Platinum Ambulance Service Limited

Hoes Farm

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

Hoes Farm is operated by Platinum Ambulance Service Ltd. They are an independent ambulance service based in Shipley, Horsham. The service provides repatriation, event medical cover and patient transport services for both adults and children. Paramedics, Technicians and emergency care assistants are used to staff services. The service had undertaken 26 patient transport journeys and three transports from events during the reporting period, from January 2017 to January 2018. It is these journeys that fall within the scope of registration with the CQC.

In England, the law makes event organisers responsible for ensuring safety at the event is maintained, which means that medical cover comes under the remit of the Health & Safety Executive (HSE). Therefore, the Care Quality Commission (CQC) does not regulate services providing ambulance support at events and this is not a regulated activity. The main service was event work, which the CQC does not regulate. Therefore, these services were not inspected.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 28 February 2018; during the course of this we saw that the service was carrying out unregulated activity of treatment of disorder disease and injury. The service was notified of this and they submitted an application to be registered for this activity within 24hours. We approved the service for this activity and returned to inspect this element with an unannounced visit on 30 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.

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 issues that the service provider needs to improve:

- A culture of reporting incidents was not embedded as we found examples of incidents that were not reported.
- Not all audits were recorded, for example, the service carried out swab testing to monitor vehicle cleanliness but did not record results. This meant the provider could not identify themes or monitor trends.
- Not all policies and procedures had a planned review date and updates were not clearly recorded, without regular reviews and clearly recorded updates, the provider could not be assured the policy was current and accurate.
- The provider did not complete hand hygiene audits. This meant we could not be assured the provider had oversight of hand hygiene compliance among their staff.
- The service did not have a policy for safeguarding adults and children that was individualised for Platinum Ambulance Service. The policy the service referred to was available as a web link that could not be reached. This meant the service could not be assured staff had access to a current and up to date safeguarding policy for both adults and children.
- The service did not have child seatbelts available for the transport of children who accompanied patients.
- The service did not have a resuscitation policy that detailed the protocol to be used when commencing cardio pulmonary resuscitation.

Summary of findings

- The service did not have a major incident plan. This meant staff may not have known their role in the event of a major incident.
- The service had a very basic staff survey in place that was not anonymised. This meant staff may not have felt able to give honest feedback.
- There were no mental capacity forms present on the ambulance. This meant the provider could not be assured that capacity assessments were undertaken in line with best practice and national guidance.
- The leadership structure was not fully embedded and concerns were not always raised through the appropriate channels; clinical leads did not have sufficient oversight of their areas of responsibility.

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

- Patient individual care records were written and managed in a way that kept people safe. The service had recently created and introduced a new patient report form. The new lay out was clear and the staff found it easy to use.
- Staff were competent in their roles and had up to date training. At induction, the provider issued a multiple-choice knowledge test to employees and staff were suitably trained to carry out driving duties safely.
- All feedback from patients was positive and showed care was supportive, compassionate and considered people's needs.
- Staff were happy working for the service and felt there was a positive open culture. Staff all spoke fondly of one another, including senior leaders, and were proud to work for the service.

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

Amanda Stanford
Deputy Chief Inspector of Hospitals (London and South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		This location (Hoes Farm) was inspected before the location was added to the providers conditions. This was because an application to change the location was made shortly before our plan to inspect the provider. We decided to continue inspection at the new location while the provider's registration certificates were amended to reflect this change. At the time of publishing, the provider was registered correctly at the new location. We regulate independent ambulance services but we do not currently have a legal duty to rate them.The service needed to improve their governance systems, policies and procedures and their monitoring and improvement of the quality of services they provided. Staff were all competent in their roles and were supported in development and training. All feedback from patients was positive and showed care was supportive, compassionate and supported peoples individual needs.

Hoes Farm

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Detailed findings

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Background to Hoes Farm

Hoes Farm is operated by Platinum Ambulance Service Ltd. The service opened in 2016. It is an independent ambulance service in Shipley, Horsham. The service serves communities throughout the UK.

The service has had a registered manager in post since 2016. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is managed.

Platinum Ambulance Service Ltd are an independent ambulance service, available 24 hours a day, seven days a week, 365 days a year. They provide repatriation, event medical cover and patient transport services for both adults and children to fund their charitable work at fundraising events. The service has two ambulances in use and has undertaken 26 patient transport journeys and three transports from events, additional to these regulated journeys they carried out two private transports and two charitable transports, during the reporting period, from January 2017 to January 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, a pharmacist and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited Hoes Farm. We spoke with six members of staff including; registered paramedics, patient transport drivers and management.

At the time of the inspection, there were no patient transport journeys, so we did not speak to patients or review clinical practice. We reviewed four patient satisfaction surveys and eight sets of patient records.

Detailed findings

Facts and data about Hoes Farm

The service is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (January 2017 to January 2018)

- There were 26 patient transport journeys undertaken.
- There were three patient transport journeys undertaken from events.

The operations manager was the only employed member of staff for the service, which also had a bank of temporary staff that it could use.

Track record on safety

- No reported Never events
- No reported serious injuries
- No reported complaints

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

- A culture of reporting incidents was not embedded as we found examples of incidents that were not reported.
- Not all audits were recorded, for example, the service carried out swab testing to monitor vehicle cleanliness but did not record results. This meant the provider could not identify themes or monitor trends.
- Not all policies and procedures had a planned review date and updates were not clearly recorded, without regular reviews and clearly recorded updates, the provider could not be assured the policy was current and accurate.
- The provider did not complete hand hygiene audits. This meant we could not be assured the provider had oversight of hand hygiene compliance among their staff.
- The service did not have a policy for safeguarding adults and children that was individualised for Platinum Ambulance Service. The policy the service referred to was available as a web link that could not be reached. This meant the service could not be assured staff had access to a current and up to date safeguarding policy for both adults and children.
- The service did not have child seatbelts available for the transport of children who accompanied patients.
- The service did not have a resuscitation policy that detailed the protocol to be used when commencing cardio pulmonary resuscitation.

Patient transport services (PTS)

- The service did not have a major incident plan. This meant staff may not have known their role in the event of a major incident.
- The service had a very basic staff survey in place that was not anonymised. This meant staff may not have felt able to give honest feedback.
- There were no mental capacity forms present on the ambulance. This meant the provider could not be assured that capacity assessments were undertaken in line with best practice and national guidance.
- The leadership structure was not fully embedded and concerns were not always raised through the appropriate channels; clinical leads did not have sufficient oversight of their areas of responsibility.

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

- Patient individual care records were written and managed in a way that kept people safe. The service had recently created and introduced a new patient report form. The new lay out was clear and the staff found it easy to use.
- Staff were competent in their roles and had up to date training. At induction, the provider issued a multiple-choice knowledge test to employees and staff were suitably trained to carry out driving duties safely.
- All feedback from patients was positive and showed care was supportive, compassionate and considered people's needs.
- Staff were happy working for the service and felt there was a positive open culture. Staff all spoke fondly of one another, including senior leaders, and were proud to work for the service.

Are patient transport services safe?

Incidents

- The service reported one incident, during the reporting period, from January 2017 to January 2018.
- The service reported no serious incidents, during the reporting period, from January 2017 to January 2018.
- The service reported no near misses, during the reporting period, from January 2017 to January 2018.
- The service reported no liability claims, during the reporting period, from January 2017 to January 2018.
- The service reported no never events, during the reporting period, from January 2017 to January 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service had a paper-based system to report incidents and near misses. The provider kept paper forms on their ambulances so that staff could easily report an incident when it occurred.
- The service had an incident reporting policy. This was in date, approved and included a review date. The policy clearly detailed that all accidents, incidents and near misses were to be immediately reported. This policy was included in the staff handbook and all staff we spoke with were familiar with it.
- However, there was limited use of the system to record and report safety concerns, incidents and near misses. Safety concerns were not consistently documented. For example, staff attended a patient who was not well enough for transport. The doctor who requested the transport had not assessed the patient. Staff told us they escalated their concern and arranged correct transport for the patient. However, staff did not report this as an incident. If staff do not report incidents, the service cannot identify themes and trends or prevent recurrence We raised this with the provider. Following our inspection, the provider told us they had arranged a

'talk' with all staff to discuss the importance of incident reporting. When we returned for our unannounced inspection staff told us this had taken place, however, we did not see minutes of this talk.

- There was no documentation to show the provider communicated lessons learned to all staff. Staff told us that lessons learned were shared informally and verbally. There was no assurance that all staff could access learning or changes to policy following an incident. We raised this with the provider. Following our inspection, the provider updated their incident reporting policy to include clear guidance on sharing learning. This included the use of staff notice boards and staff meetings to share learning. When we returned for our unannounced inspection, we saw the service were using a secure web based platform to share learning. Staff could access this at any time from any location.
- Lessons were not shared externally. Staff told us about unreported incidents that affected other teams or providers. For example, when a patient deteriorated during a journey, staff did not raise this as an incident with the provider who had discharged the patient. This meant external providers could not take action to improve safety beyond the affected crew. We raised this with the provider. Following our inspection, the provider sent us their updated incident reporting policy to include their responsibility to communicate all findings from incident reports with all relevant, external providers.
- When things went wrong and staff reported them, the provider completed reviews, investigations and identified learning. The one incident reported was a vehicle defect which caused an hour and a half delay in collecting a patient. We reviewed this incident report. All relevant staff were included in the investigation and learning was identified. The investigation identified that staff needed to raise delays, immediately, with management so they could arrange alternative transport as soon as possible.
- Openness and transparency about safety was encouraged. Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008. 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 them with reasonable support.
- The service had not had to apply the duty of candour, during the reporting period, from January 2017 to January 2018.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control policy. This policy was included in the staff handbook and all staff we spoke with were familiar with it. However, the policy did not specify a review date. Without regular reviews, the provider could not be assured the policy was current and accurate.
- The provider told us that all staff had completed infection prevention and control training as part of their mandatory training. All staff folders we reviewed contained up to date infection and prevention control training certificates.
- We saw that personal protective equipment was available to staff. Disposable aprons, masks, goggles and disposable gloves in a variety of sizes were available on the ambulance.
- Hand gel was readily available and staff told us they were using them. We did not observe any patient journeys, during our inspection, so we could not observe if staff were compliant with hand hygiene. We saw one alcohol-based hand sanitising gel dispenser on the ambulance. The dispenser worked and contained alcohol gel. Staff also showed us that they carried their own personal hand sanitisers at all times.
- Staff were familiar with the 'most fundamental times' to clean hands as outlined in the provider's policy. Staff told us they decontaminated their hands immediately before and after every contact with a patient. This was in line with the National Institute for Health and Care Excellence guideline QS61, Statement 3.
- Vehicles were visibly clean and ready for use and the staff handbook detailed a comprehensive cleaning schedule. We inspected two vehicles and found the inside and outside of both to be visibly clean. Vehicle cleaning check sheets had been completed and showed when equipment had last been cleaned.

- Staff maintained cleanliness of their vehicle and equipment during the course of transport. Staff told us they used wipes for disinfection and cleaning of equipment and surfaces. These wipes were effective against most bacteria, including methicillin-resistant Staphylococcus aureus (MRSA), Tuberculosis (TB), Norovirus and Hepatitis B & C. MRSA is a type of bacterial infection that is resistant to many antibiotics and capable of causing harm to patients. TB is an infectious disease that generally affects the lungs. Norovirus is a highly infectious group of viruses that cause diarrhoea and vomiting. Hepatitis B & C are viral infections that cause mild to serious effects on the liver.
- We also saw that vehicles had a spill kit in place to manage any small spillages and reduce the infection and hygiene risk to other patients.
- Staff were provided with a number of uniforms and were responsible for washing them themselves. If uniform became soiled or contaminated the provider would replace them. The staff handbook covered uniform and detailed that all staff were to be bare below the elbow when providing direct patient care.
- There was a schedule for deep cleaning of all vehicles; this took place every six weeks. A deep clean involved cleaning a vehicle to reduce the presence of certain bacteria. The service cleaned the inside of the vehicles, and then used a 'fogging' machine to ensure a thorough clean.
- There was not a robust monitoring system to ensure the cleaning of vehicles was effective. The provider told us they used a machine to audit the cleanliness of the vehicles. This was used every six months. However, the data from this audit was not documented anywhere. This meant the provider could not identify themes or monitor trends in vehicle cleanliness.
- The provider did not complete hand hygiene audits. This meant we could not be assured the provider had oversight of hand hygiene compliance among their staff.

Environment and equipment

- The station environment was properly designed and maintained and was purpose built to include an area for vehicles to be washed and cleaned. There was also a small cabin area for staff notices and equipment storage.
- The service ensured that all vehicles had a current Ministry of Transport (MOT), Tax, servicing records and were properly insured. Certificates and paperwork were clearly organised and stored in individual vehicle folders. The operations manager had noted certificate expiry dates on a notice board in the staff cabin to ensure vehicle certificates were renewed at the correct times. There was also a compliance notice in vehicles that clearly identified the expiry dates of all records.
- Vehicle keys were securely stored within the cabin. The keys to the cabin were secured at the entrance to the compound in a key safe. Only authorised staff knew these codes.
- Vehicle safety was assessed, monitored, maintained and recorded. Vehicles were inspected both before and after a shift. The inspection was completed on an electronic form. This form was easily accessible on a mobile phone and stored the completed data, for review, by the operations manager. The operations manager also completed a vehicle inspection, as a second check, when he cleaned and restocked the vehicle. Staff told us that each vehicle was safety inspected every six weeks by a contracted mechanic.
- The service had a process in place to manage the re stocking of vehicles, equipment and supplies. After each shift, staff filled out a 'stock used' form and the operational manager restocked these items. Staff then re checked the stock on their vehicle before going to the next job. This double checking assured the provider that staff would not be short of equipment when with a patient.
- The vehicle we inspected had safety belts that were intact. The vehicle carried a spare set of stretcher straps in case they failed or became contaminated. Staff told us that safety restraints were checked as part of the mechanic's six week inspection and stretcher belts were inspected as part of their yearly inspection. We saw records of these inspections.
- Safety harnesses were not available for children and the vehicles did not carry extenders for bariatric patients. Although the service out sourced the transport of children and bariatric patients, they could not assure the safe transport of a child if they were a friend or family member of the patient. The staff handbook

contained child protection guidelines and a child seat policy. The child seat policy detailed the use of rear and forward-facing child seats and boosters. However, they did not have these seats on board vehicles.

- Equipment was routinely checked and monitored. Staff told us they checked all equipment as part of their vehicle inspection. This included the suction unit, defibrillator, leads and the defibrillator printing paper. The provider reported that no equipment was due to for replacement.
- When faulty equipment was identified, staff had the tools to easily report those faults. An electronic application form allowed staff to flag any faults or concerns at any time before, during or after their shift. The application alerted the operational manager who contracted the mechanic or relevant service to do the repair. Additional to the application, staff told us they called the operational manager to report faults verbally.
- Staff were suitably trained and assessed to safely carry out manual handling activities. Staff were trained to pay particular attention to their environment when planning to move a patient safely. Staff were assessed during induction by lifting a dummy in a carry chair.
- The service had clear procedures in place to manage the disposal of clinical waste safely. Sharps bins were present in ambulances and waste was segregated into clinical or general waste bags. We saw clinical waste was disposed of in a lockable yellow bin that was secured to a wall. The service contracted a clinical disposal company to remove the clinical waste safely.

Medicines

- We reviewed the medicine security and storage arrangements. Medicines were kept in sealed bags in the cabin. This was double locked and monitored by 24hour CCTV. Paramedic medicine bags and technician medicine bags were kept separately. However, we found a medicine in the technician bag that was not on the provider's medicine list. This was a rehydration medicine used to rehydrate patients that may have been dehydrated after fluid loss. We raised this with the provider during our inspection; they acknowledged the error and immediately removed this extra medicine.
- We found that not all medicines showed an expiry date. These medicine packets had been cut to share between technician packs, one half had an expiry date and the other half did not. This meant that staff could not be assured that the medicines they administered, from these packs, were in date. Following our inspection, the registered manager informed CQC that they had removed medicines without expiry dates and replaced them with whole packets.
- Medicines were kept at appropriate temperatures. There was a thermostat in the cabin to ensure temperatures stayed within the correct range. This meant that the temperature in the cabin was controlled to stay within the required temperature ranges.
- We reviewed the service's patient group directives (PGDs). A PGD is authorisation to a registered clinician to administer prescription-only medicines (POMs) to patients using their own assessment of patient need. We found the PGD's gave ambulance technicians access to medicines they were not legally authorised to administer. Following our inspection, the provider told us that ambulance technicians could only access medicines they were legally authorised to access. We saw evidence that this change was sent to all staff.
- We also found that PGD's were not in place to allow paramedics to administer the range of medicines listed and administered.Following our inspection, the provider told us PGDs were under development to allow paramedics to administer a wider range of medicines. Paramedics were not able to administer these medicines until the completion of the updated PGDs. We had not seen finalised and approved PGD's.
- Although the provider told us they completed audits of medicine management they did not record the results of these audits. This meant we could not see any documented evidence that staff were adhering to company policy. This also meant they could not identify themes or areas for further training.
- We reviewed the provider's medicine management policy. This was in date and had been reviewed prior to our inspection. However, there was not a review date, and any changes from the previous review had not been clearly identified. Without planned reviews the provider could not be assured the policy would remain current and accurate.
- Medical gases were stored and managed to keep people safe. The physical security and storage of medical gases

were in line with national guidance. The provider did not carry extra oxygen or Entonox and so storage outside of the locked ambulance was not required. The company who supplied the medical gases collected and replaced them, as they were used. However, we found an expired oxygen cylinder. This meant that staff could accidentally stock ambulances with empty cylinders and attend patients without oxygen. This was immediately removed by the provider.

- The arrangements for obtaining medicines kept people safe. Over the counter pain medicines and prescription only medicines were obtained via a pharmacy. The registered manager checked the stock of all medicines monthly and completed an order form accordingly. The registered manager collected the order and checked the medicine, dose and quantity against the original order.
- The arrangements for recording and handling of medicines kept people safe. Medicines were booked in and the new stock balance was recorded. Medicines were placed in the either a paramedic or technician medicine bag and when medicines were used this was recorded and signed on the medicine usage form. Staff told us when bag seals were broken a full check of the bag was completed and used medicines replaced. These checks were not recorded.
- The arrangements for administering medicines correctly kept people safe. All staff we spoke with told us they checked that medicines were correctly labelled, sealed, in date and clear of any foreign substance before passing to their colleague to cross check the same details. Both staff members then checked their medicine pocket book to confirm the recommended dose for their patient. Staff told us they completed this before administering any medicine. We did not undertake any patient journeys with staff so were unable to observe if staff were compliant with this method of administration.
- The provider did not use controlled drugs.
- The arrangements for the disposal of medicines kept people safe. The registered manager told us that if medicines were out of date or needed disposing of, they were booked out and returned to the pharmacy for disposal.

Records

- Patient report forms were written and managed in a way that kept people safe. We reviewed eight patient report forms; these were accurate, complete and legible. Staff completed two sets of observations and clearly detailed the history and management of the patient. Included in the report was an area for clinicians to write further detail, these were thoroughly filled out and showed patient assessments had been thorough.
- Implementation of practices and processes were monitored and improved when required. The service had recently created and introduced a new patient report form. The new lay out was clear and the staff found it easy to use.
- Patient report forms were stored securely in a locked filing cabinet in the locked cabin. The keys to the filing cabinet were kept in a coded key safe. Only the operations manager knew this code.
- All transfers were clearly documented and recorded. We saw that patient report forms were filed with their associated booking form and initial booking request.
- The systems and processes for records were clear and communicated to staff. The staff handbook detailed a 'recording transfer' section. This clearly detailed what staff were required to record. This included mileage, use of blue lights, vehicle checks and invoice details. This section also referred to the Access to Medical Records Act 1990, and detailed that all clinical notes were strictly confidential.
- The service ensured that do not attempt cardiopulmonary resuscitation (DNACPR) orders were appropriately recorded. Staff told us this was identified at the booking stage. Staff were also required to see the DNACPR certificate and record this on the patient report form. Any other special requirements were communicated at booking stage, this information was handed over to the crew before departure and then filed with the patient report form.

Safeguarding

- The service had not raised any safeguarding concerns, during the reporting period, from January 2017 to January 2018.
- Staff had up to date safeguarding training to the correct level. We saw certificates, in all records we looked at, that showed staff had up to date training to at least

safeguarding level two for both children and adults. The provider also had a safeguarding lead and an additional staff member who was trained to level three. This was in line with the 'Safeguarding children and young people: roles and competences for health care staff intercollegiate document Third edition: March 2014'.

- Staff we spoke with were able to explain their safeguarding responsibilities for both adults and children and knew the safeguarding lead was the registered manager. We spoke to one member of staff who was the safeguarding lead at the local search and rescue group. They told us they used and shared their previous experience of safeguarding scenarios and outcomes with their colleagues. Other staff we spoke with told us they valued the shared learning from this member of staff.
- The provider service had a system in place to make sure children and adults were protected from abuse and neglect. However the service did not have their own procedure to report safeguarding concerns directly to the local authority.
- The service had direct links with the local NHS ambulance trust to escalate safeguarding concerns. If a staff member felt concerned, they completed a safeguarding referral form. These paper forms were available to them on the ambulance. Staff told us they would complete the form and submit it to the safeguarding lead along with a phone call to discuss the concern. The safeguarding lead would review the information and pass the concerns, via telephone, to a team at the local NHS ambulance Trust. This meant the service did not have oversight for ensuring safeguarding concerns were raised with the local authority.
- All staff we spoke with knew the process detailed on the safeguarding flow chart and told us if an adult or child was at immediate risk then they would contact the emergency services.
- The provider did not have a safeguarding policy. The staff handbook acted as a summary and signposted staff, via a hyperlink, to the Sussex wide policy and procedure for safeguarding adults. The link to the Sussex wide policy would not be effective in the event that staff were accessing the hard copy of the document. We could not check if the policy could be adapted to this service as the hyperlink no longer worked when we tried to access it. The provider did not have any assurance that staff had read the Sussex wide safeguarding policy.
- The safeguarding flow chart made reference to the safeguarding of children. The handbook also detailed child protection guidelines, these guidelines detailed the way a staff member should behave in the presence of a child. The handbook also contained a child protection statement which included 'Members of PAS … must report any concerns for [young people's] wellbeing '. However, the staff handbook did not summarise or signpost a policy or procedure for safeguarding children.
- The provider did not have a policy or procedure in place that identified the regulatory requirement to submit a statutory notification to the Care Quality Commission if they received an allegation of Abuse. There had been no allegations of abuse or safeguarding concerns raised at this service and so there has been no breach identified, however we were not assured, in the absence of a safeguarding policy that the provider knew their regulatory duty to inform us of allegations of abuse.
- The safeguarding summary provided in the handbook did not specify a review date. Without regular reviews of their summary or the Sussex wide policy, the provider could not be assured the summary was current and accurate. Without a safeguarding policy created by the service, staff could not be assured the policy was individualised for the service.

Mandatory training

- Staff had up to date training in all safety systems. The majority of staff were also employed by an NHS Trust where they maintained all of their continuous professional development and mandatory training. The service relied on the mandatory training the Trust delivered for these members of staff. The provider checked all mandatory training before staff began employment and provided training for any areas staff required.
- We reviewed six staff records. All six records contained up to date certificates for all mandatory training. We reviewed a staff record who was not employed by an NHS Trust. They also had up to date certificates for all mandatory training.

Patient transport services (PTS)

- The provider ensured that mandatory training was delivered effectively by the NHS Trust. The provider checked training certificates and issued a knowledge test as a multiple-choice answer paper. This covered the areas of mandatory training, such as, infection prevention and control, safeguarding and use of an automated external defibrillator
- The Staff handbook stated that all staff were expected to have training in first aid, manual handling and automatic emergency defibrillator use as a minimum.
- Staff were suitably trained to carry out driving duties safely. We saw that copies of driving licences were held in staff files to show that all staff had a C1 driving licence. This was compliant with the Driver and Vehicle Licencing Agency (DVLA) code of practice. All staff had completed their blue light driver training and certificates were in the staff files that we reviewed.
- Staff were suitably assessed to carry out driving duties safely. The provider completed driver assessments with their staff regularly. We saw a driver assessment document that assessed a night drive. This was a comprehensive assessment.
- The assessor checked driving licences and blue light certificates. The assessment included a review of the staff's daily checks and identified if staff noted any faults or defects. The assessor checked staff knowledge of vehicle dimensions and functions and reviewed if the staff member could identify and locate differing parts of the vehicle, for example, 'correctly locate and activate lights'. The assessment then covered the staff members drive. This assessed the staff's vehicle operations, hazard recognition and speed and manoeuvres.
- The provider used driving assessments effectively to improve driving. We saw that the assessment form documented areas where staff had been advised or reminded of legislation. For example, on the assessment we reviewed, the assessor had noted 'Reminder of speed when [traffic lights] are red'. This assured the provider that staff were suitably trained, assessed and equipped to safely carry out driving duties

Assessing and responding to patient risk

- Risks to people who used services were assessed and managed on a day-to-day basis. We reviewed the risk assessment section of the staff handbook. The handbook outlined the responsibility of each staff member to assess risk from booking a job to attending it.
- Staff told us they checked patients' details to ensure they had the skills and equipment to safely care for the patient both at booking stage and when the details were handed over to the crew.
- Staff were able to identify and manage medical emergencies. Staff told us they risk assessed patients when they arrived to ensure that a patient transport service was suitable. For example, staff told us about a time they attended a patient who had been booked in for a transfer as 'being less mobile'. When the crew arrived they carried out a full physical assessment of the patient and identified a hip fracture. The staff assessed and decided that a patient transport service was not suitable and called for an emergency ambulance crew to care for the patient.
- Staff were provided with specific training for high risk events. The registered manager told us about an event that carried out high risk activity in extremely cold and wet conditions. Staff arranged a rotation system where they assessed each patient, checked their temperature, arranged an area for patients to be wrapped in foil blankets and sat the patient on the ambulance in the warm. They also made a warming suit available to any patient at risk of hypothermia.
- Staff carried out risk assessments during a journey for signs of deteriorating health. Staff told us they observed patients by taking a full set of clinical observations. Observations included heart rate, temperature, respiration rate, blood pressure and a Glasgow Coma Score. We saw evidence of this in all the patient records we reviewed.
- The Glasgow Coma Score is an assessment of consciousness. The score is used as a guide for initial decision making and to monitor trends that may signal the need for new actions. The scale measures eye-opening response, verbal response and motor response. The tool allows calculation of a numerical score. It is the changing of this score that enables crews to easily recognise any deterioration.
- Staff were able to respond effectively to patients who deteriorated during a journey. Staff told us about a

patient who appeared to decline. Staff completed a full set of observations and found the patients oxygen levels were low. The patient was provided with oxygen and their oxygen levels were monitored. We looked at the patient records for this patient that showed effective management of the deteriorating patient.

- On inspection we did not see any policies to effectively detail the management of a deteriorating patient. Although staff could detail their responsibilities there was not a policy and the staff handbook did not document actions to be taken. This meant the provider could not be assured that all current and future staff would know their responsibilities when managing the deteriorating patient.
- We raised this with the provider. Following our inspection, the provider updated the staff handbook to include a section on the escalation of treatment. This section detailed staff responsibilities when managing the deteriorating patient. The process clarified deciding whether they should continue to the booked location, divert to the nearest emergency department or call for emergency services. The escalation process also instructed staff to report any deteriorating patient, to the duty manager, as soon as possible.
- Staff we spoke with all knew to contact the clinical manager for clinical advice, if the clinical manager was not available, staff contacted the registered manager. The registered manager also told us that the clinical advice team at the local NHS Ambulance Trust could be contacted if additional support was required.
- The staff handbook provided some guidance on what action to take in the event of a cardiac arrest. Staff were advised to make a professional judgement between commencing resuscitation while making their way, on blue lights, to the nearest A & E or whether they needed to pull over, commence resuscitation and dial 999 for additional resources.
- All staff we spoke with told us they worked to 'Protocol C' when managing a cardiac arrest. This is the protocol used by the local NHS Ambulance Trust. This protocol details the process to be followed when commencing basic and advanced life support. Protocol C was not mentioned in the staff handbook and the provider did not have a resuscitation policy to detail this protocol. The provider could not be assured that all current and future staff would know the details of protocol C when managing a cardiac arrest.
- The service had not reported any expected or unexpected deaths, during the reporting period, from January 2017 to January 2018.
- The service had policies and processes to manage the death of a patient during transit. We reviewed the service death in transit policy. This policy clearly detailed staff responsibilities and directed staff to commence resuscitation and make decisions in line with the deteriorating patient policy. However, the death in transit policy had not been dated or ratified and did not specify a review date. Without regular reviews the provider could not be assured the policy was current and accurate.
- Staff had completed training enabling them to manage disturbed or violent patients. All of the staff records we checked held evidence of conflict resolution training.

Staffing

- The company employed one member of staff, the operations manager. The remaining 20 members of staff were self-employed clinicians and opted for shifts as and when they were available.
- Assigning the correct amount of staff to bookings was implemented and reviewed by the provider. The service asked staff if they were available for bookings in a private web based group that only platinum ambulance service staff had access to. Staff made their availability known through the portal and the operations manager selected staff on a first come first served basis.
- There were effective handovers that ensured staff could manage risks to people who used services. Once booking information was received, the call taker identified the needs of the patient, medical history and any special requirements before handing these details over to the assigned crew.
- The service reported two sickness days during the reporting period, from January 2017 to January 2018 and no staff had left employment with them during that time.

Patient transport services (PTS)

- Any staff shortages were responded to quickly and adequately. If staff did not make themselves available for a booking the registered manager or director would provide cover. This was managed in the same way for any staff sickness. The registered manager felt they had the capacity to manage shortages in this way and the service had not had to cancel any bookings due to staff shortage.
- Staffing levels and skill mix were planned to keep people safe at all times. When a call was booked, the operations manager gathered information about the patient's needs and medical history. Although it was the responsibility of the caller to request the required skill level of staff, the operations manager checked that the request was appropriate to manage the needs of the patient.

Anticipated resource and capacity risks

- The service understood and managed foreseeable risks, for example, disruption to staffing levels. The service controlled this risk by only accepting a booking once staff resources had been confirmed.
- The service took potential risks into account when planning services. For example, the service always kept a back-up vehicle available in case of a vehicle being off the road due to a fault.
- The service involved staff through any changes or service development. Minutes we reviewed showed staff were consulted on any changes or decisions. For example, staff had been well consulted on key issues, such as, uniform changes, policy changes and engagement activities.

Response to major incidents

- A major incident usually requires a special response from more than one emergency service to address an incident that affects a large number of people. It is important that these organisations work together in a co-ordinated manner.
- We saw examples where the service provided support to other providers in the event of potentially major incidents. The provider made their equipment and vehicles available to the local search and rescue team when they required it.
- An objective for organisations who respond to major incidents is to maintain normal services at an appropriate level. During a period of heavy snow, the service volunteered their 4X4 vehicles to collect NHS staff from their homes to transport them safely to work.
- As part of a routine request for data, prior to inspection, the provider told us they did not have a major incident plan. While the service did not have a plan in place, it was clear they had the capacity, training and equipment to offer valuable support in the event of a major incident. The service should have a major incident plan so all staff know and understand their role. These plans should also be tested and reviewed.
- As part of a routine request for data, prior to inspection, the provider told us they did not have a business continuity plan, however, when we inspected two months later, they had created a comprehensive business continuity plan.
- The provider's business continuity plan ensured there was a process for staff to follow to ensure business continuity. The plan identified potential disruptions such as prolonged loss of utilities or prolonged loss of IT equipment use. This plan covered the emergency response, incident management and business recovery in the event of such disruptions.

Are patient transport services effective?

Evidence-based care and treatment

- The service used and updated a staff handbook. This held all processes, procedures and policies to be followed by staff. The handbook was version controlled and updated following our inspection, to address areas that were not covered, for example 'Escalation of treatment and clinical leads'. However, individual policies within the handbook did not have a review date.
- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. The staff handbook and policies were well referenced. For example, the equal opportunities policy made reference to the Employment act of 1989, The Race Relations Act 1976 and The Sex Discrimination Acts of 1975 and 1986.

We also reviewed the infection control policy that included the World Health Organisation, five moments for hand hygiene; this gave clear guidance when staff were expected to clean their hands.

- The service monitored that transport was provided in line with local guidelines to ensure consistency of care. The service carried out audits to monitor staff compliance with policies and procedures, for example, driving assessments and documentation audits. However, the provider told us of some audits that were carried out where findings were not recorded, for example, vehicle cleanliness audits and hand hygiene audits.
- Staff assessed patient needs against protocols to provide care and transport. Staff assessed patients using The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- Remote workers had access to JRCALC guidelines. All staff we spoke with carried the JRCALC pocket book so they could have immediate access to the guidelines through-out patient care.

Assessment and planning of care

- People had comprehensive assessments of their needs. When accepting a booking, the call taker documented the type of transfer, the patient's needs and the level of clinician required. This handover identified the patient's mobility, clinical needs, mental and physical health and wellbeing.
- Staff were made aware of their patient's condition so that they could plan transport accordingly. The call taker passed all information to the crew assigned to the booking. Staff told us they assessed what the patient would need. For example, staff told us they would take a carry chair into the patient's property if the patient had reduced mobility.
- Discrimination was avoided when making care and treatment decisions. For example, staff did not assume reduced mobility because of a patient's age, staff told us if they were not advised of mobility concerns then they always assessed a patient's mobility upon arrival and would return to the ambulance for a carry chair if this was required.
- Staff assessed and monitored any patient they felt needed closer observation. Staff documented observations and assessments on patient report forms to recognise the deteriorating patient so care could be planned accordingly.
- Staff assessed pain for those patients requiring closer observation using the numeric rating scale (NRS-11). The NRS-11 is an 11-point scale (0 to 10) used for adults and children, aged 10 and above, to self-report their pain. Patients were asked to rate their pain out of 10, 10 being the worst pain and zero being no pain. We saw evidence that staff routinely documented two pain scores for all the records we reviewed.
- Staff told us they would offer pain relief to patients in the event that they reported pain, however, we did not see any patient report forms that required the administration of pain relief.

Response times and patient outcomes

- The service provided 26 patient journeys for the provider they were contracted to and three transports from events. They also provided two private transport and two charitable transports during the reporting period, from January 2017 to January 2018.
- The service was accountable to key performance indicators for response times set by and agreed with a provider the service was contracted to. We saw performance review meeting minutes with this provider that showed the service responded within their assigned target times.
- Bookings were usually made for the following day however some bookings required a four hour response. The service did not monitor exact response time. The service only monitored if they were responding to patients within the target response times. The service responded within target to 100% of all accepted bookings requiring a four hour response time.
- The service provided an emergency response where an emergency vehicle would be dispatched immediately. However, the service did not carry out any emergency responses during the reporting period from January 2017 to January 2018, so we were unable to review the response times for this element.

Competent staff

- New staff were supported into their role. The registered manager told us all staff went through an induction programme. This programme included vehicle and equipment familiarisation and a review of all policies and procedures as well as a multiple-choice exam.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The staff handbook stated that all staff would be provided with first aid, manual handling and automatic emergency defibrillator use at induction. The staff files we looked at evidenced competencies above this minimum level of training and included a significant number of certificates in other areas of training, such as 'PREVENT' and infection, prevention and control. Prevent is about safeguarding people and communities from the threat of terrorism
- Staff were supported to maintain and further develop their professional skills and experience. The provider organised and ran continuous professional development days every six months. These days covered a variety of areas such as basic first aid, advanced life support and management of the trauma patient. Staff of different skill levels attended, from a basic first aider to a consultant. The registered manager told us it was important that everyone had a voice and was able to learn from each other's experiences regardless of skill level.
- The learning needs of staff were identified and training was put in place to meet these learning needs. Staff told us, if they had any training needs or queries, management would run training sessions and scenario based training one to one by a qualified trainer. Although this showed good one to one development, provided to the needs of the individual, it was not formally documented. This meant learning was not available to be shared to the wider team.
- Staff had the right qualifications, skills, knowledge and experience to drive ambulances safely and responsibly. All of the staff folders we reviewed contained a copy of their driving licence and C1 entitlement. A C1 driving licence qualified staff to drive medium sized vehicles between 3,500 and 7,500kg.
- Staff had the right qualifications and skills to drive ambulances on blue lights. The Road Safety Act 2006, Section 19 (2)(a) states 'exemptions from speed limits does not apply unless the vehicle is being driven by a person who has satisfactorily completed a course of training in the driving of vehicles at high speed'. Emergency blue light training gives emergency responders the skills required to make rapid, smooth and safe progress to their destination. All of the staff files we reviewed contained a copy of their blue light driving certificate.
- The service did not accept drivers with more than six points on their license. Staff were expected to report any points on their license throughout their employment. The service had been running just over a year, the provider told us they planned to carry out a compliance check of all driving licenses annually.
- Staff were supported to deliver effective care and treatment through appraisal. The company had been carrying on regulated activity for little over a year. Staff appraisals had begun and they were 60% complete. However, staff appraisals were not officially documented. This meant the provider could not monitor improvements or the achievements of targets set during the appraisal.
- We raised this with the provider; following our inspection, the provider had designed a performance appraisal form to document discussions at appraisal meetings. This form covered performance evaluation, areas for improvement, areas of success and an area to identify objectives. We saw evidence that this new appraisal form was being used. The revised appraisal rate, following our inspection, had improved to 76%.

Coordination with other providers and multi-disciplinary working

- All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. The provider had a contract with a private hospital. The registered manager met with this provider every six months to discuss transport statistics, key performance indicators and patient satisfaction results.
- We reviewed feedback from the procurement manager of the private hospital, who stated that 'the contract had run well' and they 'were operating at a satisfactory level with no issues raised'. The feedback also noted that Platinum Ambulance Service had attended 100% of performance review meetings.

- Staff worked collaboratively to understand and meet the range and complexity of people's needs. Staff told us that before an event, staff and managers attended briefings with event organisers to discuss any risks and expectations of the event. This would include the type of population expected at the event, enabling staff to understand the needs of the population they would be providing services to.
- Staff coordinated well with NHS providers. They had good links with the safeguarding team and the clinical help desk at a local NHS Ambulance Trust.
- The provider did not clearly identify who had clinical lead when an escort accompanied a patient. This meant they could not be assured that both the staff and the hospital escort could provide quick and effective leadership if a patient deteriorated. Following our inspection, the provider updated the staff handbook to detail who had clinical responsibility for the patient throughout a journey. The provider also shared and agreed this with their contractor.

Access to information

- Staff had access to the information they needed to assess, plan and deliver care to people in a timely way. Staff were prepared for any special requirements for each patient they attended. Special notes, advanced care plans and do not attempt cardiopulmonary resuscitation (DNACPR) orders were communicated when a booking was made. A DNACPR order is a document issued and signed by a doctor, which tells a medical team not to attempt cardiopulmonary resuscitation (CPR).
- The death in transit policy clearly detailed the specific requirements of a DNACPR policy. Staff were made aware that they were required to see an original DNACPR that was correctly completed before making any decision to not attempt resuscitation.
- The service had accurate and up-to-date satellite navigation systems. The registered manager told us that the satellite navigation was updated every two months.
- Staff had access to information to support their decision making. Staff we spoke with showed us they carried a JRCALC pocket book, a sepsis decision card and a falls decision tree card. A sepsis card enables staff to easily assess a patient's risk of sepsis by monitoring a patient's observations. A falls decision tree gives staff a step by step approach to evaluating the risk factors surrounding a fall.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had regard for the Mental Health Act Code of Practice. Staff had received training to care for patients experiencing a mental health crisis. All staff records we reviewed held up to date training records for Mental Capacity Act training.
- The staff handbook included a section on mental capacity. This defined the process of assessing capacity. However, there were no capacity forms on the ambulance. This meant the provider could not be assured that capacity assessments were undertaken in line with best practice and national guidance.
- Staff we spoke with understood the relevant consent and decision making requirements of legislation and guidance including the Mental Capacity Act 2005. For example, staff told us they always gained consent before carrying out observations but only documented this when a patient's mental capacity was questioned and assessed.
- Staff knew the importance of giving patients the positives and negatives of each option so they were able to make their own decisions. For example, staff would explain the risks surrounding walking to the vehicle against being pushed in a carry chair so that a patient could make their own risk assessments and make decisions for themselves.
- The staff handbook included a section titled 'acting in the best interests of the patient'. This listed key areas that staff had to be able to show when making a best interest decision for a patient. Staff we spoke with were familiar with the requirements of a best interest decision.
- During the reporting period, from January 2017 to January 2018, the provider had not transferred any patients subject to the mental health act.

Are patient transport services caring?

Compassionate care

Patient transport services (PTS)

- Staff told us they took the time to interact with people who used the service and those close to them in a respectful and considerate manner. A member of staff told us they always introduced themselves to patients and their loved ones so that everyone felt involved.
- Staff told us they showed an encouraging, sensitive and supportive attitude to their patients. A member of staff told us they always encouraged patients to be independent and supported them in any way they could.
- We reviewed four satisfaction surveys. All four patients gave the highest rating in all areas of care. All patient comments were positive, for example, a patient described the staff as 'fantastic, professional and caring' and 'excellent in every way'.
- Staff gave us examples of when patients' privacy and dignity was respected. They told us they used blankets to cover patients and completed examinations in private in the enclosed ambulance.

Understanding and involvement of patients and those close to them

- Staff told us they communicated with patients so that they understood their care and treatment. Staff told us they always explained what they were doing and answered any questions patients had as best they could.
- Staff told us they routinely involved people in making decisions about their care and treatment. For example, staff told us they always asked patients how they would prefer to be transported, sitting or lying down.
- Staff told us they recognised when patients needed additional support to help them understand their care. Staff told us they asked the patient or their loved ones how best to manage barriers. For a patient who was hard of hearing, staff would ask the patient how they would prefer to be communicated with for example, speaking loudly, written communication or slowly to enable lip reading.

Emotional support

- Staff told us they supported patients during distressing times. Staff told us they always tried to engage with their patients and make them feel truly cared for. A member of staff told us they cared for every patient as they would expect their mother to be cared for.
- Patient comments demonstrated a caring and supportive attitude from staff. For example, staff were described as 'fun and friendly' and they went 'above and beyond'.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The service provided event cover for national events, transport for national charities and patient transport for a private hospital. The provider covered the population of the UK. The provider reported two occasions where they could not accept a booking due to the short notice of the booking request. The provider recognised that having only two vehicles made short notice booking requests more difficult to respond to. The provider did not commit to any bookings unless they knew they had the vehicle and staff to provide that service.
- The services provided reflected the needs of the population served. The service worked with event organisers to identify and manage risks so they could plan services accordingly. The service paid particular attention to the extreme sporting events. For example, the provider purchased a warming suit for events that posed hypothermia risks to patients.
- The facilities were appropriate for the services that were planned and delivered. The service had carefully considered their resources to enable them to plan effectively. For example, the service had 4X4's so they could better respond to patients in areas an ambulance vehicle would be unable to access.
- Although the provider did not provide services directly to the local population. Their 4X4s were made available to the local search and rescue team to help deliver the needs of local people.

Meeting people's individual needs

Patient transport services (PTS)

- The needs of different people were taken into account when planning and delivering services. All staff records we reviewed contained equality and diversity training certificates. This meant the provider could be assured that all staff had been trained to consider the needs of different people when delivering care, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- A staff member we spoke with told us that a good way to meet people's needs was to ask the patient's themselves. For example, the staff member told us, where possible, they would ask if a female patient would feel more comfortable with a female member of staff carrying out physical assessments.
- There was translation support available for staff in the treatment of people who could not speak English. The registered manager told us the director spoke Spanish, French, Italian and had an understanding of other languages. All staff were able to contact the director for translation support. In the event the registered manager could not help, staff told us they had access to a language translation telephone support team who provided language interpretation for healthcare in over 200 languages. This service was accessed using a pin from the local NHS ambulance trust. This enabled patients to understand and be involved in their care.
- Journeys were planned and carried out to account for a patient's hydration and toileting needs. We saw that water was available on both vehicles we inspected and containers were available for toileting needs during a journey.
- Services were delivered to take account of the differing needs of patients. For example, a staff member told us when caring for a patient living with dementia they ensured they spoke to them in a calm and collected way. They maintained eye contact at the patient's level and regularly reassured them throughout the journey. All staff had completed a full module on dementia training.
- Reasonable adjustments were made so that patients with disabilities could access and use services on an equal basis to others. For example, both ambulances we inspected had a tailgate which enabled wheelchair users to access the ambulance safely. There was also sufficient space for a wheelchair inside the ambulance.

Access and flow

- People could access the right care at the right time. Bookings were received via phone, email and online. This meant patients had a variety of options available to access care. The booking information was recorded so that the right staff, of the correct skill level, were assigned to a booking. Services were provided at the right time because bookings were not accepted without ensuring the resources were available.
- Access to care was managed to take account of people's needs. The provider outsourced bookings for children and bariatric patients because they recognised they did not have the facilities to appropriately manage these needs.
- The booking system was easy to use and supported people to make bookings. For example, we saw that patients could easily request information on 'how to make a booking' online. The response time for this contact was under two minutes
- The service had an up to date website. The website was easy to navigate and clearly detailed the services the provider offered.
- Waiting times and delays were minimal. There was only one occasion the service was late, and the patient was kept informed. The delay was managed appropriately and an incident report form was filled out.
- Cancellations were minimal. The provider reported one cancellation. This was because the patient was assessed as not well enough to travel.

Learning from complaints and concerns

- The service reported they had received no complaints, during the reporting period, from January 2017 to January 2018.
- The CQC did not receive any complaints or concerns for this service, during the reporting period, from January 2017 to January 2018.
- The service had a complaints policy that clearly detailed the complaints procedure. This policy stated that all

complaints would be responded to within two days and investigations would be completed within 28 days. The policy stated the importance of keeping the complainant informed and outlined the importance of carrying out investigations fairly. As the service had not received any complaints during the reporting period, we could not determine whether the service was in keeping with their own policy timelines.

- We reviewed the complaints policy within the staff handbook. Although it contained clear guidance on how to manage a complaint, the policy did not specify a review date. Without regular reviews, the provider could not be assured the policy was current and accurate.
- People who used the service could not easily make a complaint or raise concerns. Although there were feedback forms available on the ambulance, these were only available to patients if they were offered or requested one. There was not clear information about how to make a complaint displayed inside ambulances or on the provider's website. This meant the provider could have been missing opportunities to learn from complaints.
- We raised this with the provider. Following our inspection, the provider placed signs within the ambulance to inform patients how to access their complaints procedure. The sign directed patients to their complaints procedure. The sign also signposted patients to their social media page where they could leave feedback.

Are patient transport services well-led?

Vision and strategy for this core service

- There was a clear statement of vision and values, driven by quality and safety. The company's mission statement covered three areas; 'To provide high quality care', 'to promote health, safety and welfare', and to 'support local charities, hospices and those in need'.
- The vision had remained achievable and relevant. There was a cost to the company when providing free support to charity at events. The service had taken on private work, repatriation, and a contract with a private hospital so that the voluntary support for charities could continue.
- The registered manager told us they wanted to expand in repatriation and insurance contracts but did not have a desire to be a large company as this was not in line with their vision.
- We asked staff what the vision was, the response was varied. There was a consistent belief that the vision was to provide good quality care, however there was no mention of the company's commitment to charitable work or the importance of safety. This demonstrated that the vision had not been thoroughly embedded.

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

- There was a new governance framework to support the delivery of the strategy but the effectiveness of this framework was unclear and was not thoroughly embedded. While there was a clinical and operational lead, it appeared that staff still directed some operational queries or concerns to the registered manager. It was also apparent that staff directed all clinical concerns directly to the registered manager. We raised this with the provider, who accepted that the governance structure was still in its infancy.
- There was no meeting schedule in place for regular formal meetings with the clinical and operational leads. This meant the provider could not be assured that the senior team regularly monitored and managed risks. We raised this with the provider. Following our inspection, the provider told us they had scheduled meetings with staff every 12 weeks.
- As part of a routine request for data, prior to inspection, the provider told us they did not have a risk register. However, by the time we inspected approximately three months later, the provider had created a risk register.
- The risk register identified, understood, addressed and monitored current and future risks. For example, a risk of staff carrying out incorrect practice.
- The risk register recognised that 'staff working too many hours' was a risk. However, this addressed the hours working for platinum ambulance service. The service did not identify there was a risk associated with their

staff working for two employers. The provider could not be assured that staff were committing to work after a suitable rest period in line with The Working Time Regulations 1998, regulation 10 (1).

- Policies did not always state a review date. All policies were part of the staff handbook. The handbook did make reference to an annual review, however, this did not clearly name a date for the provider to action this review. This meant that the provider could not be assured that all of their policies would remain up to date and current.
- The provider included Disclosure and Barring Service (DBS) checks as part of their pre-employment checks. The disclosure and barring service helps employers assess the suitability of potential staff that will be working with vulnerable groups. All of the staff records we reviewed held copies of DBS certificates that were obtained within the last three years.
- The provider did not have a clear and defined auditing schedule. This meant the provider did not have assurance that all systems were effective. The provider told us they completed audits, however, they did not document their results. This meant they could not identify themes and trends. We raised this with the provider. Following our inspection, the provider had arranged for an outside company to carry out regular audits to cover all aspects of health and safety.

Leadership

- The director and registered manager made up the senior management team. The registered manager was responsible for overseeing the day to day management of the service. The clinical lead and operational lead made up the leadership team. Concerns or queries were not directed formally to the relevant leads because the informal and family centred culture meant this structure was not embedded. This meant concerns were not always raised through the appropriate channels and so leads did not have sufficient oversight of their areas of responsibility.
- Leaders were not always clear about their roles and their accountability for quality. Leaders we spoke to were not always able to answer questions associated with their area of responsibility adequately and they did not have a clear outline of their responsibilities.
- The need to develop leaders was identified. The registered manager explained the leadership roles were still being developed and there were still areas of responsibility that needed to be handed over. The registered manager had started the company running most areas himself, and so he acknowledged that he needed to delegate responsibility to other leaders so that they could better take ownership of their role.
- Leaders did have the necessary experience, knowledge and capability to lead effectively. All members of the leadership team had extensive experience in the healthcare industry. However, the clinical lead was not employed by the service full time and so was not always available to the team. The lack of visibility meant staff felt more able to approach the registered manager for clinical advice. The provider could not be assured that the clinical lead could dedicate the appropriate level of commitment to ensure all clinical aspects of the service were well led. Following our inspection, the provider hired the support of another clinical lead who could commit more time to the role.
- Senior management were visible and approachable. All staff we spoke with told us they felt well supported by both the registered manager and the company director. Staff described the registered manager and director as their extended family.
- Leaders encouraged appreciative and supportive relationships among staff. Staff told us the registered manager and director regularly invited staff to have lunch with them. Staff felt these informal get-togethers made them feel appreciated and valued.

Culture within the service

- There was a culture of collective responsibility between teams and services. All staff mentioned ‘the platinum way’, this was a commitment to treating all staff as if they were family.
- There was a clear and consistent culture of being open and honest. Staff we spoke with told us they felt able to raise concerns or issues with each other. The provider had a whistleblowing policy which recognised the importance of staff being able to voice concerns. The policy set out their commitment to supporting andprotecting staff who raised concerns or areas of

malpractice. Staff felt able to speak to senior management, however, there was varied confidence that they would be listened to and their ideas supported.

- There was a consistent commitment to providing good quality care to patients. Staff took pride in their role. For example, one staff member actively completed additional training in their own time and regularly wrote reflective practice pieces to develop their skills and improve their delivery of care. We saw evidence of the extra training this staff member had undertook.
- Staff were happy working for the service and felt there was a positive open culture. Staff all spoke fondly of one another, including senior leaders, and were proud to work for the service.

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

- The service provided event cover and transport for charities. This was free of charge and enabled them to support fundraising activity for a variety of charities. All staff who participated in these events did so free of charge and had a commitment to giving back to the community through offering these services.
- The provider volunteered their knowledge and expertise to local schools. The registered manager told us they attended four local primary schools and delivered cardio pulmonary resuscitation (CPR) training to the children. We saw a display of children's drawings from these days displayed in the cabin.
- The provider volunteered their experiences to local high schools. This involved staff attending high schools to provide career advice. Staff would explain their role and give the young adults useful tips and guidance on how to pursue a career as a paramedic.
- The registered manager told us about a scheme they were in the process of setting up, where uniformed staff would attend local schools to listen to young children read. Their theory was that reading to a member of staff in uniform would inspire children to engage with reading.
- The service had a variety of methods to engage with their patients to assess the quality of their service. A patient feedback form was kept in the ambulance and patients were encouraged to leave feedback using social media, letter or email. The service website was also clearly laid out and displayed a variety of contact details available including mobile phone and landline.
- As part of a routine request for data, prior to inspection, the provider told us they had not completed any staff surveys. At the time of our inspection, three months later, the service had completed a short staff survey using a social media platform. Although the results were very positive the survey was not anonymised so staff may not have felt able to give honest feedback.

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

- The service was committed to increasing the support it could give to charities. The registered manager told us the charities they work with had recognised Platinum Ambulance Service as their preferred medical provider for events.
- Throughout the inspection process, the service was quick to respond to and rectify concerns raised by the inspection team. This willingness demonstrated a commitment to improve the service they provided.

Outstanding practice and areas for improvement

Outstanding practice

- The service provided free event cover and transport to charities to support their fundraising activity and was committed to increasing the support it could give to charities.
- Staff were supported to maintain and further develop their professional skills and experience. The provider organised and ran continuous professional development days every six months. These days covered a variety of areas such as basic first aid, advanced life support and management of the trauma patient.
- During a period of heavy snow, the service volunteered their 4X4 vehicles to collect NHS staff from their homes to transport them safely to work.

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure effective governance systems, policies and procedures to assess, monitor and improve the quality and safety of the service.
- The provider must have an accessible policy for safeguarding adults and children that is individualised for Platinum Ambulance Service.

Action the hospital SHOULD take to improve

- The provider should ensure staff have ongoing understanding of what should be reported as an incident.
- The provider should ensure all policies and procedures have a planned review date and updates are clearly recorded.
- The provider should ensure they complete and record hand hygiene audits.
- The provider should ensure they record and monitor audit results in all areas of health and safety so they can identify themes and trends to action improvement.
- The service should ensure they have the correct policies and procedures in place to identify when a statutory notification must be submitted to the care quality Commission. This is a regulatory duty and must include the notifying of any allegations of abuse toward staff
- The provider should consider the availability of child seatbelts, in line with their own policy.
- The provider should ensure there is a resuscitation policy that details the protocol to be used when commencing cardio pulmonary resuscitation.
- The provider should ensure they share learning from one to one training with the entire team.
- The provider should ensure capacity assessment forms are available on the ambulance for staff to follow and complete. This is to provide assurance that capacity assessments are undertaken in line with best practice and national guidance.
- The provider should ensure there is a major incident plan so all staff know and understand their role. These plans should also be tested and reviewed.
- The provider should ensure that staff are committing to work after a suitable rest period in line with The Working Time Regulations 1998, regulation 10 (1). The provider should further develop their staff survey so that staff can provide anonymised feedback.
- The provider should further develop their staff survey so that staff can provide anonymised feedback.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The service did not have their own adult and child safeguarding policy.** **The service did not have a procedure to report safeguarding concerns directly to the local authority.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The service described examples of incidents to us, during the inspection, that had not been reported.** **There was no recording or monitoring of audit results.** **The service did not have clear lines of responsibility or escalation within the governance structure**