Reliance Ambulance Service Ltd

Reliance Ambulance Station

Inspection report

Reliance Ambulance Service, Unit B1a
Fairoaks Airport, Chobham
Woking
GU24 8HU
Tel: 01276423553
www.relianceambulance.co.uk

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We are placing the service into special measures. This is because the service was rated as inadequate. Following our inspection we also served the provider with a warning notice in response to concerns they were failing to comply with Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

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. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated it as inadequate because:

- The service could not provide assurance that infection risks were controlled well through consistent standards of cleanliness.
- There was not a system to demonstrate or monitor if the staff had training in key skills.
- The service did not safely manage or store medicines, including medical gases.
- Staff did not collect safety information or use it to improve the service. The service did not investigate incidents in line with their policy and did not share lessons learnt from incidents.
- The service did not investigate complaints in line with their policy.
- Leaders were not always clear about their roles and accountabilities.
- Leaders did not monitor the effectiveness of the service. The were no, key performance indicators to enable senior staff to monitor response or journey times.
- There was no system to monitor if staff had reviewed information such as company policies and procedures.
- The service did not have a vision and strategy.
- Leaders did not effectively identify, address and mitigate key risks the service faced.
- There was limited evidence of regular staff and leader's engagement. The service had limited systems and processes to engage patients and the community to plan and manage services.
- There were limited systems and processes to take account of patients' individual needs.

However:

- Key services were available seven days a week.
- The service had adequate supplies of personal protective equipment at the base and within vehicles.
- The service had enough suitable equipment including defibrillation equipment and manual handling aids.

We rated this service as inadequate because it was inadequate in safe, effective, responsive and well led; and unrated in caring.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inadequate 	See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Reliance Ambulance Station

Reliance Ambulance Station is operated by Reliance Ambulance Service Limited. It is an independent ambulance service is based in Woking. The service is based at Fairoaks airport.

They provide private patient transport and also undertakes patient transport for a local NHS trust and an NHS Ambulance service.

The service registered with CQC in June 2020. They are registered to undertake the regulated activity of Transport services, triage and medical advice provided remotely.

The service did not transport children or patients detained under the Mental Health Act 1983.

The service had a registered manager in post at the time of inspection.

How we carried out this inspection

We carried out this unannounced inspection using our comprehensive inspection methodology on 13 January 2022.

During the inspection process we:

- Looked at the quality of the environment; this included the office, staffroom, staff kitchen, storage areas, and service vehicles. We interviewed the leaders of the service, spoke to one staff member, reviewed patient and staff records and reviewed a variety of policies and policies.

The inspection team consisted of two CQC inspectors and a specialist advisor with expertise in patient transport services.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure all vehicles are cleaned and maintained in line with national guidance and company policy and is clearly recorded. Regulation 12. (2).
- The service safeguarding policies and procedures are understood and followed by all staff. and staff are aware of who to contact for safeguarding advice. Regulation 13 (2).
- The service must ensure it undertakes audits on patient records in line existing policy. Regulation 12. (2)
- The service must ensure there is an effective process to share learning from incidents with all staff. Regulation 12. (2).

Summary of this inspection

- The service must ensure all medical gases are stored safely, in line with policy, and pose no health and safety risks. Regulation 12. (2).
- The service must ensure it is compliant with Control of Substances Hazardous to Health Regulations (COSHH) and must assess the risks associated with the use of chemicals, solvents and other agents, and take all necessary steps to prevent exposure to risks. Regulation 12. (2).
- The service must ensure there are communication and translation aids, and translation services are available to patients whose first language is not English. Regulation 12 (2)
- The service must ensure complaints are investigated in accordance with their own policy, to includes investigation of the complaint, and identification of learning. Regulation 16 (1).
- The service must ensure there is a robust system to record all staff have read and understood company policies, and to monitor compliance with these policies. Regulation 17 2)
- The service must ensure that there is an effective system to enable oversight of mandatory training and key skills. Regulation 17 (2).
- The service must ensure all leaders can clearly articulate their roles and responsibilities within the organisation, and the duties delegated to them within company policies. Regulation 17 (2).
- The service must ensure leaders are aware of risks to the service as recorded on the risk register. Regulation 17 (2).
- The service must ensure all leaders are able to access electronic files and systems relevant to their role, and that files contain all information specified within the relevant policies. Regulation 17 (2).
- The service must ensure the risk management process identifies current risks to the service, monitors and identifies actions to reduce the level of risk, and risks are kept under review. Regulation 17 (2).
- The service must ensure that risks are assessed, monitored and mitigated to improve the quality and safety of services provided (including the quality of the experience of service users in receiving those services) through use of effective patient feedback gathering. Regulation 17 (2).
- The service must ensure existing systems are utilised for all patient transport journeys so that that there is an effective process in place to record patient specific information where it relates to risk. Regulation 12 (2)
- The service must ensure incidents are investigated in accordance with their own policy, which includes analysis of the incident and identification of learning from the incident. Regulation 17 (2).
- The service must ensure governance processes provide assurance about the quality of the service provided, including audits, and that all staff are aware of the required frequency and recording of these. Regulation 17 (2).
- The service must ensure all infection prevention and control audits are effective and recorded regularly, in line with national guidance and the provider's policy. Regulation 17 (2).
- The service must ensure policies accurately reflect the service provided and current national guidance. And that compliance with policies is monitored and reported on as stated in those polices. Regulation 17 (2).

Action the service SHOULD take to improve:

- The service should consider the use of an independent adjudication service or other method as means of escalation when internal complaints processes have been exhausted.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate

Inadequate

Patient transport services

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Inadequate
Well-led	Inadequate

Are Patient transport services safe?

Inadequate

We rated it as inadequate.

Mandatory training

The service did not have an effective process to monitor mandatory training in staff key skills and were therefore not assured that staff were up to date with mandatory training.

We saw a notice that specified to staff the mandatory training they were expected to undertake. This included training on moving and handling, infection prevention and control, and dementia awareness.

Leaders told us they used an online platform to support delivering mandatory training. However, we saw no evidence to support this.

Following the inspection, we asked to see training records and the mandatory training policy for staff, but the service told us that they could not provide the record and the service did not provide a mandatory training policy.

Some staff told us they had completed training, but we saw no evidence of this. This meant leaders did not have oversight of mandatory training completion. The service was not assured staff had the correct training and skills to deliver the service safely.

Safeguarding

Staff did not understand how to protect patients from abuse. Staff had not received training on how to recognise and report abuse.

The safeguarding lead for the service had recently left the organisation. We asked leaders who the current safeguarding lead was, but they were unable to give an answer. Following inspection, the service provided documents in relation to safeguarding and this stated there was not currently a lead.

Leaders told us staff undertook safeguarding training online but were unable to provide evidence to support this.

We spoke with a staff member who told us they had completed safeguarding training. However, they were unable to discuss safeguarding processes and procedures in a way that demonstrated they understood how to protect patients from abuse.

This meant the service was not assured staff had the training and knowledge to recognise and report abuse. There was also not a designated person with the knowledge to advise and support staff with safeguarding concerns and reporting.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. They did not always keep equipment, vehicles and the premises visibly clean. Staff used some equipment and control measures to protect patients, themselves and others from infection.

Leaders and staff told us they followed infection control principles including the use of personal protective equipment (PPE). We saw the service had adequate supplies of these at their base and within vehicles. The service base was visibly clean.

We inspected two ambulance vehicles used by the service and found some areas of insufficient cleaning.

We inspected one ambulance vehicle which was not in use on the day of inspection and we saw that it was visibly clean and contained ample PPE for staff and patients.

A second ambulance vehicle that the service told us was about to be deployed had areas on the floor which were visibly dirty. There was also visible soiling on a stretcher. Overhead lockers contained visible dust and dirt, a liquid had leaked in the locker which contained PPE equipment including masks, gloves and aprons which were wet. We brought these areas to the attention of staff who told us they would clean them.

The second vehicle also contained a bag of dirty linen that was being stored within the vehicle until it could be dropped off for cleaning.

During inspection we saw two infection prevention and control (IPC) policies, there were copies of these in the staff policy folder. These contained conflicting information with regard to the products to be used for cleaning. The IPC policies were issued in June and November 2020, there was no reference or amendment to guidance to these policies with regard to COVID-19 IPC. For example, the IPC policy did not specify the use of surgical face masks to be used at any time other than when there was a risk of fluids coming into contact with the mouth. Therefore, the policy did not reflect national guidance, or the measures being taken at the time it was developed. It also did not reflect what we saw on inspection as all staff were wearing face masks.

Following inspection the service supplied an IPC policy with respect to COVID-19. This policy was not in the staff policy folder during inspection. All IPC policies for the service contained conflicting information with regard to the products to be used for cleaning, it was also not clear which IPC policy should be used by staff. There was no evidence of specific training with regard to COVID-19 PPE measures. There was no system to record if staff had read policies for the service so it could not be determined if staff were familiar with these documents.

The service used a cleaning product within vehicles that was kept in a reusable spray bottle. This product was used to clean all surfaces within the vehicles. Staff told us the person responsible for cleaning provided these bottles and they already contained the cleaning product. We saw that these bottles were not labelled to show when the product was prepared, and staff told us they did not know this. This meant there was a risk that cleaning would be ineffective due to

the product having a limited shelf life once diluted. This also not in line with COSHH requirements. Under the Control of Substances Hazardous to Health Regulations 2002 (COSHH), an employer has a duty to protect its workers from exposure. This means it must assess the risks associated with the use of chemicals, solvents and other agents, and take all necessary steps to prevent exposure to risks.

The service IPC policy detailed auditing of practice. This included observational audits of hand hygiene, cleaning, and correct use of personal protective equipment. However, when we requested these, the service was unable to provide evidence that these audits had been performed. The director who was responsible for cleaning was unable to provide any details in relation to these audits during inspection.

The service supplied staff with uniform, and we saw that all staff wore this and were bare below the elbow. We were told that staff washed their own uniform, there was no guidance for staff within the IPC policies in the staff folder, this meant there was a risk of cross contamination with the staff's personal items and possibility of ineffective washing temperatures.

There was sufficient access to antibacterial hand gels in all areas.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff managed clinical waste well. However, we saw limited evidence that staff were trained to use equipment.

The service provided 24 hour access to the ambulance base and cleaning, storage area. The outside areas of the ambulance base were also monitored with security cameras. All keys for service vehicles were stored in a lockable wall mounted box.

We saw records that related to the servicing of company vehicles and appropriate external tests to ensure they were roadworthy had been completed.

The provider's policy stated staff should undertake daily safety checks of vehicles by a vehicle inspection log. However, staff were not using the vehicle inspections logs at the time of inspection and leaders told us they were aware of this.

The service had enough suitable equipment to help them to safely care for patients. We saw that vehicles contained emergency equipment including defibrillation equipment and manual handling aids. All equipment we saw was labelled to show it had been appropriately serviced and electrical testing undertaken.

Staff disposed of clinical waste safely. We saw that there were designated bins for the disposal of clinical waste, and these were locked. The service provided documents that showed they had a contract for the regular removal of clinical waste.

Assessing and responding to patient risk

Staff completed limited risk assessments for each patient. Staff did not have clear processes to follow to identify and act upon patients at risk of deterioration.

Leaders told us that no staff had completed personalised risk assessments about the exposure to COVID-19. The meant staff employed by the service that may have a higher risk of becoming seriously ill if they were vulnerable to COVID-19.

Inadequate

Patient transport services

The service had a policy for responding to a patient in cardiac arrest. However, the service did not have a policy for recognising deteriorating patients. The policy for cardiac arrest and defibrillation also referenced guidance that was not the most recent version and were not the most appropriate for its setting. For example, the adult and paediatric advanced life support sequence referenced in the document were for use in a clinical setting such as a hospital and referred to calling for support from a resuscitation team.

The service was providing services for an NHS ambulance service at the time of inspection. However, the service had not taken measures to specify to the NHS ambulance service what patients it could transport and therefore there was a risk that staff would not always have the facilities to provide the service. For example, the service said it could be allocated jobs involving children but did not have the necessary equipment in all vehicles to safely transport these patients. This could lead to significant delays to service while equipment was sourced.

When the service completed transfers for the NHS ambulance service, patient details were provided on a handheld electronic device. This contained detail associated with risks including mobility and IPC risks.

We were told staff checked all patient information, including if there was a Do not attempt cardio pulmonary resuscitation (DNACPR) decision in place; however there was limited space for this to be recorded on the daily log sheets used when undertaking transport for the NHS ambulance service as these did not contain areas for individual patient details. Therefore the provider could not be assured these checks were being carried out.

When patients booked private transport services, the online booking form asked relevant questions about patient mobility and health. This would be used to support the staff and patient to provide safe care and mitigate and risks. The journey log sheet for private transport patients had appropriate areas to record relevant information such as mobility and if there was a DNACPR in place.

Leaders told us they did not have an acceptance and exclusion policy in place to determine what bookings they would accept; this process was instead done based on the staff taking the booking knowing what the service could accept. There was no evidenced training in place to support this decision making process.

The service website did not make clear what patients they could accept and instead encouraged booking information to be supplied in full before accepting a job. This could lead to a delay in a patient obtaining a booking if the service could not provide care and needed to contact another service.

Each vehicle carried a breakdown assistance card that enabled them to obtain vehicle recovery and maintenance support urgently.

Staffing

The service had enough staff but were not assured they always had the right qualifications, skills, training and experience to keep patients safe from avoidable harm. There was not an established induction process. Leaders reviewed and adjusted staffing levels.

The service had enough staff to keep patients safe in line with service agreements. Leaders told us staff shifts would be allocated to permanent staff in the first instance, and any remaining uncovered shifts could be allocated to bank staff.

Inadequate

Patient transport services

The service employed operational staff to provide the patient transport service alongside two directors and a registered manager. The operations manager that oversaw the day-to-day running of the service had recently left; leaders told us they planned to recruit to the role but had not yet started this process. This meant that some tasks allocated to this staff role were vacant, for example there was no safeguarding lead.

We were told if staff shortages led to gaps in staffing, that leaders would cover theses shifts.

The service had a recruitment policy that included requirements for references, background checks and employment history checks. However, the service did not consistently follow this practice. We looked at the recruitment records for five members of staff and found gaps in documentation. The service did not always document health declarations from staff and no staff folders contained personal risk assessments in relation to COVID-19 to identify staff who may be vulnerable. Although the service requested COVID-19 vaccination records, for one staff member these were not recorded.

All staff records contained a disclosure barring service (DBS) check. However, in one record this check was a copy of a certificate and no independent check had been made to verify this information, this was not in line with the providers own policy. In addition, to these photocopies of identification documents and DBS checks had been retained for more than six months since start of employment, and this was not in line with the services own policies.

Leaders told us they had implemented an induction process through a handbook, but we did not see any completed examples of this when asked.

We saw the provider had a disciplinary policy which included addressing behaviour and performance issues, there was also a misuse of alcohol and drugs policy. However these policies referred to staff groups and supportive services that were not present in the service.

Records

Staff kept some detailed records of patients' care and treatment. Records were stored securely.

The serviced completed patient care records for some patient settings such as private transport. We saw that these contained appropriate areas for clinical information. However, the service policy stated that these records should only be kept for a limited time period, leaders were not aware what this time period would be.

Paper records were stored securely in a locked cabinet.

When the service undertook patient transport work on behalf of the NHS, they received all patient information on handheld devices, these were secure and when a patient conveyance was completed the information would be removed automatically. This measure help keep patient information, such as home address and health details secure.

Medicines

The service did not always follow best practice when storing medicines.

The service had an in date medical gas policy. The policy provided clear guidance to staff on the use, administration and transportation of medical gases.

Inadequate

Patient transport services

We saw that oxygen stored in ambulances was securely fixed within the vehicle. The service had an external locked cage to store spare and used oxygen cylinders. This was clearly labelled to show empty and full cylinder areas. This system provided easy access for staff to replenish cylinders, while preventing unauthorised access.

However, we found an unlocked vehicle belonging to the service which contained 'over-the–counter' medicines. These are medicines that you can buy without a prescription. These were being stored in temperatures not recommended by the manufacturer. There was also a cylinder of Nitrous Oxide within the vehicle that could be accessed by the public. We made the service aware of this and saw that they took steps to restrict access by locking the vehicle.

Incidents

The service did not manage patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. However, leaders did not always investigate them.

The service had an adverse incident policy and associated flow charts to demonstrate how incidents should be investigated. However, the policy did not match the service being provided and referred to staff groups and investigating tools that were not in place in the service.

Staff knew what incidents to report and how to report them. We saw evidence of a patient safety incident the month prior to inspection, and that it had been reported in line with service policy. We saw the staff involved in the incident had taken steps to apologise to the patient in the first instance.

However, there was limited information to support any action had been taken by leaders in relation to this incident.

Are Patient transport services effective?

Inadequate

We rated it as inadequate.

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice.

Policies and procedures did not support staff to manage patients in a way that followed national guidance. Detail in policies did not always reflect the service and therefore did not support the delivery of an effective service.

We reviewed several policies and guidance documents available to staff. These did always reflect national guidance. For example, the cardiac arrest and defibrillation policies referenced guidance that was not in date at the time the policy was reviewed. There was also no reference to COVID-19 infection prevention and control this within two of the infection prevention and control (IPC) policies for the service.

Within policies there was also reference to government bodies and organisations that did not exist at the time of review, for example the whistleblowing policy referenced reporting to the audit commission which was dissolved in 2015.

The service had some systems to ensure staff understood changes to policies and procedures. Staff had access to policies and procedures as paper copies in the staff room. However, there was no system in place to monitor is staff had read policies and procedures. The service also did not perform clinical audit or record observational checks to evidence that staff followed these.

Nutrition and hydration

Staff assessed patients' drinking requirements to meet their needs.

The service undertook transfers and discharges within the local area. We saw all vehicles inspected were stocked with bottles of water.

Response times

The service monitored privately booked response times but there was limited evidence to demonstrate this was used to make improvements. The service did not monitor any NHS response times.

Leaders told us they had not received any concerns from the NHS ambulance service or hospital regarding transfer times in the 12 months prior to our inspection.

When the service undertook patient transport for an NHS ambulance service, transfer times were monitored by the service they provided this for. The service did not monitor its own compliance with NHS ambulance service key performance indicators and did not have a process for this. The service logged vehicle mileage and usage but not individual journey times. The service told us they planned to meet with the NHS ambulance trust at regular intervals to discuss their service and how they could improve but had not yet made plans to do this. The service also did not have a contract in place to assure them they were not required to monitor their performance

The service had systems to monitor response times for private ambulance services. Staff recorded the time they left base, the time they arrived at the destination to collect the patient, the time they left to transport the patient to their destination and the time of arrival at the destination. However, the service did not use the recorded information it collected for private transport patients to review the quality of the service. There were no internal measures in place such as key performance indicators to enable leaders to monitor response or journey times.

This meant that quality and effectiveness of the service regarding services provided to private and NHS patient transport services were monitored was not assured.

Competent staff

There was limited evidence the service made sure staff were competent for their roles.

The service had an appraisal policy. However, when we asked to see evidence of appraisals, leaders told us they had no staff in post for more than one year and therefore no staff had completed an appraisal.

Leaders completed staff records of relevant existing training when staff were recruited. However, we saw no evidence of how leaders were assured staff maintained competency and there was not an effective system in place to record ongoing training.

The service employed some members of staff who were required to be registered with a governing body such as the Health and Care Professions Council (HCPC). We saw no evidence to support how the service was assured that staff who were registered with these bodies, had continued to maintain this registration after recruitment was complete.

Inadequate

Patient transport services

Staff were required to maintain a valid UK driving licence with no more than six penalty points. The registered manager documented this check during the recruitment process. The registered managed checked this during the recruitment process with the Driver and Vehicle Licensing Agency (DVLA) and policy stated this should be reviewed annually.

Leaders did not routinely carry out safe driving checks on all staff, in the five staff records we reviewed only three staff had driving assessments documented. This meant the service could not be assured of the driving skills and standards of all members of staff.

Multidisciplinary working

All those responsible for delivering patient transport worked together as a team to benefit patients. They worked effectively with other agencies.

The provider coordinated all transport journeys with NHS hospital or ambulance service which used their patient transport service. For hospital discharges and transfers, leaders told us how they worked with the hospitals on every shift, for example, by contacting the ward, discharge lounge, or transport support desk. Staff and leaders told us they had positive relationships with hospital staff. This enabled effective handovers when they transported patients to and from hospitals. Leaders explained they had informal discussions with liaison managers from the NHS ambulance service and trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions.

Leaders described how staff would support patients and would seek verbal consent before transporting them.

The service was not assured that staff had completed training with regard to the mental capacity act. There was also no evidence that staff had appropriate training on supporting patients with dementia.

The service did not transport patients subject to the Mental Health Act 1983.

Are Patient transport services caring?

Insufficient evidence to rate

There was insufficient evidence to rate this key question.

Compassionate care

Leaders told us that staff treated patients with compassion and kindness, respected their privacy and dignity.

Leaders described how they treated patients with kindness and respect. Examples were given of how privacy and dignity were maintained when caring for and transporting patients. The service told us they always had supplies of blankets and sheets to keep patients warm.

On the service website there was an area for people booking private transport to supply details of likes, dislikes and favourite music to support their transfer.

Inadequate

Patient transport services

However, there was no evidence that staff undertook training on the needs of patients with dementia, learning disabilities or the mental capacity act.

Emotional support

Staff told us they provided emotional support to patients, families and carers to minimise their distress.

Although we were not able to observe any activity during the inspection, we reviewed two examples of feedback as this was all that was available. This feedback showed a varied experience with some positive and some negative experiences.

Leaders told us how staff talked to patients on the journey to make them feel at ease. We heard how if there were delays on the journey a member of the crew could call the hospital or ambulance service to advise they were running late; this would reduce patient anxiety.

Understanding and involvement of patients and those close to them

There were limited methods for patients, families and carers to make decisions about their care and treatment.

Patient feedback was not formally monitored or evaluated.

Patient and relative feedback collection methods were limited. We saw there was a notice in vehicles providing details for patients to provide feedback. The service also provided the facility to give feedback through their website and via social media.

One piece of feedback said how staff transported a patient and were caring and friendly. However, the second piece of feedback said they felt staff were poorly prepared for the job and did not interact with the patient or their family well.

However, leaders recognised that improvements were required in how information was collected. Whilst no formal plans were in place, conversations were ongoing at the time of inspection in how feedback methods could be improved. The service told us they wanted to gather meaningful information from patients and their relatives to improve patient involvement and care.

Are Patient transport services responsive?

Inadequate

We rated it as inadequate.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Patient transport services were the main service offered by Reliance Ambulance Station. Journeys included transportation to and from outpatient appointments and hospital discharges.

Inadequate

Patient transport services

The service liaised with the local NHS ambulance service and NHS hospital to plan and deliver patient transport services for local people.

The service undertook some private transport bookings but due to the workload from its NHS contracts this was less frequent.

Meeting people's individual needs

The service did not always take account patients' individual needs and preferences.

The service did not supply any details of training staff had to support patient needs such as the skills to care for patients with complex needs including patients living with dementia.

Leaders told us they used communication books to support patients who could not communicate or for did not speak English. However, the vehicles we inspected did not contain any communication aids. We brought this to the attention of the service who said these would be reprinted and put into all vehicles. The service also did not have any access to translation facilities despite telling us they would take patients whose first language was not English. This meant patients could struggle to communicate all their needs, particularly when travelling alone. It is also no recommended that family members are used to translate.

Access and flow

People could access the service when they needed it.

The service operated between the hours of 9am to10pm seven days a week. Staff worked with the local NHS ambulance service to provide transportation services for two NHS hospitals. The service told us they transported between eight and fifteen patients per day and that since being registered with CQC in June 2020 they had undertaken around 1,200 patient transfers for NHS services and private bookings.

Leaders told us they had a good working relationship with the local NHS ambulance service to ensure patients were informed in the event of delays. Leaders told us staff telephoned the NHS ambulance service if there was a delay with the transfer of a patient or an issue that needed to be resolved.

There were no systems or processes to formally monitor waiting or journey times at the time of our inspection.

The service did not display fees for private transport on their website. The service required the patient details to be supplied before it could supply an accurate costing. We reviewed the terms and conditions contract supplied by the service for patient transport, which was not easy to understand and contained a significant amount of legal language which patients may find information confusing.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received. The process to complain was not always accessible or transparent. The service did not treat concerns and complaints seriously, investigate them or share lessons learned.

The service had a complaints policy to provide guidance for staff in the event of complaint. However, we reviewed this policy and found it did not give a clear process for allocation of complaint investigation.

Inadequate

Patient transport services

The service supplied a complaints log which showed two complaints; both of these had been closed. The first complaint had been investigated by another CQC registered service, and no reasons were given for this.

The second complaint had notes relating to an initial investigation and recommended course of action. There was no evidence to document what actions had been take. There was also no evidence to demonstrate if the service had contacted the complainant to acknowledge their complaint.

We asked the registered manager for any learning or outcomes associated with these complaints and were told there were no outcomes documented or associated learning.

The service displayed information about how to provide feedback in vehicles and on their website, however this was only in English and did not explain how to make complaints or provide the complaints policy.

The terms and conditions contract supplied by the service for patient transport made a reference to making complaints by email.

Are Patient transport services well-led?

Inadequate

We rated it as inadequate.

Leadership

Leaders did not have all the skills and abilities to run the service effectively. They did not understand or manage the priorities and challenges the service faced. However, leaders were visible and approachable in the service for staff.

The leadership team at Reliance Ambulance Station consisted of two directors, and a registered manager. The operations director oversaw the service, and the second director took responsibility for cleaning and organising vehicle maintenance.

The post of operations manager had recently become vacant. Leaders told us that when they had recruited to the post, the operations manager would have responsibility for daily oversight, however recruitment for this had not been started.

A registered manager is the person appointed by the provider and registered with CQC to manage the regulated activity on their behalf. However, the role of the registered manager in the service was not clear and there was not a defined structure of leadership and hierarchy. The policies of the service also made limited reference to this position and their responsibilities.

A medical director supported the service, but their role within the business was also not clear and they were not referenced in any service policies we reviewed.

Inadequate

Patient transport services

Leaders could not always clearly describe their roles and responsibilities within the organisation and were not aware of some of the duties delegated to them in company policies. We saw that the last documented management meeting was held in November 2020. Leaders told us although they discussed issues informally on a daily basis, this was not documented or evidenced.

The providers policies did not reflect the service being provided. Leaders acknowledged that there was a lack of relevant policies and told us they were working on developing these.

We had limited opportunity to speak with staff, however staff told us they were clear on who held responsibility for each area. They told us they would escalate concerns to the service directors and spoke positively of their relationship with them.

Following inspection, we extended the opportunity to staff to contact us with feedback and to further support the process and understanding of the service. Leaders told us they had informed staff of this invitation however we received no responses.

Vision and Strategy

The service had limited evidence of a vision or strategy for what it wanted to achieve.

There was no vision or strategy for the service. Leaders told us they had a vision for what the service wanted to achieve but this was not documented in any format.

Inspectors saw a poster relating to service values and vision on a notice board, but leaders told us this was not something that was in use and had been developed by a previous manager.

Culture

The service culture did not support patients to raise concerns. There was limited evidence that they promoted equality and diversity in daily work.

The service had a whistleblowing policy. We reviewed this and found that it referenced job roles that did not exist in the service. There was also no clear explanation of the process staff should follow to raise concerns, the policy also stated that anonymous staff complaints may not always be investigated.

The overall culture of the service was informal. Staff told us they felt supported by leaders. The service did not undertake staff surveys. Leaders told us they had not held any staff meetings.

The service gathered information with regard to equality and diversity within its job application systems, but it was not clear what the service used this information for or why it was requested.

Governance

Leaders did not operate effective governance processes. There was limited evidence of learning from performance of the service.

There were no governance processes within the service that leaders could describe. Where policies detailed process, there was no evidence to demonstrate they were followed. There were no governance meetings taking place despite policies stating that they should.

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The service did not always have policies in place that would be expected for the service it was providing. When it did have policies, these did not always reflect the service and they contained reference to committees, supportive services and staff roles that did not exist in the service. For example, the misuse of alcohol policy referred to the company doctor, and the disciplinary policy referred to a medical operations manager, this was not a role within the business.

We reviewed the quality policy for the service and found that although it set out some service principles, these were not acted on or in place. For example, we saw no staff training taking place, but the quality policy referred to regular staff training as a fundamental principle. In addition, there was reference to regular staff knowledge check, but there was no evidence of this having ever taken place.

Service leaders did not have systems to monitor the quality of the service. Leaders did not have a comprehensive understanding of the risks to the service, policies and governance issues.

We reviewed policies that referred to use of audit to improve quality and safety such as patient care records used for private transport. Leaders told us these audits took place but did not provide evidence to support this. The registered manager was also unable to provide evidence of these audits and could not recall when they last took place. This did not reflect the providers own policy and meant we were not assured of the process to monitor the quality and safety of the service.

We saw policies that stated twice annual governance meetings should be held by the service. Leaders told us told us these did not happen, and there was no planned start date for them to commence.

Management of risk, issues and performance

Systems were not in place to manage performance effectively. The serviced had identified limited risks and issues but did not always identify actions to reduce their impact. The service did not use an effective risk monitoring tool. They were limited plans to cope with unexpected events.

We saw an incident report relating to an incident of a patient fall. The nominated individual told us the register manager would investigate this when they returned from leave. This did not match the services own policy that stated incidents should be investigated at the earliest opportunity by the leader on duty at the time or reporting.

The service supplied an incident log following our inspection that stated that the nominated individual had been allocated the incident. We saw no evidence that leaders had taken steps to contact the patient or their family following the incident.

The service had an adverse incident policy, but this did not reflect the service resources and referred to an online incident reporting form that was not present in the service at the time of inspection. This meant the service did not have adequate oversight or effective implementation of the own incident policy and lack of internal process. There was a risk of repeated harm to patients as a result of the lack of outcome and learning.

The service had a risk register, but this did not fully reflect the service offered. The risks detailed were wide ranging and non-specific to the service.

The risk register did not contain relevant mitigation of risk or appropriate triggers. Furthermore, the mitigating actions for some risks, such as fuel shortages, did not reflect the infrastructure of the service. The registered manager was unable to tell us any of the risks on the risk register.

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The service did not have policies to cope with unexpected events such as adverse weather which meant staff may be unable to respond appropriately in these circumstances and the quality of service provided would be impacted.

The service did not investigate complaints in line with its policy. Where complaints had been made there was no evidence to demonstrate learning or outcomes. There was also limited evidence to demonstrate the involvement of patients and their families when concerns were raised. The complaints policy did not detail how complaints could be escalated when internal processes were exhausted.

Information Management

The service did not collect reliable data or perform analysis. Information systems were not integrated but were secure.

The service did not have its own key performance indicators to monitor against. Where the service undertook work NHS it relied solely on them to monitor the quality of it service.

The service collected some information about response times and journey times; however it did not review this information or monitor it improve services. There was limited access to and challenge of performance by leaders and staff.

Engagement

There was no engagement with staff or patients to plan or manage services.

The service was in the early stages of providing services for a local ambulance trust therefore had not established routine engagement.

Feedback was not always reported or acted on in a timely way. The service had documented complaints within their systems but there was no clear timeline for the completion of investigations. Patient feedback was not collected in a meaningful way and where it was this was not documented in systems.

There was no evidence that staff were aware of what people who use the service think of their care and treatment beyond the limited feedback we reviewed.

The service relied on external partners to gain patient feedback for the services it provided to the NHS but had not implemented measures or process to monitor or receive this.

Learning, continuous improvement and innovation

There was limited evidence of a commitment to continuous learning and improving services.

There was no evidence of innovation or service development. Leaders demonstrated no knowledge or appreciation of improvement methodologies. There was minimal evidence of learning and reflective practice.