SSG UK Specialist Ambulance Service Ltd

SSG UK Specialist Ambulance Service - North

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

SSG UK Specialist Ambulance Service North is operated by SSG UK Specialist Ambulance Service Ltd (SSG). The service provides a patient transport service (PTS) for patients with mental ill health. They also provide medical first aid support at public and private events.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11 April 2018.

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 transporting patients with mental ill health.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Managers and operational staff were aware of the application of duty of candour and could give examples where it should be used, as well the requirement to be open and honest.
- There was detailed infection prevention and control (IPC) policy and staff were aware of their responsibilities in relation to this.
- PTS drivers had a current Business and Technology Education Council (BTEC) Level three advanced driver qualification and their eligibility to drive vehicles was checked prior to employment and on an ongoing basis.
- The staff mandatory training compliance rate at the time of the inspection was 87.5 %
- The provider`s policies were based on National Institute of Care and Excellence (NICE) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.
- Staff could explain the implications of the Mental Capacity Act 2005 and Deprivation of Liberty Standards in relation to patient consent and to record any issues on the transport booking form.
- Staff could describe how they would take steps to try and minimise distress in patients and families.
- There was positive feedback from patients.
- Staff could outline how they would deal with patients with complex needs.
- Managers planned patient transport based on risk to ensure people's individual needs were met.
- Regular monthly staff forum meetings were held where staff could raise issues.
- The provider had a well-managed extensive risk register.

However, we also found the following issues that the service provider needs to improve:

- No staff appraisals had been completed since the company commenced providing PTS in July 2017, however, at the time of the inspection the provider was within the 12 month period for completing staff appraisals.
- The provider did not record any observation or audits of staff handwashing.
- The PTS ambulances did not carry any information regarding how a patient, carer or relative could make a complaint or provide feedback about the service.
- Dynamic risk assessments carried out by SSG staff in relation to handcuffing patients were not recorded.
- There was no site specific business continuity plan for the Cramlington building.
- The provider did not have a site specific risk register.

Summary of findings

Following this inspection we identified one regulatory breach and six areas where the provider should improve, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		Patient transport services were the main service provided. The provider mainly transported patients with ill mental health. The provider had several contracts with Clinical Commissioning Groups and NHS Trusts to provide this service. There were several areas for improvement identified during the inspection including eight actions the provider should take, even though a regulation had not been breached, to help the service improve.

SSG UK Specialist Ambulance Service - North

Detailed findings

Services we looked at
Patient transport services (PTS)

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, with the company moving to the current premises in Cramlington.

The company continued to build up the business obtaining contracts with a number of clinical commissioning groups (CCG`s). 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).

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 registered locations including this service and two other sites based in Essex and Hampshire.

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

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

The service also provided a patient repatriation service for insurance and air ambulance companies. This is not a regulated activity and was not inspected. There were two patient transport service (PTS) and two urgent and emergency care ambulances based at the Cramlington site.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in transporting patients with mental ill health. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Detailed findings

Facts and data about SSG UK Specialist Ambulance Service - North

We inspected SSG UK Specialist Ambulance Service North in Cramlington, Northumberland on 11 April 2018.

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 the following staff; the Registered Manager, Regional Manager, Regional Supervisor and two Emergency Care Assistants. We were unable to speak to any patients or relatives. The service has not previously been inspected.

- In the reporting period (1 December 2017 to March 2018) there were no emergency and urgent care patient journeys undertaken.
- In the reporting period (1 December 2017 and 28 February 2018) there were 648 patients transported ten of which were aged under 18. The provider only began recording the number patient transports in December 2017.

The company had five full time employees based at Cramlington; a Regional Manager, Regional Supervisor, and three Emergency Care Assistants who work on a 45 hour per week contract. The staff were supported by a Registered Manager and Director of Operations based in the SSG corporate office in Essex. They had responsibility for the Cramlington site and the two other SSG sites. The provider had a pool of additional bank staff sub-contracted to work for SSG on an 'as required' basis. At the time of the inspection the bank staff consisted of 15 Emergency Care Assistants and five Paramedics. They were all employed by another provider and worked on a self -employed basis with SSG There was no set staff establishment for the bank staff.

Track record on safety (July 2017 to March 2018)

- No Never events
- No clinical incidents reported which resulted in, no harm, low harm, moderate harm, severe harm, death or serious injuries
- No complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

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

We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Managers and operational staff we spoke with aware of the application of duty of candour and could give examples where it should be used, as well the requirement to be open and honest.
- PTS drivers had a current Business and Technology Education Council (BTEC) Level three advanced driver qualification.
- Staff driving licences and eligibility to drive vehicles were checked prior to employment and on an ongoing basis.
- Staff 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.
- There was a detailed infection prevention and control (IPC) policy.
- Staff were aware of their responsibilities related to infection prevention and control (IPC).
- The two PTS vehicles and equipment carried in them were exceptionally clean.

However, we found the following issues that the service provider needs to improve:

- One incident form was reviewed and information was missing in relation to the identity of the patient.

Patient transport services (PTS)

- An incident where a patient had become aggressive and injured themselves was not recorded, investigated and any possible learning shared with staff.
- Managers told us that they did not carry out any audit activity to ensure staff complied with key provider policies including, hand hygiene and personal protective equipment (PPE).
- The provider did not have a policy or procedure in relation to the transportation of drugs that had been prescribed to the patient or the patient notes
- Dynamic risk assessments carried out by SSG staff in relation to handcuffing patients were not recorded.

Are patient transport services safe?

Incidents

- The service had not reported any never events between July 2017 to March. 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 a formal system for reporting and responding to incidents. 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.
- Staff reported incidents by completing an incident form. 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 through a secure e-mail address to the company headquarters.
- The provider had reported one incident during the reporting period July 2017 to March 2018.
- The provider incident reporting form was reviewed. It contained a section for the person who was involved personal details, details of the incident, a summary of the incident with a note to which explained 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.
- During the inspection we reviewed one incident form there was information missing in relation to the identity

of the patient, however, because the provider had a system where patient information is recorded on vehicle timesheets the relevant information had been recorded there.

- During the inspection we spoke to staff who described an incident where a patient had become aggressive and injured themselves. We reviewed the incident report forms and found this incident had not been recorded on an incident form. However, we did find that it has been recorded on the vehicle timesheet and had been reviewed and debriefed by a supervisor with staff.
- This was raised with the Regional Manager who recorded the information on an incident form. There was evidence the Regional Manager had set up a system where all vehicle timesheets were reviewed to ensure issues that should be reported as incidents were recorded in the correct manner.
- Any incorrect recording is fed back to the individual member of staff. The correct use of incident reporting forms was discussed at staff forum meetings to ensure staff compliance.
- Managers told us that a revised incident reporting policy and procedure had recently been brought in and staff probably lacked understanding as to how the new system worked because incidents were infrequent, so staff still used the transport booking form to report incidents which had been the method used previously
- The provider had a duty of candour policy which provided guidance for staff on how to comply with duty of candour requirements and outlined the roles and responsibilities of staff from the Chief Executive to front line staff. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Managers and operational staff we spoke were aware of the application of duty of candour and could give examples where it should be used, as well the requirement to be open and honest.
- There were no incidents reported by the service that had resulted in moderate or above patient harm that would trigger the duty of candour process.

Mandatory training

- Management staff told us induction and mandatory training was provided by the service. The courses and method of delivery had been inherited from the previous company before SSG commenced business in July 2017.
- 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, Conflict Resolution, Mental Capacity Act, Whistleblowing and Duty of Candour, Anti-Bribery and Corruption, Drug and Alcohol Abuse, ISO (Quality and Environmental) Awareness.
- Managers told us these topics were delivered by an external training provider with regard to refresher training intervals and levels of qualification appropriate to role.
- Managers told us the compliance rate at the time of the inspection was 87.5 %. During inspection we saw evidence of this on a staff training spreadsheet.
- We were told that staff who had not completed the training were new recruits awaiting their initial induction package.
- During inspection we sampled 15 staff training records which showed all had completed statutory and mandatory training on 9 and 11 May 2017.
- The Registered Manager told us that SSG had signed up for new e-learning modules for mandatory and statutory training with an external training provider. This replaced most of the face-to-face teaching that was normally undertaken annually. Computer tablets had been placed in SSG PTS vehicles which would allow staff to complete the 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 course.
- During the inspection we saw evidence that the new course content provided by the external provider provided up to date course information and was appropriate for the roles performed by SSG staff.
- During the inspection we saw evidence of a statutory and mandatory training timetable over two days, however, the timetable was dated 2016.Managers explained that this was inherited from the previous

company before SSG commenced business in July 2017 and was under review to incorporate the timescales for completion of the training modules from an external training provider.
- The Registered Manager told us staff had been informed the new external training provider modules must be completed by 31 May 2018.
- We saw evidence that all PTS drivers had a current Business and Technology Education Council (BTEC) Level three advanced driver qualification. We saw records which showed that driver training had been monitored by the provider.
- Managers told us that all drivers had their driving licence and eligibility to drive vehicles checked prior to employment and on an ongoing basis. We saw evidence of these checks.
- Managers we spoke with told us staff driving licences were checked annually using an automated system provided by the Driver and Vehicle Licensing Agency (DVLA). In addition, managers could request additional manual checks at their discretion.
- There was no record of historic checks as the provider was no longer able to access data from before July 2017 when the current company was created, however, we did see evidence of current staff driving licence details recorded on a spreadsheet.
- We found 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 6 penalty points on a licence before withdrawing driving privileges.

Safeguarding

- 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.
- We saw evidence of an extensive list of safeguarding board contacts identified by local authority area available for staff which 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.
- A safeguarding flowchart was available on each vehicle, including the contact information for the appropriate local authority safeguarding children and vulnerable adult's team for staff to use.
- Managers we spoke with told us there had been no reported safeguarding incidents in the previous 12 months.
- 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 external training modules in relation to both safeguarding adults and children Level one and two.
- We saw evidence that the staff training completion rate for Children and Adult Safeguarding Level 1 and Level 2 was 94.74%.

Cleanliness, infection control and hygiene

- There was a detailed infection prevention and control (IPC) policy in place. The policy stated staff should follow guidance on hand hygiene, personal protective equipment, environmental cleaning, waste management and uniforms.
- Staff we spoke with were aware of their responsibilities related to IPC. Staff could describe the correct procedures for cleaning following the transport of a patient with an infection.
- We saw evidence of hazardous spillage equipment being available at the station. We observed segregation of clinical and non-clinical waste took place and processes were in place for the removal of clinical waste.
- We inspected the two PTS vehicles. Both the vehicles and equipment carried in them were visibly clean.
- Managers explained that crews were required to ensure their vehicles were fit for purpose, before, during and after they had transported a patient. All vehicles we viewed were clean, tidy with fixtures and fittings in good repair, and easy to clean. Decontamination cleaning wipes were available on all vehicles. The crew assigned to the vehicle each day completed the day-to-day cleaning of vehicles. We saw evidence the daily records for the vehicles cleaning regime had been completed.

Patient transport services (PTS)

- There was evidence that a deep cleaning checklist was recorded and used to show when and which areas of the vehicles were cleaned. There were stickers on the vehicle to indicate when the next deep cleaning was due. A deep clean involves cleaning a vehicle to reduce the presence of certain bacteria.
- We saw evidence that the vehicles and equipment had been cleaned in accordance with the cleaning schedule and this was recorded and up to date at the time of the inspection.
- Both the vehicles carried personal protective equipment and a secure clinical waste bin.
- Managers and staff, we spoke with told us they maintained the cleanliness of the PTS vehicles during a shift by use of spill kits. Staff told us they had access to cleaning equipment in the station at Cramlington to replace items such as vomit bowels and urine receptacles.
- 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.
- Managers we spoke with told us they had recently bought equipment to swab surfaces on the PTS vehicles and equipment which would indicate if the cleaning carried out had been successful.
- Cleaning had been carried out by staff that were sub-contracted by SSG to perform that role. Cleaning had been monitored through the cleaning schedule and check lists which were reviewed by the Regional Manager. There was evidence of regular audit activity in relation to this.
- Managers 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.
- Data provided by the provider showed that 87.5% of staff had completed infection prevention and control training. Managers told us the staff that had not yet completed the training were new recruits awaiting their initial induction package.
- Managers told us that hand washing was included as a topic in the staff induction training which 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. However, managers told us that they did not do any staff hand washing observations after the induction course.
- There was evidence of a system to monitor cleanliness. The service carried out infection control audits to ensure that cleaning was effective, any contaminates were removed and appropriate action taken to reduce the risk of cross infection. Managers told us following the deep clean the vehicles were swabbed and the swabs tested to ascertain the level of cleanliness. We saw evidence that the swab results for the five deep cleans showed the vehicles were clean and did not carry an infection risk.
- We saw evidence that the PTS vehicles had been subject to a deep clean every six weeks since July 2017.
- We were informed that the service did not complete hand hygiene audits. This meant the service could not be assured that staff were compliant with infection control practices.
- 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. The form is used to obtain patient details and information prior to transportation.
- 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. We observed staff complying with hand hygiene requirements.

Environment and equipment

- We saw the design and maintenance of the station provided a safe environment for staff and patients.
- We saw 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.
- We saw medical gases were stored appropriately in accordance with the British Compressed Gases Association Code of Practice 44: the storage of gas cylinders in the ground floor garage.
- Managers told us medical gases were used infrequently and any replacements were obtained through the company headquarters which had a central storage facility.
- We saw evidence of a fire evacuation plan which had been regularly tested the dates of the testing were

recorded in a fire safety testing book kept in the station front office. The Regional Manager was the fire safety lead and there was evidence he had signed off the fire evacuation tests which included testing safety lighting, alarms and that fire extinguishers had been checked were working.

- All the electrical equipment we saw had electrical safety testing completed by an external company in accordance and these were in date at the time of the inspection.
- The vehicle Ministry of Transport testing (MOT) and vehicle servicing scheduling for the PTS vehicles based at Cramlington was managed using a spreadsheet. The dates were each were 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 a current MOT and had been serviced.
- We saw evidence that the vehicle keys when not in use were in a locked key cupboard. The Regional Manager and Regional Supervisor held the key to the key cupboard.
- Managers told us that any minor vehicle repairs were carried out by a local MOT registered testing station garage.
- 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.
- 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 out of date consumable items were placed in the hazard bin and items replaced were recorded on vehicle time sheets. The store room was inspected and found to be very well organised and stocked.
- During the inspection two PTS vehicles were inspected both carried relevant equipment available for both adults and children including a child restraint seat.
- Both the vehicles were used for the transport of patients detained under the Mental Health Act 1983 and we found they were appropriate and safe for such use.
- Staff told us that any risk assessments in relation to a patient`s own equipment such as a wheelchair, was done through the transport booking process being recorded on the booking form. This ensured staff arrived for the transport prepared for any difficulties this could present.
- Both PTS ambulances carried defibrillators, pulse oximeters, blood pressure cuffs, thermometers and blood sugar monitors. The blood sugar monitors were used during events only and not during PTS transfers. All the electrical equipment had been electrical safety tested and was in date.

Medicines

- Managers and operational staff told us no medicines were carried on the two PTS vehicles. Oxygen was carried and there was evidence it was stored securely on each vehicle.
- Managers told us that medicines that had been prescribed to patients did travel with the patient. However, the provider did not have any policy for staff to follow in relation to handling patient's own medicines.
- Managers and staff told us they did not administer patient medicines. Any patients that required medication while being transported would be accompanied by a healthcare professional from the provider that had request the transport.
- The provider did not have a policy or procedure in relation to the transportation of drugs that had been prescribed to a patient. Managers told us that if the patient was under escort the staff providing the escort would be responsible for the patient's drugs. If the patient had capacity they were carry their own drugs. If the patient was not escorted and did lack capacity the

patients drugs would be recorded on the vehicle timesheet and physically held by a member of SSG staff who recorded who they were handed to at the receiving facility.

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.
- Managers told us that records relating to patients from the provider requesting the PTS did travel with the patient. However, there was no provider or policy for staff to follow in relation to this.
- Due to the spontaneous booking of PTS during inspection we were unable to observe any patient handovers.
- Managers told us the patient transport booking form had recently been reviewed and revised following several occasions when staff arrived to transport a patient and found they had an infectious disease or were violent and this had previously not been disclosed. This information was now obtained during the booking process. This gap in information was fed back to the Clinical Commissioning Groups (CCGs) and NHS trusts that the provider had contracts with.
- We looked at a booking form and it covered all aspects required to ensure PTS crews were aware of special notes, do not attempt cardiopulmonary resuscitation (DNACPR) orders and any other conditions which they needed to be aware of such as allergies.
- Staff we spoke with could explain the need for the DNACPR order to be signed by a doctor and the original document must travel with the patient.
- During inspection we reviewed 19 patient booking forms all were completed fully.
- During inspection we saw evidence that the transport timesheets which contained patient information were handed to the Regional Manager by the PTS crews at the end of their shift. If the shift ended outside office hours the transport timesheets would be left in a locked post box on the wall in the garage. Staff we spoke with confirmed this. The Regional Manager who held the key to the post box would retrieve the documents next morning or if following a weekend on Monday morning.
- The Regional Manager reviewed each timesheet before transferring the information on to a spreadsheet which was shared with CCG`s each month for recharge purposes and to evidence KPI compliance.
- We saw evidence the paper transport timesheets were stored in a locked filing cabinet inside a locked office. The Regional Manager told us the transport timesheets would be retained for six years before destruction.
- The provider did not have a policy in relation to the transportation of patient notes.

Assessing and responding to patient risk

- There was a Patient Care Policy which outlined the actions a crew would take when dealing with deteriorating patients.
- Due to the nature and type of patients transported the policy did not contain how to access clinical 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 ill then the staff would dial 999 requesting an emergency NHS ambulance. This was in accordance with the providers policy.
- We saw evidence that all PTS staff had completed training in prevention and management of violence and aggression and how to deal with non- compliant or violent patients.
- Managers told us that some PTS was provided to secure Mental Health Hospitals and Police stations. When staff arrived to transport a patient from such a facility the risk assessments would be completed by the service requesting the PTS.
- 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 their advice. The provider had a use of handcuff policy which included use of force. Copies of this policy were carried in each of the PTS ambulances for staff to refer to.
- There was no evidence of a risk assessment being recorded by SSG staff in relation to whether to handcuff a patient or not. Managers we spoke with told us the risk assessments were dynamic but not recorded.
- Managers told us from July 2017 to March 2018 41 patients had been handcuffed by SSG staff.

- During the inspection 19 staff use of handcuff forms were reviewed. Four of the forms did not have a description as to why handcuffs had been used.
- The Regional Manager told us they reviewed all handcuff forms to check the action taken was appropriate and if any injuries had occurred which needed further review. However, the Regional Manager told us they did not record that the form had been reviewed and what if any action had resulted.

Staffing

- The provider did not have an alignment of a rota or shift pattern to meet demand as bookings for transport normally came with a minimum of 24-hours' notice, due to the acute nature of the patient presentations. The provider offered a one hour response for local calls.
- The shift rota of the employed staff was 6am to 3pm, 9am to 6pm and 3pm to 12am covering Monday to Friday.
- The shift rota for the bank staff was 6am to 2pm, 2pm to 10pm and 10pm to 6am covering Monday to Sunday.
- The shifts were covered 365 days of the year. Each shift had a minimum of two staff which were two employed staff, two bank staff or a mixture of each dependent upon staff availability and demand.
- We saw evidence that 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 that they used employed staff to cover most of the shifts before using bank staff.
- Staff we spoke with told us one of the main barriers to recruitment was the level of pay and the requirement to work unsocial hours. Manager told us this was made clear to potential recruits when they applied to work for SSG. At the time of the inspection the executive management were undertaking a budget and activity review to establish if pay rises would be possible to encourage applicants.
- The Regional Manager told us that staffing establishment was based on current demand and there were no vacancies. If SSG acquired additional contracts then there would be a need to increase the staffing establishment.
- 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 and Director of Operations based in the SSG corporate office in Essex. They had responsibility for the Cramlington site and two other others. The provider had a pool of additional bank staff they contacted that could be sub-contracted to work for SSG on an 'as required' basis.
- At the time of the inspection the bank staff consisted of 15 Emergency Care Assistants and five Paramedics. The bank staff worked on a self -employed basis with SSG.
- Managers we spoke with told us none of the full time employed staff had any episodes of sickness in the past 12 months. Any periods of sickness by full time employed staff would be covered by bank staff.

Anticipated resource and capacity risks

- Due to the contractual arrangements and the spontaneous requests for PTS managers told us the impact upon safety was assessed as a capacity issue. If a request for transport was received and there were insufficient crews available the request would be declined.
- Managers we spoke with told us that due to the contractual arrangements and the spontaneous requests for PTS it was difficult to plan to meet predicted demand or plan for fluctuations in demand. The potential risks were mitigated by maintaining a shift system that provided cover 24 hours per day.
- Managers told us that the demand was constant and not subject to seasonal fluctuation.
- Managers we spoke with told us the risk of disruption to staffing levels was mitigated by having a pool of bank staff who could be called at short notice to work.

Response to 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.

- There was no site specific business continuity plan for the Cramlington base because the business continuity arrangements were covered in the provider corporate plan.
- The Regional Manager could explain what steps would be taken if the building at Cramlington could not be used for example after a fire where vehicles were lost.
- There was evidence the business continuity plan covered corporate business risks across all three SSG sites which included Cramlington.

Are patient transport services effective?

We found the following areas of good practice:

- The provider`s policies were based on National Institute of Care and Excellence (NICE) Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.
- The provider had commenced clinical supervision `ride outs` were the practical skills and interaction with patients were observed by the Regional Supervisor.
- All emergency care assistants (ECAs) held either a Level 2 First Person on Scene or Level 3 First Response Emergency Care qualification and held a Level 2 Prevention and Management of Violence and Aggression qualification.
- Staff could explain the implications of the Mental Capacity Act 2005 and Deprivation of Liberty Standards in relation to patient consent and to record any issues on the transport booking form.
- A system that flagged when a member of staffs` qualification was due for renewal.

However, we found that;

- No staff appraisals had been completed since the company commenced providing PTS in July 2017, however, at the time of the inspection the provider was within the 12 month period for completing staff appraisals.

Evidence-based care and treatment

- Staff told us the SSG UKSAS Resuscitation Policy was reviewed at least annually by the Governance Director and kept up to date with national standards of the Association of Ambulance Chief Executives (AACE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.
- 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. The documents were in date, had version control information and when the document review date was.
- There was evidence the provider recorded and had the ability to measure and record levels of staff adherence to local policies and procedures. Managers told us that this would be achieved through the supervision
- Managers told us that the eligibility of a patient for PTS was assessed by the requesting service.

Assessment and planning of care

- Managers told us staff were made aware of patient's condition including any mental health issues so that they could plan transport accordingly through the PTS booking form.
- During the inspection we saw evidence on completed booking forms that showed this information was included.
- Managers we spoke with explained that if a patient was considered high risk or was under escort and the patient transport 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 told us that if a patient was considered medium or low risk and the patient transport journey was considered lengthy they would identify welfare stops 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.
- We saw evidence this information was recorded on the vehicle timesheets and communicated to staff before the transportation of the patient so they were aware of the risks.

- Staff told us that any care that had been given to a patient was recorded on the vehicle timesheets.

Response times and patient outcomes

- Managers told us that 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 CCGs 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 number of reported complaints recorded. The response times were agreed with the contracting CCGs and NHS trusts taking account of their location and the distances from the Cramlington base.
- The provider achieved the KPI`s in respect of the contractual arrangements with the providers commissioning PTS.
- The data for December 2017 to February 2018 showed the total number of patients transported to be 648.
- The provider's performance against one hour response time targets was; December 2017 (66%), January 2018 (81%) and February 2018 (84%).
- The 1.5 hour response times was; December 2017 (77%), January 2018 (100%) and February 2018 (87%).
- The two hour response times was; December 2017 (87%), January 2018 (77%) and February 2018 (85%).
- The number of transfers stood down or cancelled was: December 2017 (6%) or 13, January 2018 (4%) or nine and February 2018 (6%) or 14.
- 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. However, at the time of the inspection SSG UKSAS were undertaking a full internal review of performance across all its sites.
- Managers told us that currently they met the contracted levels of service within the agreed response times.

Competent staff

- Managers told us that they had not done any staff appraisals since the company commenced providing PTS in July 2017. Managers stated this was due to the previous company having been bought by SSG and there had been delay in bringing in a corporate appraisal system across all three SSG sites. There was evidence of a schedule in place to complete all staff appraisals in April 2018.
- Staff performance was monitored using a newly created Clinical Supervision and Personal Development Review Policies which included Clinical Supervision `ride outs` which had commenced in December 2017. The purpose was to observe and evaluate the performance of staff in an operational setting.
- During the inspection we saw evidence of two Clinical Supervision `ride outs` having been completed by the Regional Supervisor. We saw evidence staff received feedback following the `ride out` and no issues had been identified.
- Managers 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.

- We saw evidence all emergency care assistants (ECAs) held either a Level 2 First Person on Scene or Level 3 First Response Emergency Care qualification.
- We also saw evidence all staff held a Level 2 Prevention and Management of Violence and Aggression qualification.
- Managers told us qualification monitoring was based upon staff grade. There was a provider human resources system that flagged when a member of staffs` qualification was due for renewal. The staff member concerned would be informed if they need to attend a training course or do an on-line refresher course. We saw evidence paramedic registrations were checked annually on the Health and Care Professionals Council (HCPC) website.
- We saw evidence that this process had been carried out in accordance with the provider's Verification of Professional Registration Policy.

Patient transport services (PTS)

- We found 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.

Coordination with other providers

- At the time of the inspection the provider had PTS contracts with eight NHS Clinical Commissioning Groups and one local authority that spot purchased the service and invoiced the local CCG.
- Managers told us that SSG worked with social workers, Police, approved medical health professionals and secure mental hospitals to transport patients with mental ill health.
- During the inspection evidence from providers requesting PTS showed SSG were delivering the service in accordance with their contracts.
- Providers feedback comments included," overall, the service provided for Mental Health Act conveyance of detained patients to hospital has been exceptional. The staff appear well trained, compassionate and flexible in their approach to patients` needs. They are generally very supportive of approved mental health professionals (AMHPs) in their coordination of Mental Health Act assessments (MHAAs) and 'in the field', "In general the service has been received very well and has been a welcomed improvement over extensive delays previously experienced" and "the service they provide cuts down on the time people wait to be admitted to hospital under the Mental Health Act 1983".

Multi-disciplinary working

- Managers and operational staff told us that patient care was planned following receipt of the information contained in the patient booking form. We saw evidence on the patient booking forms from previous transports.

Access to information

- We saw evidence that policies and procedures were kept in a folder in the PTS ambulances that staff could access.
- Staff told us that the shift rota was projected two months in advance. The rota was displayed in the crew room. Managers told us staff would be informed of any changes of shift or additional shifts through the staff social media group.
- The Regional Manager told us that he would notify staff of any forthcoming training courses personally.
- Staff told us that at the time of PTS booking the receiving person asked for patient specific information such as if the patient had a do not attempt cardiopulmonary resuscitation (DNACPRA) order in place.
- Staff we spoke with told us at the time of booking the journey, the person receiving the request asked for information regarding the patients' background health. This included dementia, learning difficulties and physical disabilities. Staff would refer to the Safeguarding of Adults Policy for guidance in relation to patients with dementia, learning difficulties or physical disabilities.
- We saw evidence of flow charts for staff to use which provided a summary of advice and guidance in relation to DNACPR orders and for dealing with patients with dementia, learning difficulties or physical disabilities when transporting them which mirrored what was in the providers policy
- Managers we spoke with told us that staff training ensured they were prepared for the communication and occasional physical challenges associated with dealing with patients with dementia.
- The two PTS vehicles we inspected both had tracker location devices fitted which were monitored by the Regional Manager or Regional Supervisor. They advised the PTS drivers by hands free telephone if they became lost.
- The vehicles also had accurate and up-to-date satellite navigation systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act 2005 and Deprivation of Liberty Standards through the statutory and mandatory training programme.
- Staff we spoke with could explain the implications of the Mental Capacity Act 2005 and Deprivation of Liberty Standards in relation to patient consent and to record any issues in relation to this on the transport booking form.
- Managers told us when a patient lacked capacity to make their own decisions advice about consent would be obtained by staff from Mental Health Care professionals at the provider requesting the transport.

Patients who lacked capacity to make their own decisions would be accompanied by a Mental Health Care professional, relative or carer who could consent on their behalf.
- Staff told us that if a patient had capacity they would confirm their verbal consent to be transported on the vehicle timesheet.
- The provider had a policy document which included consent, Mental Capacity Act 2005 and Deprivation of Liberty Standards. The document was in date, had version control information and when the review date was.
- We saw evidence the level of staff training compliance in relation to consent, Mental Capacity Act 2005 and Deprivation of Liberty Standards was 87.5% and was included as part of statutory and mandatory training.

Are patient transport services caring?

We found that:

- Staff showed a commitment to providing the best possible care.
- Staff could describe they how they would take steps to try and minimise distress in patients and families.
- There was positive feedback from patients.
- Staff gave clear explanations of what they were going to do with patients and the reasons for it and checked to ensure they understood and agreed with the proposed actions.
- Staff checked on patients during transport asking about discomfort, and emotional wellbeing.

Compassionate care

- We were unable to observe any direct patient care during our inspection due to the spontaneous nature of the providers regulated activities.
- Although we did not observe 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 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 were 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.
- Staff we spoke with gave an example when they had been concerned about continuity of care after a patients' transfer were completed. Staff told us they checked with patients and hospital staff about the availability of ongoing care and support after the transfer had been made from hospital to home.

Understanding and involvement of patients and those close to them

- We did not observe any patient care during our inspection. However, we did see feedback from two services that had requested patient transport.
- One expressed their thanks for the way a crew had dealt with a challenging young person who`s behaviour had been difficult to manage, quote" for the tremendous commitment shown", "they were completely un-phased throughout and showed great patience and determination to safely get them hospital" and "they were a credit to themselves and to the professionalism of the service".
- Another service user expressed their thanks for transporting a difficult patient to hospital, quote" I` am most grateful for the support provided…. they are my hero`s. They did an amazing job".
- Staff told us patients were involved in decisions about their care and treatment. Staff gave clear explanations of what they were going to do with patients and the reasons for it. Staff told us they checked with patients to ensure they understood and agreed.
- Staff demonstrated an awareness of involving patients, and their relatives or carers, in any decisions that were made about their care.

Patient transport services (PTS)

- Staff we spoke with told us they had provided clear information to patients about their journey and informed them of any delays.
- There were no patient feedback forms to review due to the infrequent nature of the provider`s regulated activity to ascertain if SSG staff had understood and involved patients and those close to them.
- There was no patient feedback on the provider`s website which could be reviewed to ascertain if SSG staff had understood and involved patients and those close to them.
- Managers we spoke to told us the eligibility for the patient transport service was decided by the service requesting PTS in accordance with the contractual arrangements.

Emotional support

- Due to the spontaneous 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.
- Staff we spoke with told us they checked on patients, in terms discomfort, and emotional wellbeing during any patient transport journey.
- Staff we spoke with told us they understood the need to support family or other patients should a patient become unwell during a journey.

Are patient transport services responsive to people's needs?

We found that:

- The provider had agreed response times with CCG`s dependent upon travelling time.
- Staff could outline how they would deal with patients with complex needs.
- Managers planned patient transport based on risk to ensure people's individual needs were met.
- The provider had developed their own performance framework to measure attendance times.
- The provider`s shift system ensured coverage 24 hours per day 365 days of the year.

However, we found;

- The PTS vehicles carried any information or leaflets which would explain to a patient, relative or carer how to make a complaint. However, staff we spoke with told us they could explain to anyone wishing to make a complaint how to.

Service planning and delivery to meet the needs of local people

- The provider told us management of bookings were at short notice as requests for transport normally came with 24-hours' notice due to the acute nature of some of the patient presentations. The provider offered a one hour response for local calls.
- Managers we spoke with told us any capacity was planned to meet the differing demands depending on geography by having agreed different response times dependent upon the travelling distance from the Cramlington base to the CCGs areas of responsibility. The agreed response times were included in the contracts with the CCGs and NHS trusts.
- The provider`s shift system ensured coverage 24 hours per day 365 days of the year and the ability to respond to local calls within one hour.

Meeting people's individual needs

- Staff told us they received training and could outline how they would deal with patients with complex needs including those with a learning disability, living with dementia, older people with complex needs and patients where English was not their first language and staff had to access to a translation service.
- The provider did not transport bariatric patients.
- There was evidence the PTS ambulances carried bottled water and blankets for patients to use. There was space and anchorage points for patient wheelchairs and space and straps to secure patient walking aids.
- The Regional Manager told us staff had access to a translation booklet for patients to use when English was not their first language. However, the booklet could not be found during the inspection.

Access and flow

- Managers 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

staff on duty at any time covering 24 hours per day 365 days of the year. Staff we spoke with told us that if the request for PTS was not spontaneous they would obtain additional resources, if required, from their bank staff.
- Managers we spoke with told us that the CCGs and NHS trusts had not provided SSG with any key performance indicators. The Regional Manager had told us that they had started collecting their own data in relation to the number of patients transported and the response times from December 2017. They now collected data monthly and shared this with contracting CCGs and NHS trusts.
- There was evidence of a handover procedure on the patient transport forms where SSG transported an unescorted patient. A copy of the form would be left with the provider receiving the patient and any comments from the person receiving the patient would be included on the form.
- If the patient was escorted the staff carrying out the escort were responsible for the handover procedure not SSG staff.

Learning from complaints and concerns

- The provider had not received any complaints in the last 12 months.
- The provider`s complaints policy 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.
- We did not see evidence to show the PTS vehicles carried any information or leaflets which would explain to a patient, relative or carer how to make a complaint. However, staff we spoke with told us they could explain to anyone wishing to make a complaint how to.

Are patient transport services well-led?

We found that:

- Regular monthly staff forum meetings were held where staff could raise issues.
- All staff were kept informed of the outcome of the staff forum through a closed social media group.
- Monthly performance information was displayed in the crew room wall so staff could see the latest performance data.
- Staff files had evidence of appropriate recruitment checks having been undertaken.
- Staff felt respected and valued by their immediate manager and there was good team working.
- Operational staff could identify the local leaders and what their roles were.

However, we found that;

- There were no governance meetings held at the Cramlington site.
- The provider had carried limited audits to measure the quality and effectiveness of the service delivered such as cleanliness and infection control.
- The provider had not carried out any staff appraisals, however, at the time of the inspection the provider was within the 12 month period for completing staff appraisals.
- The Regional Manager and supervisor did not have a role specification or specific roles and responsibilities.
- Staff felt they were not consulted or kept informed of any organisational change.

Leadership of service

- The service had five full time employees based at Cramlington; a Regional Manager, Regional Supervisor, and three Emergency Care Assistants who work on a 45 hour per week contract. The staff were supported by a Registered Manager and Director of Operations based in SSG corporate office in Essex. They had responsibility for the Cramlington site and two other others.
- The Regional Manager had overall responsibility for the Cramlington site. There was no evidence of a role specific job description. The Regional Manager told us they negotiated contracts with CCGs, managed resources and planning, interviewed new recruits, provided site 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.

- 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 supervisor. The Registered Manager had responsibility nationally for governance and human resources.
- Staff told us they knew what the management and reporting structures were because they had been discussed and explained at the staff forums.
- Staff described the managers as being visible and approachable. Staff told us they could contact SSG head- quarters to raise issues if they did not want to do this at regional level.

Vision and strategy for this this core service

- The provider`s mission statement was that SSG UK Specialist Ambulance Service aimed to provide a quality service in accordance with, and adhering to, the codes and practices of the British Ambulance Association and the Patients' Charter.
- The provider `s mission statement was supported by six values which were; to recognise that patients in their care have the right to be transported with dignity in a safe, secure environment, providing the best possible patient care, ensure personnel are highly aware of, and respect, the individual needs of the patient, and their relatives, encourage patients and purchasers to comment on the service they receive in an open manner, adopt a close working environment with their employees, where dialogue is encouraged and valued and to provide every member of its staff with the opportunity to progress and acquire new skills.
- The Registered Manager told us the mission statement and values had been adopted by SSG from the previous company UK SAS and that they would be reviewed by the end of April 2018 by the headquarters management team.
- We saw evidence the vision and strategy was displayed on the wall in a prominent position in the building entrance lobby. A copy of the vision and values was also in each of the PTS ambulances. They would also be included as part of the staff appraisal.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was a corporate governance structure in place. The provider's executive leadership oversaw three areas of business through committees; the risk management clinical committee, finance procurement committee and strategic direction committee. The medicines guidelines working group reported to the risk management clinical committee. The equipment working group and vehicle working group reported to the finance procurement committee. The registered manager told us they attended these meetings.
- The Regional Manager was responsible for overseeing local governance processes at Cramlington, with support from the Regional Supervisor. The Regional Manager reported to the Registered Manager.
- Managers told us there were no local governance meetings held at the Cramlington site because the provider was relatively new and governance was dealt with across all three operating sites by the corporate leadership at the providers head-quarters. Managers explained the reason for this was to ensure governance operated in the same way across all three sites and would allow the executive leadership team to hold the Registered Manager to account.
- We saw evidence that local governance issues had been raised by the Regional Manager and taken to corporate governance meetings by the Registered Manager.
- The Regional Manager told us any information from that meeting which was specific to the Cramlington site and required immediate action had been shared with them by the Regional Manager by e mail or a phone call. The Regional Manager was responsible for ensuring any actions were carried out.
- Any information that did not require immediate action or were governance issues from other sites which were applicable to the registered activity carried out at the Cramlington site were raised by the Registered Manager and discussed with the Regional Manager and staff at the monthly staff forum meetings. We saw evidence the minutes and actions of that meeting were recorded.
- The provider had corporate risk register that listed 32 risks which identified the possible consequence, risk score including a 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 the headquarters management meetings.
- Although there was not a site- specific risk register for Cramlington the risks in relation to the regulated activity carried out at the site were included in the corporate risk register. However, there were no risks identified, for example, in relation to the premises at Cramlington.

- Staff we spoke with told us they were kept routinely informed of what had been discussed at SSG headquarters governance meetings. In addition, the Regional Manager cascaded information to staff through the staff`s social media group. This included sharing information about complaints, incidents and changes to policies.
- Managers we spoke with told us that the CCGs 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 shared this with contracting CCGs and NHS trusts.
- During the inspection we saw evidence that the monthly performance information was displayed in the crew room wall so staff could see the latest performance data.
- The provider did carry audits to measure the quality and effectiveness of the service delivered such as cleanliness and infection control and monitoring of performance. However, there were potential risks to staff and patient safety because no observation of staff handwashing was carried out or audited.
- The service had not carried out staff appraisals since the business commenced in July 2017, however, the provider was within the 12 month period for completion of staff appraisals at the time of the inspection and there was evidence of an appraisal process in place including a timescale for completion.
- The service had a recruitment procedure. The director of governance told us that as part of the staff recruitment process appropriate background checks were carried out. This included a full Disclosure and Barring Service (DBS), proof of identification, references, check as well as driving license checks.
- We reviewed seven staff files and found evidence the appropriate recruitment checks had been undertaken.

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.
- 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.
- Staff we spoke to told us that they were not consulted or kept informed of any organisational change.
- During inspection we saw evidence of leaders encouraging appreciative, supportive relationships with staff. One example being how a manager had dealt with an issue where one member of staff had been upset by the way another member of staff had interacted with them. When the member of staff were spoken to they had no idea how they had been perceived by the other person. This resulted in the member of staff changing how they acted and appreciating the views of others.

Public and staff engagement (local and service level if this is the main core service)

- 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, January and February were reviewed. The minutes illustrated that the meeting was driven by staff issues. Managers explained that this meeting would also be used to update staff with information from the corporate governance meeting.
- A good 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 were purchased and issued to staff.
- 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 meeting through a message in closed social media group.
- Managers we spoke with told us the service level agreements with contracting CCGs and NHS trusts were the agreed response time.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- Managers told us that sustainability was difficult to guarantee because the provider was in a very competitive business with other similar providers.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must have a policy regarding the transportation of drugs prescribed to patients and patient notes during patient transport.
- The provider must ensure staff record the dynamic risk assessments in relation to all patients transported which are handcuffed.
- The provider must ensure managers review all handcuffing forms to ensure the action taken was appropriate and if any injuries had occurred which needed further review.

Action the hospital SHOULD take to improve

- The provider should act 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 handwashing and staff adherence to provider polices in respect of that.
- The provider should carry out staff appraisals before July 2018.
- The provider should ensure all staff were aware of the incident reporting criteria and procedure.
- The provider should ensure information and guidance about how to complain is available and accessible to everyone who uses the service inappropriate languages and formats to meet the needs of the people using the service.
- The provider should have a site specific risk register to enable identification of local issues.
- The provider should actively seek feedback about the quality of care and overall service provided. The feedback may be informal or formal, written or verbal. It may be from people using the service, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment •The provider did not have a policy regarding the transportation of drugs prescribed to patient or patient notes during a patient transfer. •The provider did have a system for staff to record their dynamic risk assessments in relation to all patients transported which were handcuffed. •The provider did not have a system in place for managers to review all handcuffing forms to ensure the action taken was appropriate and if any injuries had occurred which needed further review. Regulation 12 (1)(2)(a)(b)(g)