SSG UK Specialist Ambulance Service Ltd

SSG UK Specialist Ambulance Service - South

Quality Report

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

Ratings

Overall rating for this ambulance location	Not sufficient evidence to rate
Emergency and urgent care services	**Not sufficient evidence to rate**

Summary of findings

Letter from the Chief Inspector of Hospitals

This report describes our judgement of the quality of care at this location. We based it on a combination of what we found when we inspected and from all information available to us, including information given to us from people who use the service, the public and other organisations.

SSG UK Ambulance - South is operated by SSG UKSAS. The service provides emergency and urgent services and patient transport service. Most of services provided are commissioned by NHS trusts.

Following our inspection on 23 August and 04 September 2018, we rated the service as inadequate and placed it in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

We also served the provider with two warning notices relating to breaches for safe care and treatment and governance. The provider was required to be compliant and make the necessary improvements by 23 November 2018.

We carried out an unannounced focus inspection at the provider's headquarters in Rainham, Essex on 28 November 2018 and the Fareham station on 6 November 2018, to review compliance with the two Warning Notices. We did not look at all the domains and key questions, instead we focused on specific areas of concerns in the Warning Notices.

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.

Our inspection targeted the key concerns identified in the warning notice.

At our inspection we found the provider had not made progress on all issues identified in the warning notice. Issues outstanding were;

- Medicines including controlled drugs (CDs) were not managed safely and in line with best practice guidelines which may impact on the safety of patients.
- There were no audits of CDs which were stored off site and individual paramedics' CD registers audits were not consistently undertaken. We found that compliance with installation and storage of home CDs had not been assessed for all paramedics storing CDs off site.
- The provider was considering re introducing administration of medicines via patient group directions. However, the procedures and staff training had yet to be developed.
- The provider was unable to produce accurate data relating to the number and batch number of CD ampoules issued to individual paramedics.
- Policies for the management of medicines had been developed; however, this was not currently effectively managed as the staff could not access these.
- The process for managing risks was not effective, risks were not consistently identified and action plans developed to mitigate these. The management team were not aware of the serious risks we identified during the inspection.

Summary of findings

- There were significant risks of misappropriation of CDs as staff who had left the service remained in possession of CDs and had not been returned to the service.
- The process for the use of patient group directions (PGD) had not been resolved as these had not been fully developed in line with National Institute for Health and Care Excellence (NICE) guidelines and approved for use. These have not been approved by commissioners.

However, they had addressed the following issues in the warning notice:

- The meeting including monthly board meetings and committee structure had been developed but not implemented at the time of our inspection. Procedures for sharing this information with the staff were being developed but not implemented at the time of the inspection.
- The provider had suspended the destruction of CDs and other medicines while they develop procedures for their safe destruction.

Following this inspection, we concluded the provider was not compliant with all aspects of the warning notice.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. We also issued the provider with two requirement notice(s) that affected SSG UK Ambulance - South . Details are at the end of the report.

Name of signatory

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Not sufficient evidence to rate	Urgent and emergency services were the main service provided. The majority of the service was carried out under contract with NHS ambulance trusts. We have not rated the service at this inspection as we were reviewing the provider's compliance with the two Warning Notices.

SSG UK Specialist Ambulance Service - South

Detailed findings

Services we looked at
Emergency and urgent care.

Detailed findings

Contents

Background to SSG UK Specialist Ambulance Service - South

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

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

The service is registered to provide the following regulated activities:

- Triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, another CQC inspector, and a specialist advisor with expertise in emergency and non-emergency patient transport services.

The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the location in Fareham Hampshire on 6 November 2018 and the provider's headquarters in Rainham Essex where the regulated activities were carried out. We carried out this inspection to review compliance with the two Warning Notices which were served on 04 October 2018.

We checked the improvements the service had been made and compliance with the Warning Notices. We spoke with staff including; managers, technicians and paramedics. We reviewed documentation and data provided by the service and commissioning trusts.

Emergency and urgent care services

Safe	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

SSG UK Ambulance - South is operated by SSG UKSAS. Urgent and emergency care was the main service provided but a patient transport service was also delivered.

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

The service provided, emergency and urgent transfers on behalf of NHS trusts. At the time of our inspection, the provider had four NHS contracts.

Summary of findings

We found the provider was not meeting all aspects of the warning notice and was non-compliant in the following areas:

- The overall management of controlled drugs (CDs), ensuring there are clear processes for CD allocation, returned, administration and these are recorded accurately.
- Assurance including auditing of CD storage off site to ensure they are stored safely and in line with medicines regulations and guidelines.
- The use of patient group directives is managed safely by staff who have completed the required training and in line with guidelines.
- Develop systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others.

However, found the following areas of compliance with the warning notice:

- We found improvements had been made at the Fareham station to improve medicine security. Medicines storage facility had been developed and medicines were maintained safely and securely.
- Technicians were no longer administering medicines using patient group direction as this was not within their scope of practice.
- The destruction of controlled drugs had been suspended until policies and procedures had been developed in line with medicines legislation and national guidance.

Emergency and urgent care services

Are emergency and urgent care services safe?

Not sufficient evidence to rate

We did not rate safe as we did not look at all aspects of the safe domain.

At our last inspection we identified concerns with the management of medicines including controlled drugs (CDs). Significant improvements were required to ensure medicines were stored, transported, administered and disposed of in line with national guidance and legislation.

Medicines

- At the last inspection medicines were not stored, managed, administered and of disposed of safely and in line with national guidance and controlled drugs legislation. This posed risks to patients' safety. During this inspection we found some improvements had been made but risks remained and these have not been mitigated.
- During our inspection in September 2018 the registered manager confirmed that all paramedics employed by the company were issued with personal issue controlled drugs (CDs), such as morphine that they stored at their home in a safe, provided by the service. There were no checks or audits of either the safes, CDs or individual CD registers to ensure these medicines were stored securely and usage was traceable.
- During this inspection,the provider has started an audit of CDs stored at home; however; this had not been undertaken for all paramedics who had personal issue CDs stored off site. Therefore, there continued to be no effective systems and processes in place to ensure safe storage, monitoring and to minimise accidental or intentional loss of CDs or consumption by others.
- The current individual CD registers did not facilitate accurate record keeping. When CDs were issued to paramedics the batch number on the ampoule was recorded in the central CD register held at the head office. This was not entered onto the individual paramedic CD registers and the name of the individual issuing the CDs was not recorded. Staff also raised concerns and we noted the newly designed personal CD registers did not have facility to record any wastage.
- The provider stated that they had recalled all CDs from paramedics' homes and these had been returned to the head office at Rainham. Paramedics were now expected to withdraw CDs at the start of their shift and return any unused CDs back at the end of their shift.
- We found that some paramedics had left the service and the provider could not provide any evidence that the personal issue CDs had been returned or these had been accounted for. This posed a risk of misappropriation of control drugs.
- The information provided by the registered manager during this inspection showed some paramedics on the list did not have CDs issued to them and that not all CDs had been returned to Rainham. As this information contradicted what we had been told we requested further information from the registered manager to confirm which paramedics had never been issued with CDs, this information was not supplied. Therefore, we did not have assurance that the service was assured which paramedics had been issued with CDs.
- The procedures for the management of CDs continued to be ineffective. We undertook a review of a sample of paramedics' CD registers, patient care records (PCR) and commissioning trust's computer aided dispatch (CAD) records for the period October 2017 to October 2018. We found only 37% of the 151 CD transactions could be tracked from CDs being issued by head office and administration to the patient.
- The remaining 63% could not be tracked for various reasons including no record of the job on the CAD system. In other cases, the patient care record (PCR) did not include evidence of administration of a CD or no paramedic had been assigned to the job. Therefore, the crew could not have administered a CD unless they had called for paramedic back up but this was not recorded on the PCR.
- Staff did not always maintain an accurate record of the CD batch number when administering CDs. An analysis of the 151 CD transactions for the period October 2017 to October 2018 found 33.5% of CDs administered included a batch number in the individual CD register.

We found 63.5% had no batch number recorded in the paramedic's individual CD register. This meant it was not possible to track all CDs from issue to the paramedic to administration to a patient. These transactions related to both the Rainham and Fareham locations.

- In line with guidance, CDs administered should be witnessed by a second person and recorded. In most of the 151 entries seen, there was no record of a witness when CDs were administered or wasted. We also found occasions when the entry on the patient care record (PCR)did not match the entry in the CD register, such as different doses.
- On one occasion the record showed that oral morphine was administered on the PCR but the paramedic individual CD register recorded that intravenous morphine was administered.
- The provider was unable to produce accurate data relating to the amount and batch number of CD ampoules issued to individual paramedics. The central records of CDs being issued to paramedics did not correspond with entries in individual CD registers. While the majority of transfers were included we noted on several occasion CDs were transferred from one paramedic's CD register to another paramedic or additional supplies were entered but there was no record of the source of these CDs. The registered manager told us paramedics could only collect CDs from the head office and that no other source, such as hospital or high street pharmacy were used for the supply of CDs to paramedics.
- At the inspection in September 2018, we identified that the registered manager undertook the destruction of CDs witnessed by another staff member, which was not in line with the provider's policy as they were also the controlled drug lead officer.
- At this inspection the registered manager told us they were no longer responsible for CD destruction and that CD destruction had been suspended until an individual had been identified to undertake this role and training had been provided to the person acting as witness.
- During the inspection in September 2018, the service did not have a valid CD licence from the Home Office reflecting the changes in staff responsible for CDs at the service. At this inspection in November 2018, the registered manager stated an application had been submitted to the Home Office for a CD licence. This had not been issued at the time of the inspection visit and the Home Office confirmed to us that the provider had submitted an application.
- Improvements had been made at the Fareham station to improve medicines security. A new medicine storage facility had been installed, the room was locked, CD and medicines cupboards and access to the medicines room was restricted to paramedics and managers only. This ensured unauthorised individuals could not access medicines.
- Since our last inspections the codes to the key safes at Fareham station had been changed and we were told these would be changed on a regular basis. This assisted in ensuring only authorised members of staff could access keys to medicines and vehicles.
- Improved security measures had been implemented at the Rainham CD store. The CD cabinet had been secured to the floor and wall. We also noted the provider had installed cameras inside and outside the CD storage area to assure themselves only authorised personnel had access to the CD room.
- During the last inspection medicines were administered by technicians via patient group directions (PGDs) which was not compliant with the medicines Regulations. The provider had taken steps to stop this practice and confirmed that technicians were no longer administering medicines using PGDs.
- At our last inspection the provider did not have PGDs in place for the range of medicines identified by the provider as being administered by staff via PGDs. As no staff training or competency assessment had been developed and implemented to prepare staff for the reintroduction of PGDs we were unable to assess if only staff who had been trained and assessed were administering medicines via PGDs.
- Following the inspection , the use of PGDs had been suspended and we noted they had not been reinstated at the time of this inspection.
- The commissioning trusts were aware that the staff at this service could not administer medicines via PGDs and would require the assistance of another crew if these medicines were required. The service and commissioning trusts could not provide data to

demonstrate on how many occasions staff had requested support to administer medicines and how the lack of ability to use PGDs had impacted on patients' care.

- At the last inspection we identified technicians and paramedic were accepting remote prescribing orders but, the service did not have remote prescribing procedure. At this inspection the registered manager confirmed remote prescribing had been suspended until clear guidelines were developed.
- At the last inspection there was no effective process for the review of incidents or undertaking investigations including root cause analysis, identifying and sharing learning and implementing improvements following incidents. At this inspection the registered manager told us that this was being developed as part of their critical change programme. The provider could not tell us when this would be implemented.

Are emergency and urgent care services well-led?

Not sufficient evidence to rate

We did not rate safe as we did not look at all aspects of the safe domain.

Leadership of service

- Local managers were supported by the operation's manager, staff told us they were on site regularly and accessible.
- The board which consisted of executive and non -executive members including their chief executive, director of services and director of finance and support services who chaired the meeting. The board met on a monthly basis and included staff with both clinical and financial backgrounds. We were told that board reports were now being presented at the monthly board meetings and that these covered a range of topics including finance and training. We requested these during our visit and they were not provided to us.

Governance

- At our last inspection we identified and the registered manager confirmed that there were no minutes of the senior management or governance meetings. Therefore, there were no records of the discussions that had taken place or evidence that the board were fully briefed on risks and areas of non-compliance to inform their decisions.
- During this inspection we were provided with a new committee structure and terms of reference for a risk management and clinical governance committee. However, these structures had not yet been implemented. Therefore, we could not evaluate the effectiveness of this structure in identifying and escalating risks and issues to ensure timely action was taken.
- The provider had set up an executive management committee with membership including directors of services, governance and finance, head of operations, workforce management and associate director of HR. One of key purposes of the committee was to provide assurance to the board that key risks were managed and action plans had been developed and implemented to mitigate known risks. Meetings had been planned and the provider had confirmed they would occur monthly with recorded minutes. At the time of our inspection these meetings had not taken place and therefore, there were no minutes of the meetings and we were unable to asses their effectiveness. At the factual accuracy stage, the provider sent us some information about governance meetings which had taken place.
- At our last inspection we identified there was no evidence of audits being carried out to confirm the effectiveness of medicines management or that procedures and practices were safe. There was no agreed audit plan and the only audits taking place were the monthly individual paramedics self-audits of their CD stock witnessed often by a second member of staff. We were told these audits were not reported to head office or local managers and there was no independent audit of completion of individual CD registers or stock levels. Therefore, the provider could not be assured that staff were managing CDs safely and in line with national guidance and legislation.
- The registered person confirmed there was no central record or audit trail of who had used patient group directions (PGDs) when providing care and treatment to patients. Following the last inspection, the use of PGDs had been suspended and we noted they had not been

reinstated at this inspection. Work had commenced to redraft the PGDs and the medicines policy stated each competent health professional must sign and would receive a personal copy of the patient group direction (PGD).

- Training, assessment and audit processes to ensure only trained and competent staff used PGDs had not been developed. Therefore, we were unable to assess if the provider could demonstrate only trained, competent paramedics had used PGDs and if audits were being undertaken to confirm the frequency PGDs were used and if only authorised individual were using these.
- At the last inspection we identified that remote prescribing was taking place without any governance arrangements in place to support this practice or audit the frequency. The provider stated they had suspended this practice but made no changes to their scope of work.
- During this inspection we were told the practice remained suspended but, the staff continued to be dispatched to cardiac patients who may require immediate medication. This meant there was an inconsistent approach on how this was managed in practice and may impact on patients care.
- At our last inspection, we identified the provider did not have effective governance arrangements to ensure policies reflected the latest best practice and national guidance. At this inspection the medicines policy had been developed and was in the process of being signed off. The provider told us that policies were being reviewed with a deadline for submission to the critical change programme team by 15 February 2019.
- In September 2018 we identified that there was no standard operating procedure (SOP) and the medicines management policy had not been fully developed to effectively and safely manage medicines. During this inspection we were provided with a copy of the SOPs for CD administration, carrying CD and missing CDs. The registered manager told us that they had secured support from an external person to review medicines management within the service and they were due to start work at the service.
- The medicines policy and procedures had not been shared with the staff responsible for medicines administration. This meant that staff may not be managing medication in line with the provider's policy and guidance.

Management of risk, issues and performance

- At the last inspection we found the provider did not have systems and processes in place for effectively identifying potential or actual risks and mitigating these. Although the provider was developing some procedures, these had not been fully implemented and we were told this was a work in progress.
- The risks associated with CD management were not effectively managed. There were no triggers in place to identify outliers of CD administration and ensure these were followed up. This meant that individual administration was not monitored or reviewed posing risks of misappropriation of controlled drugs.
- At our last inspection a lack of audit of known risks such as technicians administering certain medications without these being prescribed had not been completed. Local managers had commenced patient's records audits but these did not include a review of medicines administered or if the record included evidence of decision making.
- The provider's current systems and processes for storage, administration, recording and disposal of CDs were not effective. Audits were not in place to ensure all CDs received, administered and disposed of were in line with CD regulation and compliance with their Home Office licence.
- In September 2018, we identified the risk register did not include known local risks or those identified during the inspection. We requested the provider addressed this issue and ensure senior managers and the board had oversight of the service's risks. At this inspection, the risk register had been reviewed and updated with the register contained some of the provider's current risk. Senior managers told us the risk register was on the agenda at their monthly board meetings.
- The provider was unable to provide accurate data to inform performance and risks. For example, the data relating to the location paramedics worked from and

the quantity of CDs held by individuals and records of CDs returned for destruction was inaccurate. This meant it was not possible to ensure risks and issues could be identified in a timely manner.

- At the last inspection in September 2018, there were no systems or processes in place to ensure that when staff left the service or had not worked for a period, their CDs and individual CD registers were returned to the head office. The provider has told us they were working towards this. However; the risks of misappropriation of CDs had not been managed effectively, as all CDs had not been returned to the service and accounted for as required.
- Staff had been issued with a belt pouch for storage of CDs, meaning staff carried their CDs on their person. The registered manager confirmed that this change had not been risk assessed and procedures were being developed to manage this in practice. This demonstrated that new practices were being implemented without risk assessments being undertaken to identify and mitigate risks.
- During our meeting with the senior management team on 04 September 2018, the registered person confirmed there was no central record or audit trail of who had used a patient group directions (PGDs) when providing care and treatment to patients. This meant there was no assurance that only trained, competent staff administered medicines via PGDs. At this inspection the provider confirmed that the use of PGDs had been suspended, they were working with their commissioning trusts to re-introduce the use of PGDs.
- At the last inspection, there was a lack of effective governance to ensure policies were kept under review and updated in a timely manner to ensure they reflected the latest best practice and national guidance. At this inspection we were told the provider had developed a process for the review of policies and procedures.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must take prompt action to address the concerns identified during the inspection in relation to medicines management and controlled drugs.
- Ensure that all medicines including controlled drugs (CDs) are managed safely, securely including transport and destruction of medicines and CDs.
- Ensure that there are clear processes and lines of accountability for the management of patient group directives (PGDs).
- Ensure that CDS are accounted for at all times and returned when staff leave the service.
- Ensure that risks are assessed and mitigations put in place to manage risks and safeguard patients.
- Ensure policies and procedures are developed which support staff's practices in line with current regulations . An audit programme is developed to gather accurate data to inform performance and risks.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Treatment of disease, disorder or injury. Care and treatment must be provided in a safe way for service users. The registered person must ensure that medicines are managed safely and securely at all times. This must include overall safe management of controlled drugs. Systems and current processes for the safe management of controlled drugs were not effectively managed. Controlled drugs audits were not consistently undertaken. Staff who had left the service were in possession of controlled drugs. The risks for misappropriation of controlled drugs had not been safely managed.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Treatment of disease, disorder or injury The provider must 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. There was limited management oversight around risk management and its impact on the service provided. The governance processes, policies and procedures had not been fully developed to support current practices.

This section is primarily information for the provider

Requirement notices