Track record on safety

- No Never events
- Clinical incidents, there were none reported with no harm, none with low harm, none with moderate harm, none with severe harm and no deaths
- No serious injuries
- One complaint

Detailed findings

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Patient transport services (PTS)

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

Information about the service

SSG UKSAS nationally is a provider of urgent and emergency care, patient transport services and secure transportation services to numerous NHS Trusts around the country. SSG UKSAS had three main sites including the Cramlington site which we inspected.

The Cramlington site provided patient transport services for patients with mental ill health 24 hours per day 365 days of the year on behalf of CCGs and hospital trusts.

Summary of findings

The overall rating of the service was requires improvement.

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

- During the previous inspection the provider was given six should do actions to improve the service. During this inspection we found four of the six should do actions had not been dealt with.
- The provider did not have their own procedure for identifying high risk/infectious patients.
- We found limited evidence the provider carried out audits to measure the quality and effectiveness of the service delivered because the number of observations or gathering of information was so low they were not considered to be a representative sample of the number of staff employed or the number of patient transports undertaken.
- The provider did not actively seek feedback about the quality of care and overall service provided.
- There was no evidence that dynamic risk assessments in relation to patients were recorded.
- There was not a system to record or measure the levels of staff adherence to local policies and procedures.

Patient transport services (PTS)

- There were very limited supervisory operational observations of staff carried out to identify either good or poor practice.
- There was no evidence the PTS vehicles we inspected carried any information or leaflets which would explain to a patient, relative or carer how to make a complaint.
- We did not see evidence of an effective system to actively seek feedback from patients, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.

However, we found the following areas of good practice:

- We saw evidence the provider had acted to deal with the three must do actions, two of the six should do actions and the requirement notice issued following the previous inspection.
- There was evidence of a formal system for reporting and responding to incidents.
- There were high levels of staff compliance with statutory and mandatory training.
- The station and working environment were visibly clean, safe and fit for purpose.
- There was evidence during this inspection that the five employed staff had a current appraisal.
- Staff observed during inspection displayed a caring, empathetic and supportive attitude.
- Staff were observed working well with hospital staff to calm a patient who was refusing to be transported.
- Patient transport journeys were planned to take account of patient risk.
- There was a shift system to manage access and flow covering 24 hours per day.
- provider had a mission statement, values and strategic priorities for 2019.
- There was evidence of recent 1:1 staff employment consultation in relation to increasing the number employed staff.

Are patient transport services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- Management reviews of submitted incident forms had not been completed on eight of the 13 forms selected.
- The provider did not have their own procedure for identifying high risk/infectious patients.
- During this inspection we saw evidence of limited hand hygiene audits. The number of observations or amount of information gathered was so low that they were not a representative sample of the number of staff employed or the number of patient transports undertaken.
- There were no personal protective equipment (PPE) audits carried out.
- Vehicle keys were not routinely locked away to prevent theft. During inspection they were found left in an unlocked draw in the front office.
- The non-liveried vehicle did not display signs indicating the vehicle was carrying medical gases. There were no communication aids available on the vehicle for patients when English was not their first language.
- There were no general waste bins or clinical waste bins on either vehicle inspected which presented and infection risk.
- Wheelchair patients were transported using a mobile rear impact protection (RIP) seat, but this did not offer neck protection in the event of a crash.
- We did not see any evidence the fire evacuation plan had been tested.
- Managers we spoke with told us dynamic risk assessments in relation to the handcuffing of patients were not recorded.
- There was no additional patient documentation in addition to the patient booking form which was completed by staff which could be used to assess and provide the appropriate service. Staff were totally reliant upon the patient booking form.

However, we found the following areas of good practice:

- The station and working environment appeared visibly clean, fit for purpose and safe for staff to use.
- There was evidence of a formal system for reporting and responding to incidents.
- There were high levels of staff compliance with statutory and mandatory training.
- We saw evidence half the PTS drivers had a current Business and Technology Education Council (BTEC) Level three advanced driver qualification. This is an emergency driving qualification. We saw records which showed that driver training had been monitored by the provider.
- During the inspection the store cupboard in the station garage area was inspected and found to well stocked with numerous items of cleaning equipment for staff to use.

Incidents

- The service had not recorded any never events during the past 12 months. Never events are incidents of serious patient harm that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There was evidence of a formal system for reporting and responding to incidents. The system was that incidents had to be reported to the director of governance who was based in the company headquarters in Essex within three working days. The incident form would be scanned and e-mailed to the company headquarters.
- During inspection the provider incident report form was reviewed. The report form had sections to complete which covered all relevant information to record which would be required to investigate an incident.
- The report form contained a section for the personal details of the service user/patient, details of the incident, a summary of the incident with a note stating the information must be clear and concise describing what happened including a description of any injuries sustained, what had been learnt from this incident, what changes would be implemented as a result of this incident, a section with the details of the person completing the report, a section for the local manager to complete including a risk assessment matrix and a section if the incident was a Report of injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) report.
- Managers we spoke with told us work was ongoing to make the form digital so staff could complete them using their work computer tablets. The completed forms would then be sent to governance lead.
- The provider had an incident reporting policy which contained an introduction, purpose and scope, key responsibilities, training, reporting incidents, levels of investigation, risk assessment, reporting to external agencies, monitoring and review, related documents including a glossary, an incident reporting form, an incident coding card, a flow chart for staff reporting incidents and how to complete a risk matrix.
- We reviewed 13 completed incident forms; each consisted of two pages. Five forms had been reviewed by the regional manager, five forms had no review regional manager review and three forms were incomplete as the second page, which was where the manager signed to say the incident had been reviewed was missing.
- During inspection we pointed out the deficiencies on the incident forms we reviewed to the regional manager who immediately reviewed them.
- The duty of candour places a legal responsibility on every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress and to apologise to the patient or, where appropriate, the patient's advocate, carer or family.
- The provider had a duty of candour policy which included the purpose of the policy, an introduction and background, objectives and purpose of the policy, responsibilities from the chief executive to front line staff, definitions of incidents where duty of candour would apply, clinical support and advice, procedure for the nominated investigation manager, what documentation was required, monitoring of the policy which would be done through feedback from patients or relatives, the principles of openness, professional support, confidentiality and continuity of care. The policy document was SSG branded.

- Managers and operational staff we spoke with were aware of the application of duty of candour and could give examples where it should be used as well as the requirement to be open and honest.
- The provider had no reports of having had to apply the duty of candour.

Mandatory training

- Management staff told us mandatory training was included as part of the induction training and was provided by the service.
- Mandatory training was delivered by an accredited external training provider.
- Managers we spoke with told us the current topics covered in mandatory and statutory training included; Health and Safety, Fire Awareness, Risk Management, Infection Prevention and Control, Safeguarding, Manual Handling, Resuscitation, Equality and Diversity, Information Governance, Mental Capacity Act and Whistleblowing.
- Duty of candour training was delivered internally through an in-house e-learning package. Staff read the material and when they thought they were ready they did a multiple-choice exam; the questions of which were provided by the SSG. The pass mark was 70% with 10 questions to answer. There had been no staff to date which did not achieve the pass mark.
- There was evidence staff did a preventing violence and aggression course (PVA) over two days which was delivered by an external accredited training provider. The course was both classroom and scenario based which covered the law and practical scenario exercises. There was an exam with a 75% pass mark. Only one member of staff was awaiting this training.
- Managers told us the mandatory and statutory topics were delivered in accordance with the Skills for Health UK core skills training framework regarding refresher training intervals and levels of qualification appropriate to role.
- The compliance rate for mandatory and statutory training at the time of the inspection is listed below. We saw evidence managers had plans in place so that training compliance would be 100% in all topics.
- Conflict Resolution 19 staff or 90%,Consent 21 staff or 100%, Duty of Care 21 staff or 100%,Equality, Diversity and Human Rights - General Awareness 20 staff or 95% ,Equality, Diversity and Human Rights - Promoting Understanding 20 staff or 95%, Fire Safety 20 staff or 95%, Health, Safety, and Welfare 20 staff or 95%,Infection Prevention and Control for Clinical Staff 21 staff or 100%,Information Governance 15 staff or 71%, Learning Disabilities Awareness 21 staff or 100%, Mental Capacity Act 2005 21 staff or 100%, Mental Health Awareness 20 staff or 95%, Moving and Handling 13 staff or 62%, Patient Moving and Handling 16 staff or 76%, Prevent 18 staff or 86%, Resuscitation Level one19 staff or 90%,Resuscitation Level 2 - Paediatrics BLS 21 staff or 100%,Safeguarding Adults Level one18 staff or 86%, Safeguarding Adults Level two 20 staff or 95%, Safeguarding Children Level one 20 staff or 95%, Safeguarding Children Level two 19 staff or 90%, Safeguarding Children Level 3 - Voluntary 8 staff or 38% and Stand By Me - Dementia 14staff or 67%.
- We saw evidence staff who had not undertaken the PVA training were not allowed to transport patients with a mental health condition.
- During the last inspection the Registered Manager told us that SSG had signed up for new Skills for Health (SfH) e-learning modules for mandatory and statutory training. During this inspection we saw this was fully embedded and had replaced most of the face-to-face teaching that had normally been undertaken annually.
- We saw evidence computer tablets had been placed in SSG PTS vehicles which would allow staff to complete training modules whilst on duty in downtime. Staff would be invited to SSG education centres to complete the practical elements, along with any local procedural topics that could not be addressed with on line courses.
- We saw evidence the Registered Manager had informed staff the new Skills for Health (SfH) modules must be completed by 31 May 2019.
- We saw evidence that half the PTS drivers had a current Business and Technology Education Council (BTEC) Level three advanced driver qualification. This is an emergency driving qualification. We saw records which showed that driver training had been monitored by the provider.

Safeguarding

- We saw evidence that the training completion rate for safeguarding training was as follows; 86% or 18 staff Adult Safeguarding Level one, 85% or 20 staff Adult Safeguarding Level two, 95% or 20 staff Children Safeguarding Level one and 90% or 19 staff Children Safeguarding Level two. Eight staff had voluntarily completed Children Safeguarding Level three.
- The provider`s safeguarding lead was the Registered Manager. During the inspection we saw evidence the lead had a level four safeguarding qualification.
- The service had a policy for safeguarding children and protecting vulnerable adults from abuse. The policy gave clear guidance to staff on how to report urgent concerns and included contact information for the appropriate local authority safeguarding children or adult teams.
- During inspection we saw evidence of an extensive list of safeguarding board contacts identified by local authority area available for staff which also explained how to make a referral.
- Staff we spoke with were aware of guidance related to specific safeguarding issues. The safeguarding policy included the legal requirement for reporting incidents of female genital mutilation (FGM) and the 'PREVENT' strategy for identifying and preventing terrorism. Prevent is part of statutory and mandatory training.
- A safeguarding flowchart was available on each vehicle, including the contact information for the appropriate local authority safeguarding children and vulnerable adults' team for staff to use.
- Managers we spoke with told us there had been one reported safeguarding incident in the previous 12 months. The report was concern about possible neglect when a patient was returned home following treatment. They lived alone, and the home environment was not clean. This was reported by staff to the to the SSG Safeguarding Lead, who escalated it to the local authority.
- Safeguarding training had previously been completed as a part of mandatory training and had been delivered by the director of governance. We saw evidence that staff had recently completed the new Skills for Health (SfH) modules in relation to both safeguarding adults and children Level one and two.

Cleanliness, infection control and hygiene

- During the inspection we saw evidence of a detailed infection prevention and control (IPC) policy. The policy stated staff should follow guidance on hand hygiene, personal protective equipment, environmental cleaning, waste management and uniforms.
- Managers told us following transportation of an infectious patient, the process was to bring vehicles back to the station as soon as possible for cleaning before another patient was transported.
- The provider did not have their own procedure for identifying high risk/infectious patients. The service was reliant upon information from the provider requesting the PTS.
- We saw evidence of hazardous spillage equipment being available for use at the station.
- We observed appropriate segregation of clinical and non-clinical waste took place and processes were in place for the removal of clinical waste.
- The regional manager we spoke with explained crews were required to ensure their vehicles were fit for purpose, before, during and after they had transported a patient by completion of a vehicle checklist.
- The service used an adenosine triphosphate (ATP) monitor to measure the level of cleanliness. ATP is a protein produced when bacteria respire. If levels of ATP were less than 50 parts per million the area swabbed was deemed to be clean. If the parts per million ATP score was higher than 50 parts per million the area would be recleaned and swabbed until the ATP score was found to be under 50 parts per million.
- During the inspection the store cupboard in the station garage area was inspected and found to be well stocked with numerous items of cleaning equipment for staff to use.
- Cleaning had been carried out by staff who was sub-contracted by SSG to perform that role. Cleaning was monitored through the cleaning schedule and check lists which had been reviewed by the Regional Manager.
- At the last inspection managers told us that they only carried out limited audit activity which did not include audits to ensure staff complied with key provider

policies including, hand hygiene and personal protective equipment (PPE). During this inspection we saw evidence of limited hand hygiene audits and no PPE audits.

- Managers told us that hand washing was covered as a topic in the staff induction training; this included staff being observed washing their hands. There were posters displayed in the Cramlington station toilets which had a pictorial step through process which outlined how staff should wash their hands.
- During this inspection we were told by staff direct observations were carried by the regional supervisor who watched staff cleaning their hands to ensure the correct techniques were used. We saw evidence of two members of staff were observed washing their hands by the Regional Supervisor in December 2018. The observations were recorded, and no issues identified. We were told no further handwashing observations had been carried out since.
- Managers we spoke with told us the current infection, prevention and control (IPC) training included information regarding transmission of infection, handwashing techniques, mop and bucket colour coding, separation of clinical and non-clinical waste, sharps management, sharps injuries. The percentage training compliance at the time of the inspection was 100% or 21 staff.
- Staff we spoke with told us that they had been made aware of specific infection and hygiene risks associated with individual patients through the patient booking form, however, there was not a process for staff to follow if they received this information. The form was used to obtain patient details and information prior to transportation. There was no evidence SSG staff carried out and recorded a risk assessment for infectious patients including mitigation of the risks.
- During inspection several operational staff were observed in the Cramlington station; their uniforms appeared to be clean and did not display signs of wear and tear.
- One member of staff was observed not adhering to infection prevention procedures; they were not bare below the elbow. They were also wearing a watch and rubber wrist band.
- We saw evidence of single use mop heads around the station accompanied by colour coded cleaning sheet which told staff which type of cleaner to use and how to dispose of the mop head after use. The coding was red for toilets, sluice and wash basins, green for the station kitchen areas, blue for the reception areas, public areas, corridors, offices and general open areas and yellow for isolation and possible infectious cleans.
- During the inspection six brand new mop heads still in the packaging were seen to be hanging on the wall next to the mop handles. They obviously had not been previously used and were available to replace used mop heads used during cleaning.
- Managers and staff, we spoke with told us clinical waste was taken from the PTS vehicles at the end of a shift and placed in a large yellow clinical waste bin. A sub-contracted cleaning service picked up the contents of the large yellow clinical waste bin every five weeks.

Environment and equipment

- During inspection there was evidence the design and maintenance of the station environment kept people safe.
- The building was accessed via a locked door at the front of the building.
- Although there was a key press in the garage to store vehicle keys they were not routinely locked away to prevent theft. During inspection the vehicle keys were found in an unlocked drawer in the front office.
- Since the last inspection the service had commissioned an external Health and Safety consultancy company who carried out site visits, provided feedback and an action plan if required. At the time of this inspection there were no Health and Safety issues requiring action identified by the external Health and Safety consultancy company.
- The building had a roller shutter at the front of the building to allow internal access to vehicles. There was no evidence of the door having been serviced and therefore did not comply with the Lifting Operations Lifting Equipment Regulations 1998 () which are a set of regulations created under the Health and Safety at Work etc. Act 1974 which came into force in Great Britain on 5 December 1998 and replaced several other pieces of legislation which covered the use of lifting equipment.

Patient transport services (PTS)

- There was a crew room which appeared clean and tidy. It contained comfortable seating and a television. There was a notice board with information for staff to read.
- The service had 13 vehicles in total, five identified as off the road/out of service. At the time of inspection SSG had one rapid response vehicle for transplant transfers, two patient transport ambulances which doubled up as mental health vehicles depending on the risk, two emergency ambulance vehicles and eight secure mental health ambulances.
- During inspection two patient transport vehicles were inspected. One was an ambulance the other was a non-liveried vehicle used to transport patients with mental ill health.
- Both vehicles were on station awaiting deployment. Each had no visible damage and the tyre tread on all the tyres on each of the vehicles was within the legal limits.
- The non-liveried vehicle was plain white and clean, the ambulance was liveried with markings indicating it was an ambulance, however, there were no reflective strips. The ambulance appeared to be dirty on the exterior. Both vehicles did not weigh more than 3.5 tons and therefore were not classed as C1.
- Both vehicles lights were in working order. The ambulance blue lights, siren and audible warning instrument were in working order. The other vehicle inspected was not fitted with these.
- The ambulance was used for mental health transfers when the contracting service had identified the patient as a low risk patient and suitable for a conventional PTS ambulance transfer.
- The PTS ambulance displayed on the rear two signs indicating the vehicle was carrying medical gases. The non-liveried vehicle did not display signs indicating the vehicle was carrying medical gases.
- The medical gases were stored securely in the vehicles we inspected.
- The interiors and cab areas of each vehicle appeared visibly clean and tidy. The vehicles did not have a satellite navigation system and road maps. The vehicles did not utilise an electronic data terminal for the automatic allocation of calls.
- There were no feedback forms, complaints forms, patient report forms, or miscellaneous forms carried on the vehicles. There were no torches carried on the vehicles and staff had personal issue high visibility vests.
- The vehicle ramp was in working order and the side step met height regulations. The vehicle had privacy glass and blinds fitted. Both vehicles did not carry a glass hammer which would be used to break the vehicle windows to allow staff and patients to leave the vehicle in the event of a road traffic accident if the doors became inoperable.
- The non-liveried vehicle did not have privacy glass or blinds fitted and the side step appeared to be broken.
- The ambulance was fitted with an emergency button in the rear cabin area. The non-liveried vehicle was not fitted with an emergency button as it was an open cab/ saloon design.
- The PTS ambulance carried two powder fire extinguishers, one in the front and one in the rear. Both were within the next inspection date which was displayed on a sticker and both were correctly secured. The non-liveried vehicle carried a powder fire extinguisher which was correctly secured in the front of the vehicle which was within the next inspection date which was displayed on a sticker.
- The provider did not have a policy regarding the equipment to transport children which included the height and weight considerations.
- There was no paediatric transportation equipment on both vehicles.
- All the seats and mattresses in the ambulance were intact being free from rips and tears and they were made of an infection control wipeable material. All the seats in the non-liveried vehicle were intact being free from rips and tears, however, they were not made of an infection control wipeable material.
- There were no general waste bins or clinical waste bins on either vehicle.
- Clean linen was stored securely in overhead lockers on the ambulance. The moving and handling transfer board, tub of cleaning wipes and smart lock rip seat

clamps were not secured and could become a hazard to patients and staff in the event of a road traffic accident involving the ambulance or the ambulance having to stop rapidly.

- Both vehicles appeared to have enough stocks of linen, vomit bowls, urine bowls, gloves and basic first aid supplies.
- On the ambulance there was one item, a size zero oropharyngeal airway, with an expiry date of 4/19. All other consumables were in date and intact in their packaging.
- The ambulance carried a temperature monitor, blood sugar monitor, manual blood pressure cuff and pulse oximeter probe. There was evidence the service had the items serviced on a regular basis in line with Medicines and Healthcare products Regulatory Agency (MHRA) guidance. The blood sugar monitor was due a service 4/19.
- The non-liveried vehicle carried an automated external defibrillator which was in working order and within the next service check which was displayed on a sticker. The defibrillator pads were in date.
- The PTS ambulance carried an onboard wheelchair, carry chair and stretcher. These all appeared to be in working order and the next services were due March 2020.
- The first aid grab bag on both vehicles was made from an infection control friendly material. The only IPC equipment on the ambulance were gloves and detergent cleaning wipes. There was no IPC information displayed in either vehicle.
- The non-liveried vehicle carried full dress PPE, face masks, FFP3 masks, eye shields and latex free nitrile gloves
- There were no wall mounted hand gel dispensers in the vehicle. Staff told us they used belt carried alcohol dispensers. There was no hand moisturiser carried on the vehicle.
- The non-liveried vehicle did carry hand gel or hand moisturiser.
- All gas pipelines and outlets in the ambulance were within their service date next service which was due March 2020.
- The ambulance had a transfer board and turntable but no slide sheet. The non-liveried vehicle did not carry this type of equipment. There was no bariatric equipment available on either vehicle.
- Wheelchair patients were transported using a mobile rip seat, but this did not offer neck protection in the event of a crash. A rip seat was typically used in accident and emergency and PTS ambulances. The chair was bolted to the vehicle floor. The non-liveried vehicle did not transport wheelchair patients.
- The non-liveried vehicle was used for mental health patient transfers. There was a locked secure cell in the rear of the vehicle which prevented the patient accessing the front and possibly distracting the driver. The rear cell had a light, was well ventilated with an extractor and heater.
- The side door of the non-liveried vehicle did not stay locked whilst in transit, which was a safety feature. Staff told us patients would never be transported being seated next to the door.
- Any repair, servicing or replacement of vehicles was arranged through the Regional Manager.
- During the inspection we did not see any evidence the fire evacuation plan had been tested. The Regional Manager was the fire safety lead and there was evidence they had signed off other fire evacuation tests which included testing safety lighting and alarms.
- During inspection the fire alarm system data book was checked which showed the fire extinguishers were last tested in August 2018. There was evidence the regional manager had contacted SSG head office who organised the checks of the fire extinguishers to have them checked. The date when the battery replacement for the emergency lighting was due was missing from the fire alarm system data record book.
- During the inspection we saw evidence that all electrical equipment, where required, had been tested by an external company in accordance with portable appliance testing (PAT) and were in date at the time of the inspection.
- We saw evidence that the vehicle Ministry of Transport testing (MOT) and vehicle servicing scheduling for the PTS vehicles based at Cramlington was managed using an excel spreadsheet. The dates were each colour

coded which made the due date for a MOT or service easily recognisable. The spreadsheet was monitored by the Regional Manager and Regional Supervisor to ensure the PTS vehicles were booked in for service or MOT in time for a temporary replacement vehicle to be identified.

- During the inspection we saw evidence the PTS vehicles based at Cramlington had current MOTs and had been serviced.
- Managers told us that any minor vehicle repairs were carried out by a local MOT registered testing station garage. The provider had two additional vehicles that could be used if an operational vehicle was off the road.
- Managers told us if vehicles needed to be replaced this was done through the company headquarters.
- Staff we spoke with told us if any equipment was faulty or consumable items were out of date they would be taken off the PTS vehicle and placed in a bin labelled hazard in the garage. Staff would record what had been placed in the bin on the vehicle time sheet.
- Staff told us they could replace any item either faulty or out of date equipment from the ground floor stock room.
- During inspection we saw evidence of out of date consumable items in the hazard bin and items having been replaced on vehicle time sheets. The store room was inspected and found to be very well organised and stocked.
- Staff told us that any risk assessments in relation to a patient`s own equipment such as a wheel chair was done through and recorded on the transport booking process and form. This ensured staff arrived for the transport prepared for any difficulties this could present.

Assessing and responding to patient risk

- We saw evidence of a Patient Care Policy which outlined the actions a crew would take when dealing with deteriorating patients.
- During the previous inspection we found the policy did not contain how to access clinical advice in the event of a patient becoming ill while being transported. The registered manager told us this was because none of the patients transported had or would be suffering from a physical illness or disease.
- During this inspection the policy was still the same. However, the registered manager told us work was ongoing to have a clinical on-call out of hours and on duty facility during working hours covering duty 24 hours per day for staff where they could seek advice.
- Staff we spoke with explained that if a patient appeared to be deteriorating or was taken ill during transport they would use basic first aid in accordance with their training. If the patient was seriously deteriorating or obviously seriously ill, the PTS vehicle would stop, and staff would dial 999 requesting an emergency NHS ambulance.
- During inspection we saw evidence all PTS staff had completed training in prevention and management of violence and aggression and how to deal with disturbed or violent patients.
- Managers told us that some PTS was provided to secure mental hospitals and police stations. When staff arrived to transport a patient from such a facility the risk assessments would be done by the service requesting the PTS. Staff would review and confirm they were happy with the risk assessment.
- We were told if staff identified any issues not previously identified or the patient was totally uncooperative and non-complaint they would not do the transport.
- Managers explained that if the service requesting PTS considered the patient to be high risk which included being violent or an absconding risk the patient would be handcuffed on the advice of staff from the service requesting the patient transport.
- We were told SSG staff could carry out dynamic risk assessments and remove handcuffs if they felt it was safe to do so and this did not present a risk to the patient, staff or public. Conversely, if SSG staff felt the risk to the patient, staff or public was high a previously unhandcuffed patient would be handcuffed.
- There was no evidence at the previous inspection of a risk assessment being recorded by SSG staff in relation to patient journeys including whether to handcuff a patient or not. During this inspection we saw evidence the risk and rationale as to why handcuffs were used was recorded on the handcuffing record form.

Patient transport services (PTS)

- Managers we spoke with told us dynamic risk assessments carried out by staff in relation to whether to handcuff a patient or not were not recorded.
- Managers told us that between April 2018 and March 2019 70 patients had been handcuffed by SSG staff. This was 1.7% of the total number of patients transported.
- At the last inspection managers told us staff recorded the use of handcuffs on the handcuff record form but did not record the risk assessment that led them to the decision to handcuff a patient.
- During this inspection 10 handcuffing forms were reviewed. All were fully completed and had a description as to why handcuffs had been used including a record of the risk assessment leading to that decision.
- The Regional Manager told us they reviewed all handcuffing forms to ensure the action taken was appropriate. If any injuries had occurred because of using handcuffs this was subject to an investigation to establish why this had occurred.
- However, the Regional Manager told us they did not record that the forms had been reviewed and what, if any action had resulted if it was considered the decision to handcuff the patient had been incorrect.
- There was evidence the only formal auditing of handcuffing forms was done for a hospital commissioning group contracting the service who had requested it as one of the key performance indicators, which was to record how many patients in their cohort had been handcuffed and why.
- This information was shared with the commissioning service monthly, however, there was no evidence the findings of the audits were shared with SSG staff.

Staffing

- The company had five full time employees based at Cramlington; a Regional Manager, Regional Supervisor, and three Emergency Care Assistants who worked on a 45 hour per week contract. The staff were supported by the Registered Manager based at the SSG corporate office in Essex who had responsibility for the Cramlington site and the two other SSG sites. The provider had a pool of bank staff they could contact to work on an 'as required' basis.
- At the time of the inspection the bank staff consisted of 15 Emergency Care Assistants. The bank staff worked on a self -employed basis with SSG. There was no set staff establishment or skill mix for the bank staff.
- At the time of the inspection there were no paramedics used as bank staff.
- Managers we spoke with told us none of the full time employed staff had any episodes of sickness in the past 12 months, but it was impossible to track the sickness of the bank staff because they simply declined the option to work when offered it if they were unwell.
- The provider did not have an alignment or a rota or shift pattern to meet demand as bookings for patient transport normally came with a minimum of 24-hours' notice, due to the acute nature of the patient presentations and staff were contacted to work accordingly. The provider offered a one-hour response for local requests for patient transports if the call was unplanned.
- A shift rota was in place to cover any 24-hour demand once the patient transport bookings were confirmed
- The shift rota of the employed staff was six am to three pm, nine am to six pm and three pm to twelve pm covering Monday to Friday. If the employed staff were not used on patient transports, they worked at the providers base carrying out administration duties.
- The shift rota for the bank staff was six am to two pm, two pm to ten pm and ten pm to six am covering Monday to Sunday. Bank staff who wanted to work were added to the rota and made aware of the requirement to work 24 hours prior to the start of the shift. If there were no requests for patient transports, then bank staff would be told they were not required.
- The shifts were covered 365 days of the year. Each shift had a minimum of two staff which were either, two employed staff, two bank staff or a mixture of each dependent upon staff availability and demand.
- Staff working outside of office hours were supported by the Regional Manager who was on call to provide advice and guidance if required.
- Managers we spoke with told us they used employed staff to cover most of the shifts before using bank staff.

Patient transport services (PTS)

- During inspection the Registered Manager told us the service was undergoing a consultation with employed and bank staff about an employment model where 60% of the staff would be employed by the company. The new model was due to be launched on 1st June 2019.

Records

- Managers and operational staff told us PTS crews were made aware of special notes and do not attempt cardiopulmonary resuscitation (DNACPR) orders through the transport booking system. The information was obtained from the provider requesting the PTS and was included on the patient booking form.
- At the last inspection managers told us there was no policy or procedure in place relating to the transportation of patient records and patient medication during the transportation of a patient. During this inspection we saw evidence of a provider policy for staff to follow in relation to this, however, the policy did not include the transportation of patient's personal property
- We saw evidence all records relating to vehicles including servicing, MOT and deep cleans were kept on station on a computer-based spreadsheet. The vehicles we inspected were within the servicing schedules, had a current MOT and had recently been deep cleaned.
- During observations of staff carried out on inspection there was no evidence additional patient information was recorded in addition to that which was on the patient booking form. There were no records completed by SSG staff detailing risk assessments, infection control status, care plans, medication, property being transported and if the patient had been sectioned.
- Any risk assessments in relation to handcuffing patients on the patient records had been made by provider requesting the service not SSG staff.
- We saw evidence patient booking forms were stored securely on station after each shift.

Medicines

- Managers told us there were no medicines carried on the vehicles or stored in the station. Oxygen was carried and there was evidence it was stored securely on the vehicles we inspected.
- We saw evidence that medical gases were stored in accordance with the British Compressed Gases Association Code of Practice 44: the storage of gas cylinders in the ground floor garage. However, there was paper stored in boxes next to the cylinder cages which could have presented a risk in the event of a fire. When this was pointed out the boxes were removed.
- Managers told us because the use of medical gases was so infrequent any replacements were obtained through the company headquarters which had a central storage facility. There was not a formal system in place to record the stock control of medical gases.
- During the previous inspection the Regional Manager told us medicines prescribed to patients did travel with them, however, there was no provider policy for staff to follow in relation to this.
- During this inspection we saw there was a policy in relation to this. We saw evidence of the use of zip locking plastic bags to carry personal medicines and the patient booking form.

Response to major incidents

- Managers told us none of the SSG staff had been trained in respect of major incidents.
- Managers told us SSG were not included in any NHS hospital trusts` major incident plans.
- The provider had a business continuity plan that provided a strategic framework for SSG UK Specialist Ambulance service (SSG UKSAS) business continuity arrangements and described the SSG UKSAS business continuity management program that would ensure SSG UKSAS met its legal obligations to ensure the organisations prioritised activities and services were protected against potential disruption because of incidents and emergency situations or climate change adaption.
- At the last inspection there was no evidence of a separate site-specific localised business continuity plan for the Cramlington base. During this inspection the Registered Manager told us there was still no separate business continuity plan and the service would rely upon the strategic framework for SSG UK Specialist Ambulance service (SSG UKSAS) business continuity arrangements.

Patient transport services (PTS)

Are patient transport services effective?

Requires improvement

We rated effective as **requires improvement.**

We rated effective as requires improvement because;

- There was a lack of audit activity and some of the improvement actions resulting from the previous inspection had not been completed.
- The provider did not have a system to record or measure the levels of staff adherence to local policies and procedures.
- There was no separate patient record form where staff could record their risk assessments or record any issues which occurred during the patient transport which could be reviewed and audited to improve the service.
- There were very limited supervisory operational observations of staff carried out to identify the levels of competence of staff or good or poor practice.

However, we found the followings areas of good practice;

- There was evidence the service had met the contracted levels of service within the agreed response times.
- There was evidence during the inspection the five employed staff had a current staff appraisal.
- Staff we spoke with were able to explain the implications of the Mental Capacity Act and Deprivation of Liberty safeguards in relation to patient consent and to record any issues in relation to this on the transport booking form.

Evidence-based care and treatment

- During the inspection we saw evidence that the provider had 58 policies and 25 procedures. Eleven policies were reviewed and there was evidence they were all based on National Institute of Care and Excellence (NICE) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.
- During the last inspection there was no evidence the provider recorded or had the ability to measure the levels of staff adherence to local policies and procedures. During this inspection there was still no system in place to do this.
- Managers told us that the eligibility of a patient for PTS was assessed by the requesting service. If on attendance to transport the patient they were found to be uncooperative, non-complaint or violent staff could decline to transport the patient.

Assessment and planning of care

- Managers told us staff were made aware of patient's condition including any mental ill health issues through the PTS booking form. This information was used to plan the transport.
- During the inspection we saw evidence on completed booking forms that showed the condition of the patient had been included, however, there was no evidence of staff having a separate SSG patient record form where they could record their risk assessments or record any issues which occurred during the patient transport which could be reviewed and audited to improve the service.

Response times / Patient outcomes

- Managers told us they had started collecting data in relation to the number of patients transported and the response times from December 2017. The provider collected data monthly and shared this with contracting CCG`s and NHS trusts.
- The data was spilt between one-hour response times, one-and-a-half-hour response times, two-hour response times, number of transfers stood down or cancelled and the number of reported complaints recorded. The response times were agreed with the contracting CCG`s and NHS trusts taking account of their location and the distances from the Cramlington base.
- The data for April 2018 to March 2019 showed the total number of patients transported to be 4,014 of which 80 were children aged under 18 years.
- The one-hour response times for the first three months of 2019, covering 1077 patients were; January 82%, February 93% and March 94%

- The one-and-a-half-hour response times were; January 99%, February 100% and March 100%.
- The two-hour response times were; January 80%, February 80% and March 100%
- The number of transfers stood down or cancelled were; January 3%, February 2% and March 1%
- Managers we spoke with told us that the provider did not compare the services provided with similar providers. There was no evidence of any corporate and wider benchmarking.
- Managers told us that currently they had met the contracted levels of service within the agreed response times. There was evidence to confirm this.

Competent staff

- During the last inspection managers told us they had not done any staff appraisals since the company commenced providing PTS in July 2017. During this inspection we saw evidence the five employed staff had a current appraisal.
- The Registered Manager told us sub-contracted bank staff did not have an appraisal. We were told work was ongoing to develop a contract review document for bank staff which identified key areas of work including shifts attended, punctuality, complaints, compliments and levels of statutory and mandatory training. These areas would be reported on and discussed with staff annually.
- The process for monitoring staff performance was outlined in the clinical supervision and personal development review policies which included clinical supervision `ride outs` which had commenced in December 2017. The purpose of these was to observe and evaluate the performance of staff in an operational setting and provide supervisory feedback for staff and to identify areas of development.
- During the last inspection we saw evidence of two clinical supervision `ride outs` having been completed by the Regional Supervisor. During this inspection there was evidence two ride outs had been carried out in March 2018. No issues had been identified. The Regional Supervisor told us they had not carried out any others since then.
- Managers we spoke with told us all newly recruited staff would attend a one-day induction course. The subjects on the course were health and safety responsibilities: fire training, infection prevention and control including sharps, SSG UKSAS organisational structure, organisation environmental and quality objectives, confidentiality and information governance, manual handling, anti-bribery and corruption policy, alcohol and drugs policy, safeguarding vulnerable persons – children and adults, equality and diversity, incident reporting, resuscitation, medicines management policies and issuing of a copy of the medicines management policy to staff.
- Staff had received training in the Mental Health Act.
- During the last inspection we saw evidence all emergency care assistants (ECAs) held either a Level two First Person on Scene or Level three First Response Emergency Care qualification. During this inspection we saw evidence all emergency care assistants (ECAs) were all first response emergency care level three trained.
- During this inspection we saw evidence all staff held a level two prevention and management of violence and aggression qualification. This training was delivered by an external accredited training company.
- Managers told us qualifications and the need to complete a refresher course was monitored and the identification of courses were based upon staff grade.
- We saw evidence of a provider human resources system that flagged when a member of staffs` qualifications were due for renewal. The staff member concerned would be informed by e mail if they needed to attend a training course at the providers base or do an on- line refresher courses.
- We saw evidence that this process had been carried out in accordance with the provider verification of professional registration policy.
- There was evidence all staff were required to hold a full valid driving licence for the category of vehicle which they were required to drive. The minimum requirement was for staff to be 21 years old and have held a full licence for a minimum of 2 years. In addition, they must have no more than 3 penalty points on their licence and no disqualifications on their DVLA record.

- The provider had a policy regarding driving endorsements, thresholds and disclosure of penalty points. All points had to be disclosed and the provider only allowed a maximum of three penalty points on a licence before withdrawing driving privileges.
- The recruitment team based at SSG corporate headquarters took and certified a copy of the individual's original driving licence when they applied to work with SSG. An initial check was made on the driving licence using an automated system provided by the Driver and Vehicle Licensing Agency (DVLA), and periodic rechecks conducted every six months to ensure no endorsements had been added. In addition, managers could request additional manual checks at their discretion.
- The same processes were used for checking the driving licences of bank staff.
- We did see evidence of current staff driving licence details recorded on a spreadsheet.
- We saw evidence that training, particularly for those working remotely, had been made available by the provider supplying computer tablets for PTS vehicles so staff could complete on-line training courses while on their down time. Managers told us staff would be given time to attend classroom training sessions if required to maintain their professional qualifications.
- Staff we spoke we told us they did get time to do their training.

Multi-disciplinary working

- Due to the type patient SSG transported the service was not involved in multi-disciplinary work assessing, planning and delivering patient treatment. They were a patient transport only.
- Managers and operational staff told us that patient care was planned following receipt of the information contained in the patient booking form. The care and comfort of the patient was considered when planning transports. We saw evidence of this on the patient booking forms from previous transports.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During the inspection we saw evidence employed and bank staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards through the statutory and mandatory training programme. Since last inspection there was evidence the service Deprivation of Liberty Safeguards and MCA provider lead had attended training courses to speak to staff.
- The Registered Manager was the company dementia champion for the Alzheimer society and was qualified to run courses for staff to become dementia friends and to train them to have the ability to use different communications techniques with patients who had cognitive communication difficulties. At the time of the inspection we saw evidence course dates had been identified for staff, so this training could be delivered.
- Staff we spoke with were able to explain the implications of the Mental Capacity Act and Deprivation of Liberty Standards in relation to patient consent and to record any issues in relation to this on the transport booking form.

Are patient transport services caring?

Good

Our rating of caring was **good.**

We rated caring as good because;

- Staff were observed during inspection displaying a caring, empathetic and supportive attitude toward the patients they were transporting.
- The staff were observed introducing themselves to the patient and explaining why they were there.
- Staff were observed working well with hospital staff to calm a patient who had been sectioned and was refusing to be transported. They succeeded in getting the patient to cooperate.

Compassionate care

- Due to the spontaneous nature of the providers regulated activities there were limited opportunities to observe any direct patient care during our inspection.
- Although we only observed one example direct patient care staff we spoke with told us they would ensure

dignity in public places and for those in vulnerable circumstances by using blankets to cover patients. Any activity inside the ambulance such as moving a patient was done with the doors closed.

- Staff were observed during inspection displaying a caring, empathetic and supportive attitude toward the patient they were transporting.
- The staff were observed introducing themselves to the patient and explaining why they were there.
- Staff we spoke with described how they would take steps to try and minimise distress in patients and families. This included speaking to patients in a reassuring, polite, and friendly way, and explaining what was happening.
- All the staff we spoke with during the inspection showed a commitment to providing the best possible care.
- Staff told us they took the necessary time to engage with patients which included introducing themselves, explaining why they had arrived and where the patients was being transported to.
- Staff told us they tried to put patients at ease by discussing their interests and communicated in a respectful and caring way.

Emotional support

- Due to the nature of the providers regulated activities we were unable to observe or evidence any direct emotional support for patients, relatives or carers.
- Staff we spoke with understood the impact that they could have on patients' wellbeing and acted to emotionally support their patients during transfers by talking to patients in a calm and polite manner.
- Staff we spoke with told us they checked on patients, in terms discomfort, and emotional wellbeing during all patient transport journeys.

Understanding and involvement of patients and those close to them

- Staff were observed working well with hospital staff to calm a patient who had been sectioned and was refusing to be transported. They succeeded in getting the patient to cooperate.

Are patient transport services responsive to people's needs?

Requires improvement

Our rating of responsive was **requires improvement.**

We rated responsive as requires improvement because;

- Following the previous inspection, the provider had been given some actions to improve the service during this inspection some of the actions had not been completed.
- There were no communication aids for staff to use with patients when English was not their first language in the vehicles we inspected.
- The PTS vehicles we inspected did not carry any information or leaflets which would explain to a patient, relative or carer how to make a complaint.

However, we found the following areas of good practice;

- There were agreed response times dependent upon the travelling distance from the Cramlington base to the CCG`s and NHS trusts areas of responsibility and were included in the providers contracts.
- Patient welfare was a consideration in planning long journey`s.
- Patient transport journeys were planned to take account of patient risk.
- There was a shift system to manage access and flow
- The service had devised their own key performance indicators collecting data in relation to the number of patients transported and the response times to improve the service provided.

Service delivery to meet the needs of local people

- The provider told us management of bookings were short term because requests for patient transport normally came with 24-hours' notice due to the acute nature of some of the patient presentations.
- Managers we spoke with told us the ability to meet demand had been planned to depend on geography and the effect this had on journey times. We saw

evidence of agreed different response times dependent upon the travelling distance from the Cramlington base to the CCG`s and NHS trusts areas of responsibility. The agreed response times were included in the contracts.

Meeting people's individual needs

- Managers told us staff, through the statutory and mandatory training, were trained to deal with patients with complex needs including those with learning disability, dementia, older people with complex needs and patients where English was not their first language and access to translation was required.
- During the inspection we saw evidence of this in the course content and the availability of language line, however, in both the vehicles we inspected there were no communication aids for staff to use with patients.
- Operational staff we spoke with we were able to outline how they would deal with patients with complex needs including those with learning disability, dementia, older people with complex needs and those patients where English was not their first language.
- Managers we spoke with explained if a patient was considered high risk or was under escort by staff from the service requesting the patient transport and the journey was considered to be long they would contact identified Police stations in advance on the route requesting to use their welfare facilities. This meant the patient would be in a secure environment reducing the possibility of them absconding or harming themselves or others while allowing their welfare needs to be dealt with.
- Managers we spoke with told us that if a patient was considered medium or low risk and the patient transport journey was considered to be long they would identify welfare stops in public places in advance. They told us the stops would be planned to be at small garages with welfare facilities as opposed to large busy service stations. The reason for this was to reduce the risk of being around a lot of people in a busy place that could upset the patient and the smaller facility would be a more controlled environment which would reduce the risk of the patient absconding.

Access and flow

- Managers we spoke to told us because of the contractual arrangements with the clinical commissioners the provider did not have the ability to manage the access and flow of bookings for PTS.
- The provider`s contingency to manage bookings was to have a shift system in place with a minimum of two PTS employed staff on duty at any time covering 24 hours per day 365 days of the year. Staff we spoke with told us if the request for PTS was not spontaneous they would obtain additional resources, if required, from their bank staff.

Learning from complaints and concerns

- The provider had received one complaint from a commissioner in the last 12 months but none from any patients or family members, therefore no benchmarking could be carried out.
- The provider`s complaints policy was reviewed and was in date. It included an introduction, receiving complaints, recording complaints, options for resolution, informal resolutions, formal resolutions, disciplinary implications of complains, unjustified complaints, unresolved complaints, serious incidents, compliments and positive feedback, support and implications for bank or self- employed staff.
- Following the last inspection, the provider was given a should do action to ensure information and guidance about how to complain was available and accessible to everyone who used the service in appropriate languages and formats to meet the needs of the people using the service.
- During this inspection there was no evidence the PTS vehicles we inspected carried any information or leaflets which would explain to a patient, relative or carer how to make a complaint.

Are patient transport services well-led?

Requires improvement

We rated well- led as **requires improvement.**

We rated well-led as requires improvement because;

Patient transport services (PTS)

- Following the previous inspection, the provider had been given some actions to improve the service during this inspection some of the actions had not been completed.
- There was not an effective system to actively seek feedback from patients, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.
- There was limited evidence the provider carried out audits to measure the quality and effectiveness of the service delivered
- There were limited cleanliness and infection control audits
- The number of hand washing observations were so low, and the amount of other audit information collected was so small it was not a representative sample of the number of staff employed or patient transports completed.
- There was no inclusion or exclusion policy in relation to the type or acuity of the patients the provider would transport.
- There was no site-specific risk register.

However, we found the following areas of good practice;

- The service had a mission statement, values and strategic priorities for 2019.
- Staff we spoke with told us they felt respected and valued by their immediate manager and there was good team working. They told us managers were open and honest.
- There was evidence of recent 1:1 staff employment consultation in relation to increasing the number employed staff in the company.
- There was evidence of staff forums having taken place and what had been discussed recorded. There was no set agenda as the meeting was driven by staff issues raised in advance.

Leadership of service

- The company had five full time employees based at Cramlington; a Regional Manager, Regional Supervisor, and three Emergency Care Assistants who worked on a 45 hour per week contract. The staff were supported by a Registered Manager based in the SSG corporate office in Essex. They had responsibility for the Cramlington site and the two other SSG sites.
- The Regional Manager had overall responsibility for the Cramlington site. The Regional Manager did not have a role specific job description.
- The Regional Manager told us they negotiated contracts with CCG`s, managed and planned resources, interviewed new recruits, provided site managerial oversight, ensured equipment and stock was available, worked as a driver on PTS vehicles if enough staff were not available and provided out of hours on call contact for providers and staff.
- The Regional Supervisor supported the Regional Manager. There was no evidence of a role specific job description for the Regional Supervisor. The Regional Supervisor told us they carried out tasks allocated to them by the Regional Manager.
- The Registered Manager told us he visited the Cramlington site once a month to chair the staff forum meetings and catch up with the Regional Manager and Regional Supervisor. There was evidence in the staff forum meeting minutes the Registered Manager had attend and chaired meetings each month.
- The Registered Manager also had responsibility nationally for governance.

Vision and strategy for this service

- During the last inspection the Registered Manager told us the mission statement and values had been adopted by SSG from the previous company UK SAS and they would be reviewed by the end of April 2018 by the headquarters management team. During this inspection there was evidence of a new provider mission statement and supporting values.
- The provider`s mission statement was, quote; “We aspire to be a people focussed service that strives for excellence and innovation”.
- The provider`s mission statement was supported by three values which were; quality, care and growth.
- The mission statement and values were displayed in the front entrance lobby but nowhere else in the station at Cramlington.

Patient transport services (PTS)

- The mission statement and values were evident as the bottom of SSG staff work e mails.
- We saw evidence of the strategic priorities for 2019 which were called Project North Star. The aim was to improve quality, reduce complexity and ensure excellence in the way the service did business.
- There were six identified business priorities which were; meet CQC compliance, implement new structure and lines of accountability, build an engaged workforce to meet contractual commitments, implement new SSG systems, measure performance – understand what good looks like and target earnings before interest, taxes, depreciation, and amortisation (EBITDA) return, amortisation described gross profits before certain business costs were considered.
- Each priority had an objective, action points, milestones and status, a deadline for completion and a link to a key performance indicator.
- At the time of the inspection the actions were ongoing.

Culture within the service

- Staff we spoke with told us they felt respected and valued by their immediate manager and there was good team working. They told us managers were open and honest.
- Operational staff we spoke with could identify the local leaders and what their roles were. Local leaders were visible because often they were operational.
- During inspection evidence was obtained through interview that the leaders had the skills, knowledge, experience and integrity to perform the role.
- Staff we spoke to told us leaders were visible and approachable.
- Employed staff we spoke to told us they were consulted and the informed of any organisational change.
- There was evidence of recent 1:1 staff employment consultation in relation to increasing the number employed staff in the company.
- During inspection we saw evidence of leaders encouraging appreciative, supportive relationships with staff.

Governance

- Managers we spoke we told us what the corporate governance structures were; the executive leadership who were responsible for three areas of business; the risk management clinical committee, finance procurement committee and strategic direction committee.
- The medicines guidelines working group reported to the risk management clinical committee. There was an operational committee sitting above departmental working groups included, PTS, accident and emergency and secure teams (organ transplant).
- Each department held governance meetings.
- The local governance structures at Cramlington were; the Regional Manager was in overall charge supported by the Regional Supervisor. The Regional Manager reported to the Registered Manager.
- Local managers we spoke with told us they held monthly governance meetings held at the Cramlington site and there was a staff forum meeting held each month. Any issues from the staff forums were fed into the governance meetings.
- During the inspection we did see evidence of the forums having taken place and what had been discussed recorded. There was no set agenda as the meeting was driven by staff issues.
- Staff we spoke with told us they were kept routinely informed of what had been discussed at SSG headquarters governance meetings.
- Following the last inspection, the provider was given a should action to address the gaps in audit activity to measure the quality and effectiveness of the service delivered such as cleanliness and infection control in relation to hand washing and staff adherence to provider polices in respect of that.
- During this inspection we found limited evidence the provider carried out audits to measure the quality and effectiveness of the service delivered including cleanliness and infection control because the number of hand washing observations observed and recorded were so low they were not a representative sample of the number of staff employed.

- The service did carry out appraisals for employed staff and had developed robust mandatory training updates and monitoring demonstrated by the high levels of mandatory training compliance of both employed and bank staff.
- The service had a recruitment procedure. The director of governance told us as part of the staff recruitment process appropriate background checks were carried out before appointment. This included a full Disclosure and Barring Service (DBS) check, proof of identification, checks of references driving licence checks and checks on the right to work in UK.
- We reviewed seven staff files and found evidence the appropriate recruitment checks had been undertaken and were recorded.
- There was no evidence of an inclusion or exclusion policy in relation to the type or acuity of the patients the provider would transport.
- The provider did not have a policy in relation to the transportation of children which included consideration of height and weight.

Management of risk, issues and performance

- The provider had an extensive risk register that had 32 identified risks which identified the possible consequence, risk score including a red, amber and green (RAG) status, mitigation, which manager had responsibility for managing the risk and what the risk review date was. The risk register was reviewed and managed through SSG headquarters management meetings and local governance meetings.
- Following the last inspection, the provider was given a should do action to have a site-specific risk register to enable identification of local issues. During this inspection we did not see evidence of a site-specific risk register. The local service risks were included on the risk register managed through SSG headquarters.
- Managers we spoke with told us that the CCG`s and NHS trusts had not provided SSG with any key performance indicators. The Regional Manager had told us that they had started collecting data in relation to the number of patients transported and the response times from December 2017. They now collected data monthly and was shared this with contracting CCG`s and NHS trusts.
- There was evidence of staff disclosure and barring service (DBS) checks in their personal files.
- There was no evidence the provider recorded the driving hours of staff.
- During the inspection we saw evidence that the monthly performance information was displayed on the crew room notice board, so staff could see the latest performance data.
- The performance data showed the provider was meeting the contractual agreements with the services contracting patient transport.

Public and staff engagement

- Managers and operational staff told us that staff engagement was maintained through the monthly staff forum meetings.
- During the inspection the minutes of the staff forum meetings for December 2018, January and February 2019 were reviewed. The minutes illustrated the meetings were driven by staff issues.
- An example of staff engagement was when staff raised an issue that their work mobiles did not support the closed social media app used to quickly get messages to staff. The Registered Manager secured funding and new mobiles had been bought and issued to staff to enable access to the app.
- During inspection we saw evidence of a book left in the front office where staff could record issues they wanted discussed at the staff forum meeting. All staff were kept informed of the outcome of the meetings if they could not attend through a message in a closed social media group.
- Managers we spoke with told us the service level agreements had been agreed with contracting CCG`s and NHS trusts through engagement and discussion when contracts were negotiated.
- Following the last inspection, the provider was given a should do action to actively seek feedback about the quality of care and overall service provided. The provider was advised the feedback could be informal or formal, written or verbal. It could be from people using the service, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.

Patient transport services (PTS)

- During this inspection we did not see evidence of an effective system to actively seek feedback from service users, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies. The registered manager told us they were aware of this, however, because of the type of patient they transported obtaining meaningful feedback in the main was virtually impossible.

Innovation, improvement and sustainability

- During the inspection we did not see any evidence of innovation.
- Managers we spoke with told us sustainability was difficult to guarantee because the provider was in a very competitive business with other similar providers.
- There was evidence the staff consultation and work in relation to the change in the provider employment model where 60% of the staff would be employed by SSG. This was evidence of business improvement because managers would have improved management and oversight of resources, their training and development.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must act to address the gaps in audit activity to measure the quality and effectiveness of the service delivered. This is in relation to Regulation 17: Good governance.
- The provider must actively seek feedback about the quality of care and overall service provided. This is in relation to Regulation 17: Good governance.
- The provider must record the dynamic risk assessment for patients which resulted in them being handcuffed. This is in relation to Regulation 17: Good governance.
- The provider must have a policy in relation to the transportation of children which includes consideration of height and weight. This is in relation to Regulation 17: Good governance.
- The provider must ensure information and guidance about how to complain is available and accessible to everyone who uses the service in appropriate languages and formats to meet the needs of the people using the service. This is in relation to Regulation 16: Receiving and acting on complaints.
- The provider must have paediatric transportation equipment on PTS vehicles. This is in relation to Regulation 15: Premises and equipment.

Action the hospital SHOULD take to improve

- The provider should have a system in place to ensure all completed incident forms are reviewed by a supervisor.
- The provider should have a system in place for identifying high risk/infectious patients.
- The provider should ensure vehicle keys are routinely locked away to prevent theft.
- The provider should ensure the non-liveried vehicle displays signage indicating the vehicle is carrying medical gases.
- The provider should ensure communication aids for patients whose first language is not English and leaflets explaining how to complain were available on their vehicles.
- The provider should ensure general waste bins and clinical waste bins were carried on their vehicles.
- The provider should ensure wheelchair patients who were transported using a mobile rear impact protection seat had neck protection in the event of a crash.
- The provider should regularly test the fire evacuation plan and record any resultant actions or remedial testing to ensure the plans effectiveness.
- The provider should have their own patient documentation in addition to the patient booking form detailing risk assessments, infection control status, care plans, medication, property being transported and section information.
- The provider should have a system to record and measure the levels of staff adherence to local policies and procedures.
- The provider should carryout frequent operational observations of staff to confirm their professional competency.
- The provider should have a site-specific risk register to enable identification of local issues.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). During inspection there was no evidence of effective audits to measure the quality and effectiveness of the service delivered such as cleanliness and infection control in relation to hand washing and staff adherence to provider polices in respect of that.

This section is primarily information for the provider

Requirement notices

The provider did not actively seek feedback about the quality of care and overall service provided from service users.

The provider did not record all the risk assessments carried out by SSG staff in relation to the decision to handcuff patients.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints (2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. During inspection there was no evidence the provider ensured information and guidance about how to complain was available and accessible to everyone who used the service in appropriate languages and formats to meet the needs of the people using the service.

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15(1)(f) appropriately located for the purpose for which they are being used. The provider did not have paediatric transportation equipment on both vehicles inspected.