

Reliance Ambulance Service Ltd

Reliance Ambulance Station

Inspection report

Reliance Ambulance Service, Unit B1a
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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

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. The service met agreed response times. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs.
- The service took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff did not always demonstrate good understanding of manual handling practices.

This service has been in Special Measures since 6 April 2022. During this inspection the provider demonstrated significant improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service has been removed from Special Measures. We rated this service as good because it was safe, effective, caring and responsive, and well led.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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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 based in Woking. The service is based at Fairoaks airport. They provide private patient transport and also undertake patient transport for a local NHS trust.

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.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 5 October 2022.

During our inspection we spoke with 7 staff members including ambulance care assistants, administrative staff, supervisors and managers. We checked 4 vehicles and reviewed 12 patient records. We accompanied 2 crews who were transporting patients and observed patient care. In addition to this we also reviewed policies in use by the service and employment records of 12 staff.

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 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 SHOULD take to improve:

- The service should ensure that all equipment necessary to make sure patients can be safely transported is available on every vehicle. Regulation 12(2).
- The service should consider how they are assured that good manual handling practices are maintained following training.

Our findings

Overview of ratings

Our ratings for this location are:

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

Patient transport services

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are Patient transport services safe?

Good 

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Staff were required to complete online mandatory training before commencing employment with the service. The service target for mandatory training was 95%, we saw evidence that the service had met this target and had 99% compliance.

The mandatory training was comprehensive and met the needs of patients and staff. There was training in a wide range of areas such as moving and handling, oxygen administration, and procedure and paperwork training. The clinical lead for the service had provided additional training sessions for staff, these included how to use an automated external defibrillator and anaphylaxis.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. The service had recently implemented training in supporting patients with learning disabilities and autism, we saw evidence that 91% of staff had completed this training. This was in response to a recommendation made following the previous inspection that the service should consider implementing this.

The registered manager and clinical lead monitored mandatory training and alerted staff when they needed to update their training. Staff told us they received notifications to alert them to when training was due.

Staff were aware that training completion was a requirement of their role and that they would not be able to work for the company if this was not completed. We saw managers had a system in place to enable effective oversight of staff training, this included alerting them to training approaching expiry so staff could be made aware.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Patient transport services

Staff received training specific for their role on how to recognise and report abuse. All staff were required to complete training in Safeguarding adults and children up to level 3. We saw that 100% of staff working for the service had completed this.

Staff could give examples of how to protect patients from harassment and discrimination. The service had a safeguarding disclosure standard operating procedure in place, staff had read to say they understood this.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were able to explain ways they may identify patients who were vulnerable or who required additional support such as visible injuries or indications of an unsafe home environment

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a designated safeguarding lead who was also the CQC registered manager. The registered manager was able to detail the safeguarding procedure and had also recently created a dedicated safeguarding form on their website. This made it easier for patients and their carers to raise a concern, and also that when they did these referrals they were picked up by the correct member of staff and acted upon immediately. We also saw examples of safeguarding referrals completed by the service when staff raised concerns.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service supplied cleaning records for the previous week and we saw these had been completed in full. The checklist used prompted staff on the areas to be cleaned.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We inspected four ambulances in use by the service, we saw that they were visibly clean.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed ambulance staff providing care to patients, and saw that all equipment was cleaned immediately following patient contact.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was an Infection Prevention and Control (IPC) in place, we saw that this referred to best practice policy such as Department of Health and Social Care and The National Institute for Health and Care Excellence (NICE) guidance. We reviewed the results of 6 observational PPE audits and found that they showed full compliance. The service also undertook uniform audits to ensure staff were complying with measures such as being bare below the elbow and had a visibly clean uniform.

Staff were provided with appropriate personal protective equipment. Staff understood procedures to manage patients identified as having infectious diseases. Staff had access to handwashing gels and wipes in all vehicles. Leaders carried out hand hygiene audits which were 100% compliant. Staff understood these procedures were in place to keep the risk of infections low.

Patient transport services

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The location of the service provided 24 hour access to the crew and vehicle base, this included the cleaning and restocking areas. 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.

The vehicles were regularly maintained, serviced, and appropriately repaired. We saw a system in place to monitor when vehicles needed to be serviced and all vehicles had a regular safety service. If there were concerns about any item of equipment it was taken out of use and repaired.

Staff carried out daily safety checks of specialist equipment. Staff completed and signed daily vehicle and equipment checklists before use, in line with the service policy. All daily vehicle checklists we looked at were complete and up to date. There were vehicle readiness flipcharts displayed on the dash of all vehicles when parked at the base. This showed relevant information such as if the vehicle was cleaned, out of use, or awaiting cleaning. Vehicles were taken off the road when faults were reported.

We reviewed risk assessments for equipment and vehicles used by the service which included stretchers, carry chairs and medical devices. We saw that these had been risk rated with control measures in place to mitigate risks while in use. For example, the mitigating actions in place for the use of the stretcher included dynamic risk assessment and sign-off that staff had completed individual equipment training.

Staff used personal digital assistants (PDA) to obtain patient details, be directed to their patient pick-ups and to communicate with the control room. Staff could also use these devices to identify risks associated with the patient and their mobility status. Each vehicle had a PDA assigned. Each vehicle was also fitted with an internal satellite navigation system and dashboard cameras. Vehicles carried a breakdown assistance card that enabled them to obtain vehicle recovery and maintenance support urgently.

The management of control of substances hazardous to health (COSHH) standards within the organisation was in line with best practice. The equipment was locked away and stored appropriately.

Staff disposed of clinical waste safely. We saw that there were designated bins in the ambulance base 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. However clinical waste was not always stored appropriately. We saw clinical waste bags were tied onto the back of chairs within the vehicle whilst transporting a patient. Following our inspection, the service provided evidence to demonstrate they had installed fixed clinical waste bins within all of the service vehicles. This minimised the risk of spillage and airborne transmission of infection.

Vehicles were equipped with standard equipment, such as fire extinguishers and we saw evidence they were serviced regularly. Leaders ensured vehicles met the needs of the individuals transported. Patients often used their own wheelchairs whilst travelling on the vehicles. The NHS trust completed risk assessments to ensure these were safe to use. We saw staff secure the wheelchairs to the floor of the ambulance correctly.

Patient transport services

However we observed one instance of a vehicle not having a hydraulic winch to load a wheelchair. When staff reported this to managers, they took action to ensure this was replaced when the service returned to base. Following the inspection the service has assured us that they have checked all vehicles to ensure the correct equipment is in place on vehicles.

Assessing and responding to patient risk

Staff had access to risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service provided by this location was patient transport services delivered by ambulance care assistants for patients who were not acutely unwell. Staff did not take routine observations of vital signs for standard patient transport journeys but were aware that if a patient became acutely unwell on a journey, they could contact the control room which was run by an NHS ambulance service.

Staff completed risk assessments for each patient on booking and reviewed this regularly for patients who undertook regular journeys. Ambulance care assistants (ACAs) knew about and dealt with any specific risk issues. Control room staff completed risk assessments for all planned activities. This included any potential risk factors such as if a patient had additional needs or used specialist equipment. ACAs reviewed the electronic patient records prior to picking patients up to identify any potential risks or areas of additional needs. This enabled ACAs to review risk assessments and notes about the patient.

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 to provide safe care and mitigate and risks. Leaders told us that administrative staff had training on taking private bookings and risk assessments. There was a training record and standard operating policy in place to support staff who undertook these tasks.

The journey log sheet for private transport patients had areas to record relevant information such as mobility and if there was a Do not attempt cardiopulmonary resuscitation order in place. Do not attempt cardiopulmonary resuscitation (DNACPR) is an advanced decision not to attempt CPR when a named patient's heart stops beating. Where necessary clerical staff contacted patients after booking if it was decided more information was required such as to assess whether they were suitable to travel with other people in terms of clinical vulnerability. ACAs also escalated to control staff if they felt a patient was not appropriate for travelling with others and their record was updated to reflect this.

The service also redirected patients to other local ambulance services if it was deemed they were not suitable to travel with the service. For example a high dependency patient who required medications to be administered during their journey.

Staff shared key information to keep patients safe when handing over their care to others. We observed ACA's handing over patients to hospital staff and updating with relevant information.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. Managers regularly reviewed and adjusted staffing levels and gave bank staff a full induction.

Patient transport services

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.

The service employed operational staff to provide the patient transport service alongside two directors, a clinical lead and a registered manager. The registered manager oversaw the day-to-day running of the service.

The manager could adjust staffing levels at short notice according to the demands of the service. We were told if staff shortages led to gaps in staffing, that leaders would cover these shifts.

The service had low vacancy rates. The service had a recruitment policy that included requirements for references, background checks and employment history checks. We reviewed 12 staff recruitment folders and found they contained all information that was required by the recruitment policy.

Managers limited their use of bank staff. Managers made sure all bank staff had a full induction and understood the service.

Records

Staff kept some records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service completed patient care records for some patient settings such as private transport. We reviewed 10 sets of clinical patient records and saw that they contained relevant information such as mobility, if a DNACPR was in place and if the patient had an infectious disease.

Paper records were stored securely in a locked cabinet.

When the service undertook patient transport work on behalf of an NHS trust, 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 helped to keep patient information, such as their home address and health details secure.

Medicines

The service followed best practice when administering, recording and storing oxygen.

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. Oxygen was the only medicine used at the service. Staff stored and managed this safely. Full and empty oxygen cylinders were stored separately in locked cages and clearly labelled. A system was in place to check the oxygen cylinders and ensure they were in date. Oxygen was only given to patients in an emergency or if it was documented within their patient notes.

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.

Patients could bring their own medicines with them, for example if being discharged from hospital. These were kept with patients' belongings and were the responsibility of the patient.

Patient transport services

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service has a standard operating policy for reporting incidents, we saw that staff had read this and signed to say they understood. The service had also undertaken incident reporting training to ensure staff were familiar with the process.

The service had no 'never events'. 'Never events' are serious incidents that are entirely preventable.

Staff raised concerns and reported serious incidents in line with the service's policy. We saw evidence of incidents that had been reported by staff. The incident policy informed staff to report an incident within 24 hours. We saw that all incidents reported met this period. The service told us how they would be providing additional training to support staff to gain a better understanding of what constituted a 'near miss' and the benefit of reporting these.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. We saw evidence that staff received training in this area as a part of mandatory training. Supervisors and managers apologised when things went wrong and where appropriate in complaint responses. Managers exercised the legal duty of candour in line with the CQC regulations.

Staff received feedback from investigation of incidents. We saw learning bulletins sent to all staff that shared learning outcomes and lessons learned from incidents.

Staff met to discuss the feedback and look at improvements to patient care. There were weekly staff meetings, and these discussed any complaints feedback and incidents reported in the previous weeks, and the ongoing update to those already known to staff.

There was evidence that changes had been made as a result of feedback. For example, we reviewed the response to an incident when a patient was injured on a footplate while exiting the vehicle. Following this staff were reminded in a learning bulletin to complete dynamic risk assessments while patients exited the vehicle and to remove footplates if they were deemed to pose risk of injury. This incident was also discussed in the clinical governance meeting.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw how the leaders had, in the first incidence, contacted every patient or family discuss an incident with them. This was recorded on the incident log.

Managers debriefed and supported staff after any serious incident. Leaders always spoke to staff following an incident to establish if there was an emotional or physical impact to them. If it was determined they required further support, for example medical treatment, leaders supported them to access this.

Are Patient transport services effective?

Patient transport services

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies we reviewed referenced using up to date national guidance and linked to further reading. For example, the patient nutrition policy referenced NICE guidance. Leaders told us they planned to implement observational audits to further monitor compliance with guidance contained within policies.

Staff had electronic access to the provider's policies to support their roles. Staff were sent up to date policies and guidance to read via their electronic compliance system. These policies were also placed into a folder in the crew room and staff would sign to say they had read them. This meant managers were able to see that staff had read policies and agreed they understood them.

Staff spoke with hospital and care home staff, carers and family when collecting or dropping off patients. They shared information about the patient relevant to the patients' needs.

Nutrition and hydration

Staff assessed patients' drinking requirements to meet their needs.

Due to the nature of the service, food and drink was not routinely served to patients during journeys. However, bottled water was available for patients going on longer journeys. Some patients were given food by the hospital if needed.

The service had a nutrition policy in place and this met the needs of the service.

Response times

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

In the month prior to inspection the service had completed 713 NHS patient transfers, and 39 private patient transfers. The service used 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.

The service had key performance indicators (KPIs) in place 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 was assured.

The KPIs for NHS patients were set by the trust, the target for compliance was 100%. For the month prior to inspection these were:

Patient transport services

- KPI 1 – 98.9% of patients were collected within 120 minutes of pre-planned collection time.
- KPI 2 – 96.6% of journeys completed within 60 minutes of pre-planned completion time.
- KPI 3 – 98.9% of patients arrived on time to appointment, no earlier than 90 minutes prior to their planned appointment time
- KPI 4 – 83.2% of journeys met the maximum travel time allocated for journeys.
- KPI 5 – 99.3% of patients arrived on time for appointments where timeliness is essential.
- KPI 6 – 75% of journeys undertaken with complete data capture.
- KPI 7 – 98% of Renal patients were collected within 30 minutes of being allocated.

The service discussed performance regularly with the NHS trust they undertook patient transport for and identified areas of improvement.

The KPI's for private patients were set by the service, the target for compliance was 100%. For the month prior to inspection these were:

- KPI 1 – 92.3% of patients collected within 30 minutes of pre-planned collection time. This had improved from 85.7% the previous month.
- KPI 2 – 94.8% of journeys completed within 60 minutes of pre-planned completion time.
- KPI 3 – 94.8% of patients delivered to appointments within 15 minutes of pre-planned time.
- KPI 4 – 71.8% of journeys undertaken with complete data capture. This was an improvement from 60.7% the previous month and was thought to be linked to training that had been provided to staff that month.
- KPI 5 – 5.1% of journeys with completed patient feedback. Staff had been reminded to support patients to provide feedback but the service told us how 50% of this patient group were unable to provide feedback due their individual needs.
- KPI 6 – 92.3% of patients collected within 10 minutes of pre-planned collection time after treatment.
- KPI 7 – 89.7% of crews returned to base within 45 minutes of pre-planned drop off to return to base completion time, this was an increase from 75% the previous month.

This data was shared with staff to highlight areas for improvement and also so staff could see the improvements in the service.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However we observed staff demonstrating poor awareness of manual handling.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. When the staff were employed the service took steps to ensure they had the relevant qualifications for their post. The service outlined clear criteria for the post of ambulance care assistants which included experience of caring for people and proven customer care and communication skills with the public. The service specified staff must hold a qualification in first aid with a minimum of first aid at work accepted. We reviewed 12 staff competency folders and saw that they contained the appropriate qualification details and all staff had at least one personal and one employment reference.

Managers made sure staff completed specialist training for their role. There was a spreadsheet detailing staff qualifications and the renewal dates so that staff could be prompted when they needed to complete any training again, and were given the opportunity to do this.

Patient transport services

Managers gave all new staff a full induction tailored to their role before they started work. New staff were allocated to work with staff who had worked in the role for a longer period.

The clinical lead was responsible for signing off the competency of all new staff. New starters underwent a probationary period of 6 months to ensure they were performing in line with the service requirements. They had meetings at regular intervals within this period to discuss their performance and to ensure they were being supported.

Managers identified poor staff performance promptly and supported staff to improve. If the service identified staff were not meeting their competency then measures were put in place to support them to achieve this. The registered manager gave us examples of the service needing to do this.

Staff were required to maintain a valid UK driving licence with no more than 6 penalty points. The registered manager documented this check during the recruitment process. This was checked during the recruitment process with the Driver and Vehicle Licensing Agency (DVLA) in line with policy, and was reviewed annually. Staff were expected to disclose if they received any driving convictions whilst in the role.

There were safe driving checks carried out on all staff who drove vehicles, we saw that these contained appropriate observations and covered a wide range of driving skills. This meant the service was assured of the driving skills and standards of all members of staff who drove vehicles.

Managers supported staff to develop through yearly, constructive appraisals of their work. The target for appraisal completion was 100%. At the time of our inspection, 100% of staff had completed their appraisals. The service held records which showed when appraisal dates were scheduled to ensure all staff would be compliant by the end of the financial year.

Staff said that the appraisals were supportive and highlighted areas for development and progression. Staff told us they had opportunities to discuss training needs with managers and were supported to develop their skills and knowledge.

The clinical lead supported the learning and development needs of staff. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was additional staff training given on basic life support and defibrillation. There had also been additional training in vehicle familiarisation. The service was approved to deliver some regulated qualifications by a training provider approved by The Office of Qualifications and Examinations Regulation. This meant the service could support staff with development and qualifications for their role and be assured of the training delivered.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service had weekly staff meetings and the minutes for these were available electronically and within folders in the staff room.

We observed instances of staff using poor patient manual handling techniques. For example, a patient was lifted using their arms, and this posed a risk of injury to the patient and staff.

In addition, we observed ambulance staff using a ramp on an uneven surface to offload a patient in a wheelchair. We saw that this issue had previously been highlighted in staff bulletins to make staff aware. Due to the surface also being wet, the staff member slipped but no injury to the patient or staff member occurred. This was observed by the clinical

Patient transport services

lead and we were advised this would be addressed directly when the crew returned to base. We also brought these issues to the attention of leaders on the day of our inspection. Following our inspection, leaders advised they were implementing a post training assessment in this area. This would ensure that training had been effective and identify improvements in training.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked alongside health care disciplines and with other agencies when required to care for patients. Staff liaised with the hospital staff closely to ensure patients being discharged were collected as responsively as possible. Managers worked with clinical team leaders at the local NHS acute trust to determine which patients to prioritise when the demand for the service outweighed the available vehicles and crews. The service had a named contact at the local NHS acute hospital trust to support the hospital staff with appropriate bookings. When the service undertook work for an NHS trust these bookings were arranged by the control centre of the trust.

The managers' reported they had a good relationship with the trust and issues were raised and dealt with promptly. Staff said that they had built up a good rapport with the hospital staff through regular contact. We spoke to hospital staff who spoke positively of the service and their interactions with them, they described staff as "friendly and professional".

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The Deprivation of Liberty Safeguards were not applicable for this service. Staff gained consent from patients for their journey in line with guidance. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff had access to an up to date policy on consent.

Where patients with capacity to consent declined to go on the transport, staff respected this decision although they did try to encourage patients to make the journey. The policy stated that if a patient declined transport this should be clearly recorded consent in the patients' electronic or paper record however the service has not needed to do this.

Staff received training in the mental health awareness and consent. At the time of inspection, 100% of staff had received their training.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service told us that patients with more severe dementia who were less likely to have capacity were usually supported by carers on the journey therefore asking registered carers in the best interests of the patient was appropriate.

Are Patient transport services caring?

Our rating of caring improved. We rated it as good.

Patient transport services

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We observed two sets of ambulance staff interacting with patients while on shift. We saw how they interacted with all patients with compassion and care at all times.

Patients said staff treated them well and with kindness. In the feedback we reviewed, patients mentioned staff were professional, helpful and kind. One piece of feedback provided stated that staff “made them feel safe”.

Staff followed policy to keep patient care and treatment confidential. There was a standard operating policy in place for the completion of patient care records (PCRs). PCRs were used for private patient bookings only, as for NHS trust bookings were detailed electronically. When patient information was in a paper format, these records were placed into a sealed envelope on the completion of each job. Staff then returned these records to the base at the end of shift and posted them into a locked box.

Staff we spoke with understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when discussing patients with mental health needs. Staff we spoke with during the inspection presented with a non-judgemental approach at all times when describing the patients, they worked with.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were able to build supportive professional relationships with regular patients and understood how having long-term health conditions impacted upon a person's life.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff told us they spoke with families and carers to ensure they could be involved in the patients care either before the journey or at the end of the journey.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. All service vehicle we inspected contained communication aid books. As part of mandatory training all staff completed training on communication. In addition to this there were also modules on Equality, Diversity and Human Rights, Promoting Understanding, and General Awareness. These modules had been completed by 100% of staff.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service provided multiple opportunities to provide feedback. Within the service vehicles, there were posters providing details on how feedback could be provided. The service website had a clear and simple feedback form.

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Patients and their families could also provide feedback following their booking through their booking confirmation emails. In addition to this, the service could provide patients, on request, pre-paid addressed envelopes with feedback forms inside. This supported patients who may not be digitally aware or may wish to reflect on their care before providing feedback. These multiple opportunities also supported patients should they wish to provide negative feedback anonymously.

Patients gave positive feedback about the service. We reviewed patient feedback received by the service. In the 6 months prior to inspection the service had received 100 compliments. We reviewed this feedback and noted it was overwhelmingly positive and patients often gave the service a review of being excellent.

Are Patient transport services responsive?

Good 

Our rating of responsive improved. We rated it as good.

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.

Managers planned and organised services so they met the changing needs of the local population. The service was supporting a local NHS trust by providing conveyance for patients to hospital treatments. Senior leadership of the service had future plans to expand the service and were in communication with a large NHS Ambulance trust to provide conveyance on their behalf.

Facilities and premises were appropriate for the services being delivered. The service had a large outdoor parking area with space for vehicles and dedicated space for cleaning of vehicles. We saw evidence that the service planned to add a sheltered area to this section so that vehicles could be cleaned in all weathers. The service base was clean and well maintained. We reviewed cleaning records which showed all areas were routinely cleaned.

Staff had space to store equipment and consumables and to take breaks. There was space for food preparation, an administrative space work and staff facilities such as lockers. Patients did not visit the base. All vehicle keys were stored in locked boxes to restrict access.

The service had systems to help care for patients in need of additional support or specialist intervention.

Staff monitored and took action to minimise missed journeys. Staff told us that if a patient declined transport or did not answer when they called, they would phone the patient. If they still failed to contact an NHS patient, they would inform the control room so a welfare check could be made. Control room staff for the NHS trust ensured that patients who did not attend appointments were contacted. If the patient was a private booking, administrative staff would first try to contact the patient, or next of kin. If they could still not contact the patient and were concerned for their safety, staff escalated this so that managers could ensure welfare checks took place.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Patient transport services

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Control room operatives documented any additional patient needs within the patient notes. Therefore, staff were aware of any additional needs prior to picking the patients up either through their personal digital assistants (PDA) or paper record.

The service had recently included autism and learning disability awareness in their inductions. All staff completed this when they started with the service and then annually.

The service provided additional communication tools to support patients who did not communicate verbally or who had cognitive impairment. Within all service vehicles were communication books to help staff support patients with additional needs. In addition to this, the control room operators recorded information about any communication needs for patients so that staff were aware of this and could liaise with family or carers as appropriate.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to a 24-hour foreign language interpreter telephone line if required. All vehicles were also provided with a mobile phone to access online translation services.

The NHS trust completed risk assessments for patients and these were recorded within the vehicle PDA. All risk assessments were recorded on the patient record. The service had agreed an inclusion criterion with the NHS trust to ensure that the patients they were allocated were appropriate for the service they could provide.

This included if a patient was transported using their own wheelchair a risk assessment was performed on this to ensure it was safe to be used. If the patient was privately booked the service completed risk assessments of the patient's wheelchair when they attended. However, it was not clear if this process was always effective. For example, there had been incident where crew had attended and found a patient wheelchair to be unfit for purpose. Although the staff used the service vehicle wheelchair to transport the patient, they transferred the patient back into their own wheelchair on arrival and did not raise concerns with the NHS trust. This posed a risk of injury to the patient during transfer and at the hospital. It also meant the staff collecting the patient may not be aware of the concerns regarding the wheelchair. The registered manager has issued a learning bulletin to staff regarding the safe use of patients own wheelchairs.

In addition to this we saw a patient transported in their own wheelchair, when asked staff were unable to locate the risk assessment for the patient. We were later informed by leader that this was available electronically, therefore it was not clear why staff were unable to locate this. The registered manager assured us they would discuss this with the staff following their shift.

Access and flow

People generally could access the service when they needed it, and received the right care in a timely way.

The service had developed internal key performance indicators, these were outlined in a performance monitoring policy. Service managers monitored these to ensure they complied with targets and to identify improvement. The service provided private patient bookings in addition to supporting the NHS trust. The service monitored their performance and timeliness to deliver this service.

For NHS bookings, the service monitored journey activity via the PDAs. The staff used this to state their arrival and departure of journeys. They also used this to communicate with the NHS Trust control room when there were any changes to their schedule or delays. This helped the trust staff manage the journeys to reduce the delays to patients.

Patient transport services

When transporting privately booked patients, staff communicated any delays with the service base so that other bookings could be reallocated to avoid patient delay.

The service always made sure that it had additional vehicles that were road worthy on site which could be used if an ambulance was taken off the road. This meant that the service was not affected by vehicle breakdowns.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives and carers knew how to complain or raise concerns. Details of how to make a complaint were displayed on the booking website and in email confirmations. The service supported patients to contact them with feedback by providing multiple ways to raise concerns following a journey.

The service clearly displayed information about how to raise a concern in patient areas. The service now had signs in ambulance vehicles that now provided clear guidance on providing feedback and complaints.

Staff understood the policy on complaints and knew how to handle them. All staff had completed complaints handling training. There was an up to date complaints policy that referenced appropriate organisations. We saw records that showed staff had read these policies and agreed they understood them.

Managers investigated complaints and identified themes. Leaders investigated all complaints in line with the service policy. These had been reviewed to identify learning and service improvement. When complaints identified themes, these were addressed. For example, when the service received complaints regarding staff communication with the control centre, staff were reminded verbally and in learning bulletins reading the service expectations when crews are delayed. Additional training using PDAs was also to be arranged to support staff in using these.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw evidence that staff were involved in all complaint investigations to ensure all the information was available.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw how the leaders had, in the first incidence, contacted every patient or family who had made a complaint to discuss it with them. This was recorded on the complaints log and also ensured the manager could acknowledge complaints verbally and confirm they would acknowledge within seven days in writing. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw learning bulletins that had been sent to all staff highlighting areas for improvement following a complaint.

Staff could give examples of how they used patient feedback to improve daily practice. For example, following a complaint regarding staff driving abilities. Additional training and driving assessments were provided to the staff involved.

Are Patient transport services well-led?

Patient transport services

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The leadership team had undergone a change since our last inspection. Leaders were fully focused on improvement of the service. The service had a clear leadership structure in place. A clinical lead and the service directors supported the registered manager. The registered manager had extensive experience in patient transport services and had implemented numerous service improvements.

Staff told us the managers supported them. A member of staff described working for the service as “the best job they ever had”.

Leaders had implemented staff newsletters to inform and communicate staff of changes. The service has made all policies electronically available to staff, this could be done via an application on their mobile phones.

We reviewed staff meeting minutes which showed discussion and open communication between leaders and staff. Managers supported staff to attend team meetings provided access to the minutes when they could not attend.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The service now had a vision and strategy in place. The vision of the service was to become ‘one of the leading private ambulance provisions for the NHS Trust and to provide pre-hospital care driven by training, development, and technology’.

The business plan set out clear priorities for the service to establish its reputation as an effective provider.

Leaders told us that they used the currently used CQC values and key lines of enquiry. The planned to further develop its own company values. The service values were displayed on this staff notice board and these were outlined as:

- Safety - To ensure patients and staff are kept safe.
- Care - To value health, welfare and compassion in working relationships.
- Quality -To consistently aim to achieve high standards.
- Respect -To value all individuals promoting equality and diversity.
- Honesty -To develop a culture that is honest and open and transparent.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Patient transport services

All staff spoke positively about working for the provider. Staff told us they felt valued and respected by the service. Staff felt valued by the service, were able to go to managers if they had concerns and felt that changes were professionally managed. Staff told us that managers were supportive and fair in their approach.

The service promoted equality and diversity in daily work. Leaders told us they supported staff to be themselves at work. In staff areas there were contact numbers of mental health support networks.

Staff reported good relationships with their colleagues and clients who used the service. Staff told us they were supported, trained, and given opportunities to further develop. We saw evidence of a culture of engaging with patients who used the service in a positive way. Staff told us and feedback from people who used the service stated there was a safe, caring, positive experience while in the care of staff employed by the service.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance structure in the service. Leaders were able to fully explain their job roles and tell us their responsibilities. Leaders were able to identify key roles within the service, for example the infection prevention and control lead and Safeguarding lead. Staff were clear on the roles leaders had and who they should communicate concerns with depending on the nature of it.

We saw a staff structure which was shared with staff. Staff knew who leaders were, and we saw there were noticeboards with information for staff such as meeting minutes and incident reporting flow charts.

We saw there was a governance policy, this fully reflected the service being provided. All staff has signed to say they had read and understood this policy.

The governance policy stated that there was twice yearly governance meeting, we saw that this had occurred in the 6 months prior to inspection. We reviewed minutes from these meetings and saw that they discussed pertinent issues such as patient experience, incidents and risk management. Meetings were structured and followed a clear agenda.

There was clear oversight by the leadership team of staffing and internal process. The service had implemented audits in key clinical areas. These audits were well established and when improvements were highlighted these were acted upon. Standard operating procedures had been implemented to support consistent implementation of tasks.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events..

The service supplied an incident log following our last inspection. We saw the incident reporting log for the service now showed progress for all issues reported. These had been progressed through the investigation pathway and appropriate actions noted.

The service had investigated all incidents prior to our last inspection and gained additional learning. This gave a clearer view of the risk and improved patient safety. incident report relating to an incident of a patient fall.

Patient transport services

The registered manager individually completed all performance and risk based actions in line with policy. The service had an adverse incident policy that reflected the service resources, for example there was a paper based reporting form and we saw these were easily available in vehicles and at the service base.

The service had improved oversight of the risk and incident policies. Internal processes had been developed and there was a reduced risk of repeated harm to patients.

The service had a risk register, and this reflected the service offered. The risk register broke risks down into four areas. These included operational, organisational, clinical, and fleet risk. The risk register contained relevant mitigation of risk and appropriate triggers. For example, an operational risk was negative patient feedback. The mitigation in place for this was access to leave feedback to the service, the investigation of all incidents and further training. An example of a clinical risk was patient deterioration while in the services care, a mitigation for this was a standard operating procedure for the recognition of deteriorating patients and staff training in basic life support every six months.

The registered manager and clinical lead were able to give details of risks identified and the mitigating actions in place. The service had policies to cope with unexpected events such as adverse weather which meant staff could better respond appropriately in these circumstances and the quality of service provided would not be adversely impacted.

The service investigated complaints in line with its policy. Where complaints had been made there was evidence to demonstrate learning and outcomes. There was evidence to demonstrate the involvement of patients and their families when concerns were raised

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers had systems in place to collect and analyse data. Staff had access to electronic systems where data could be viewed to understand performance.

Staff used their hand-held devices to access performance and jobs information. In addition to this monitoring of KPIs was shared with staff on a monthly basis showing areas for improvement and areas that the service had exceeded the previous months performance.

Staff understood information governance and the importance of securely storing client information. Client records, hard copy and electronic were stored securely and only assessable to those with permission to do so. Leaders kept paper records stored in cupboards that were kept locked and only accessible to those with the authority to do so.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders and staff actively and openly engaged and collaborated with subcontracting providers and other professionals, for example, local hospital staff and control room staff which helped improve the quality of services.

Patient transport services

Staff collaborated with local NHS providers to ensure they worked together to safely care for clients. Staff engaged with NHS providers to share appropriate information to help provide suitable care and improve the service.

Leaders told us that engagement with the local health economy helped with growth and improvement to meet the needs of the clients who used the service. This service immediately communicated with the local NHS trust if concerns were identified they also had monthly contact calls with them.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Leaders supported continual improvement and development of the service. They did this through providing learning opportunities, including formal training of staff and use of technology. There was a programme of learning opportunities and investment in ongoing development of staff.

A clinical lead was employed to identify areas of learning and development. Staff development had improved and training had occurred to further support staff in their roles.

Leaders had established system in place to support continuous improvement. Staff used feedback from people who used the service, learning from incidents and complaints to help with improvements.