E-Zec Medical Transport Services Ltd

E-Zec Medical - Gloucester

Inspection report

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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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out a focused inspection of E Zec Medical Gloucester on 7 April 2021, due to concerns about another location managed by this provider. As this was a focused inspection, we only inspected parts of our key questions: safe and well led. We did not inspect effective, caring or responsive. This is the first inspection for this service since it was registered with the Care Quality Commission in December 2019. Before the inspection we reviewed information we had about the provider, including information we had received and intelligence available.

The inspection had a short announcement (24 hours) to enable us to observe routine activity. Due to the narrow focus of this inspection, we did not rate this service at this inspection.

We found;

- Equipment was left on patient transport vehicles that was not required, and staff were not trained in their use. Some vehicles were being used when they had been identified as having maintenance issues. This was not safe practice.
- Governance systems used to monitor the quality of the service did not always identify shortfalls in service provision. The recruitment process did not ensure that safety checks about new staff were used to protect patients. Senior depot staff were not always made aware of any staff risks needed to ensure patient safety.

However:

- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Services were run using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients using their service. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to E-Zec Medical - Gloucester

E-zec Medical Transport service is an independent private ambulance company set up in 1998 to provide patient transport services. E-Zec Medical – Gloucester, is a regional hub for transport services in Gloucestershire and supports four satellite locations in Lydney, Keynsham, Swindon and Salisbury. This service has contracts with four local Clinical Commissioning Groups to provide patient transport services. They operate seven days per week and can provide transport until to midnight each day.

This location is registered to provide the following regulated activity;

Transport services, triage and medical advice provided remotely.

E-Zec – Medical Gloucester was registered with the CQC in December 2019. The registered manager has remained in post since the date of registration.

The service has provided 89,213 transport journeys since they registered with us in December 2019 to March 2021. This is for the contract which covers Gloucestershire only.

This is the first inspection of this location since being registered with the CQC.

How we carried out this inspection

The team that inspected this location comprised of one CQC inspector and a specialist advisor. During the inspection we spoke with 11 staff including the management team. We also reviewed documents and records kept by the service.

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:

- We told the service that it must take action to bring services into line with three legal requirements.
- The service must ensure that vehicles used for patient transport are fit for purpose and maintained.
- The service must ensure systems used for monitoring service provision identify quality and safety issues and from these actions devised to address these areas.
- The service must ensure recruitment processes confirm the information required for each new member of staff is obtained before they are employed.

Action the service SHOULD take to improve:

Summary of this inspection

- We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.
- The service should address the issue of equipment being left in vehicles when it is not needed.
- Administration of oxygen guidelines should be updated and reviewed.
- The service should consider updating the medicines management policy so that it is relevant for use in patient transport vehicles.
- The service should consider improving their knowledge of the Duty of Candour regulation.
- The service should be clear about the frequency sub-contractors need to visit the Gloucester location for updates.
- The service should consider way in which senior managers who recruit staff have better access to all their recruitment files to ensure they have sufficient oversight of any management of risks.
- The service should consider auditing local recruitment records to make sure they are in line with the providers policy.
- The service should ensure risk assessments for new staff are devised prior to them starting work.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Patient transport services safe?

Inspected but not rated

We inspected aspects of safe, but we did not rate this section.

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 premises visibly clean.

The service controlled infection risk well. Staff wore the right personal protective equipment (PPE) to keep themselves and others safe from the risk of cross infection. Staff had access to PPE at each base, this included gloves, aprons, goggles, visors and hand gel. Staff told us at the beginning of the Covid-19 pandemic in 2020 there were issues accessing equipment but that had since improved. Hand washing facilities were provided at each base location.

Staff had access to personal protective equipment (PPE) to prevent the risks of cross infection. Senior managers told us crews were assessed using national guidance as needing to wear level two PPE. This was gloves, aprons and a mask or full-face visor. They also had access to goggles to cover their eyes if needed. During our inspection of two patient transport vehicles, we found Filtering Face Pieces (FFP3) masks in one of the vehicles. Level 3 masks were to be worn during an aerosol-generating procedure., An aerosol generating procedure is a medical or health-care procedure that results in the production of airborne particles or respiratory droplets, which may be pathogenic (a bacterium, virus, or other microorganism causing disease). We also found one was missing from the pack. These masks must be properly fitted by a person who has been trained to fit them to ensure their safe use. We asked staff and a manager about the use of these masks. They were not aware what these masks were used for or that aerosol-generating procedures were undertaken on patient transport vehicles.

Standards of cleanliness and hygiene were maintained at each base and in the vehicles used. This was to protect patients who used the service and staff from healthcare-associated infection. The Gloucester location and other satellite bases were cleaned by external contractors. We saw this was monitored and the cleaning contractor used cleaning schedules to demonstrate when they had cleaned an area. This was overseen by a senior manager. We saw monthly monitoring records where the senior manager had checked the cleaning and record sheets completed by the external contractor. ‘Touch points’ were cleaned several times a day by members of staff responsible for that area. Touch points are identified areas which are touched frequently by several people and so need regular cleaning to reduce the risk of cross infection. We saw cleaning records were maintained of these checks.

Systems were used by staff to reduce cross infection risks. For example, to reduce the risk of cross infection colour coded mops, brushes and buckets were used in each base. The colour of the mop indicated the area for use. Mop heads were all single use and were disposed of after use. We saw stocks of these available to staff to ensure there was a reduced risk of re-use.

Patient transport services

When staff/crews visited the base locations, they were required to maintain social distancing. On the door to each office, posters advertised how many staff could be in there, this included the staff rest areas. Face masks were required to be worn by all staff inside the buildings except when eating and drinking.

Patient transport vehicles were cleaned during each shift. We inspected two vehicles and found them to be clean. Senior staff told us crews wiped down vehicles in-between patients, undertook a deep clean after transporting any Covid-19 positive patients, and vehicles were cleaned at the end of each shift. We were shown the weekly vehicle cleaning check list which had been completed by staff. A small sample of these (about one percent) were checked by management each week to ensure compliance. We found written and computer records of cleaning compliance did not accurately reflect the same date. We saw two vehicles deep clean records which demonstrated the last deep clean was January 2021, but the computer records stated March 2021. Managers confirmed they were behind with inputting this information and they were also in the process of changing their computer system and this would account for the inaccuracy. We were not therefore assured how monitoring of compliance could be maintained if weekly record sheets and computer records were not the same.

Patient transport vehicles received a deep clean every six weeks by an external contractor. During this process a micro bacterial count was conducted before and after the clean to establish the level of hygiene. We saw evidence that the deep cleans occurred and management monitored this process. When vehicles were seriously contaminated the vehicles were able to be cleaned as a matter of urgency and would be taken out of use until completed.

Crews told us they were not always made aware of specific infection and hygiene risks associated with individual patients. Crews said this related to patients discharged from hospital and their COVID 19 risk. Crews told us the staff from the hospital did not always tell them or were unaware themselves of the Covid-19 status of the patient. Senior staff told us as part of the booking process the COVID 19 status of each patient was requested and then recorded on the form. Crews had access to this information. We were shown a copy of the booking form used by the call taker who booked the transport which had a dedicated question to record the Covid-19 status of each patient.

Staff could go to the managers for advice and support regarding infection control matters and the provider had a Covid-19 hotline for immediate advice and guidance for staff if needed.

All staff had received infection control training as part of induction and annual refresher training. Training figures from the provider showed 78 out of 85 staff had completed this training. They were also trained in the correct methods for putting on and removing personal protective equipment (this is known as donning and doffing) between each patient journey and when entering and leaving hospital wards. Donning and doffing is the term used to describe the safe way to put on PPE and remove it to prevent the risk of cross infection.

The service had reported a Covid-19 outbreak amongst staff at the beginning of 2021. An outbreak is described in healthcare-associated setting as two or more test-confirmed or clinically suspected cases of Covid-19 among individuals (for example patients, health care workers, other hospital staff) associated with a specific setting (for example bay, ward or shared space). This related to more than one of their satellite locations, therefore it was staff and crews who didn't work together. From a review of this outbreak no learning was identified as it related to more than one of their satellite locations and Gloucester.

To help minimise the risks of Covid-19, twice weekly Covid-9 lateral flow testing for staff had been introduced. This was not mandatory, and staff could choose whether they took them. Rapid lateral flow tests help to find cases in people who

may have no symptoms but could still be infectious. The test provides a result in 30 minutes. To help minimise risks to other staff/crews strict infection control guidance had to be followed. This always included wearing face masks and other PPE depending on where they were. For example, if in the staff room they had to sit socially distanced and if eating they could remove their face mask.

Staff were also being offered Covid-19 vaccinations and the provider was able to record this information with the permission of each member of staff. At the time of our inspection senior staff felt this was about 50% of their staff had received a vaccine.

Clinical waste was managed safely to reduce risks to staff. An external contractor collected the waste on a frequent basis. This could be altered if needed if the service had a lot of waste, to prevent prolonged storage at the depot. The clinical waste areas at both locations were clean and the bins were closed and not overfull.

To help reduce the cross infection risks to staff the provider had a uniform policy which described how to wash and care for uniforms. This included the temperature the uniform needed to be washed at. We did not ask staff if they were aware of this policy.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each person and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Risk assessments were carried out for patients as part of the transport booking process, and this was done from a central location. We were shown a booking form which was a set format with sets of questions for the call taker to follow on the computer system. Information was obtained about the needs of the person, for example, about their medical health and environment. If the booking form demonstrated the person needed a more in-depth risk assessment this would be referred to the location for them to complete. Leaders at each base were able to undertake these in-depth risk assessments or if the person was in hospital a patient liaison officer for the provider would complete it.

We were shown the risk assessment for two patients. One was at the end of their life and was being transferred and the other was for a patient who used the service three times a week for transport to their dialysis session. Each risk assessment contained information about the patients risks and needs, which in these cases was for moving and handling. Equipment needed was identified and the number of staff/crew was identified to safely transfer each patient. Crews/staff had access to this information before the transport was agreed.

Staff were able to identify and respond to changing risks to patients, including deteriorating health and wellbeing and medical emergencies. Staff were not given specific training to manage a patient with deteriorating health but had completed first aid and basic life support training. The service had reported to us two incidents where patients had deteriorated during transfer and the staff had immediately referred them to medical staff. Staff reported any incidents of deteriorating condition of the patient via their incident reporting system which was then reviewed by senior management and any identified learning shared with all staff.

The service was able to tell us about an incident where a sub contractor who was working for them, found a patient whose condition had deteriorated. They called the emergency services and reported it to the senior managers at E-Zec Medical Gloucester.

Patient transport services

The service did not routinely transfer patients detained under the Mental Health Act or any patient who had a history of violence or aggression. Staff had access to policies and procedures to help them manage challenging behaviour.

Medicines

The service used systems and processes to safely store medicines. Not all policies were up to date.

The process supporting the administration of oxygen in an emergency was not clear for staff and had the potential to pose a risk to patients. The patient transport vehicles did not carry any medicines for emergency purposes, except for oxygen. The policy for medicines management and transportation had a generic risk assessment for the use of oxygen. Senior staff told us crews could administer oxygen in an emergency if they had received training. However, there was no guidance in this policy on the use of oxygen in an emergency. Senior staff told us crews were only allowed to administer four litres of oxygen via certain mask (28%). We found nasal canula (for administration of oxygen through the nose) on one of the vehicles despite staff not being trained to use this. Guidance on the use of nasal cannula was not included in the above policy. The provider's administration of oxygen guidelines was last updated in 2016 and no reviews were seen. This carried a risk that there may have been changes staff had not been updated on. We were told a clinical governance bulletin had been issued to staff that clarified the use of emergency oxygen and these were stored in staff rooms, however we did not ask to see this specific bulletin during the inspection. Following the inspection, the provider shared a copy of this bulletin with us.

Patients receiving prescribed oxygen were supported by trained staff. The service only administered oxygen when prescribed by a health care professional, for example, patients discharged from hospital with oxygen that had been prescribed by a doctor. The vehicles had access to small oxygen cylinders to enable the transfer of patients who required oxygen.

Storage of oxygen at the locations was safe and secure to reduce risks. Empty and full oxygen cylinders were stored separately from each other and secure. Warning signs to alert staff to the risk of oxygen cylinders were on display.

The service did not take responsibility for patients' medication during transport. Patients carried their own medicines in their belongings. Staff confirmed they did not carry or take responsibility for patients' own medicines, and these travelled with the patient.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. When things went wrong, staff apologised and gave patients information and support.

Safety was monitored using information from a range of sources this included incidents, complaints, safeguarding and feedback from patients. The provider was in the process of introducing a new computer system that was due to be fully implemented by the end of April 2021. In the meantime, staff completed paper incident forms, and these were given to the registered manager (also known as the compliance manager) for review. These were then scanned into the system, reviewed and/or investigated if required.

Inspected but not rated

Patient transport services

The provider had arrangements for reviewing and investigating safety and safeguarding incidents and events when things went wrong. Relevant staff, partner organisations and patients were involved in reviews and investigations. The registered manager undertook any investigation into the incident. Where necessary these incidents were reported, and the investigation outcomes shared with other bodies for example the Health and Safety Executive and the Care Quality Commission (CQC). Patients were contacted and the outcomes discussed with them.

Lessons were learned, and action taken when things went wrong. We saw these were shared with staff through the clinical governance bulletins and these were on display in the staff areas.

Staff understood their responsibilities to raise concerns, to record safety incidents, and to report them. Staff confirmed they knew how to report any incidents. We saw that the staff induction programme covered serious untoward incidents.

The Gloucester Medical E-Zec location used subcontracted services. Each sub contracted provider was informed of their responsibilities for reporting incidents. They would report any incidents to E-Zec Medical Gloucester using their reporting system. CQC were notified of an incident which involved a sub-contractor. The report demonstrated they had taken the correct action at the time of the incident by calling for medical support.

Staff working within sub contracted services had to attend the E-Zec Medical Gloucester location to update themselves with changes to policies or procedures that were made following safety incidents. We did not ask how often they were expected to attend this location and so could not be assured that shared learning was disseminated in a timely way.

Staff had an awareness of their role and responsibilities under the Duty of Candour. The provider had a policy which described their responsibilities under the duty of candour legislation. A risk matrix was used to assess all incidents to see if they met the criteria for duty of candour. Senior staff were aware of duty of candour, but they were not fully aware of requirements of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Are Patient transport services well-led?

Inspected but not rated

We inspected aspects of well led, but we did not rate this section.

Leadership

Leaders had the skills, knowledge and experience to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience needed to manage the service. This location was registered with CQC in December 2019. At the same time the manager also registered with CQC. This was their first role as a registered manager. They had completed training courses in health and safety, and they were the lead in health and safety for the provider across all their locations. This meant staff from other locations could contact them for advice and support in relation to health and safety.

A management structure had been introduced at location level and this showed the contract manager was in overall charge with other managers each having set responsibilities for their role. For example, the operations manager over saw the day to day running of this location and one of the satellite locations (Lydney) with support from operations

supervisors who mainly supported and managed the staff. Lydney satellite location had their own operations supervisor due to the distance from Gloucester. We were told each satellite location had an operations supervisor on site. The registered manager (also known as the compliance manager) was accountable to the organisation's lead compliance manager. Crews and other staff were aware of the lines of accountability and who was their immediate line manager.

The provider also had a management structure for their senior leadership team which included their roles and responsibilities.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address these. The pandemic had brought changes to the way the service was run. This included the changes to the number of service users they could carry on each transport journey based on their contracts with the Clinical Commissioning Groups (CCG), which had altered several times during the pandemic. Further changes included the implementation of national guidance to reduce the risks of spreading COVID 19.

Leaders were visible and approachable. Staff told us they could go to their line manager or any senior manager if needed. The registered manager told us they visited the other satellite locations each month and operated an 'open door policy' which meant staff were welcome to raise concerns or discuss any issues, at any time. Out of hours staff and crews had access to a 24-hour control room for support and guidance.

Managers supported staff to develop their skills and take on more senior roles. We were told some staff had worked their way up from care assistants on the patient transport vehicles to management positions.

Each member of senior management team had their own responsibilities to maintain the service provision. This included meeting the key performance indicators (KPIs) from each contract from the Clinical Commissioning Groups.

Culture

Staff felt respected, supported and valued. They were focused on the needs of service users receiving transport. Staff had opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported, respected, valued, positive and proud to work for the organisation. The provider operated employee of the month awards where any staff could nominate any of their colleagues. We saw this was the case for two crew members who assisted in an emergency whilst they were working but unrelated to their normal duties. They had received recognition for their response from an external source.

The providers vision and core values refer to "being caring, honest, polite, respectful and reliable" The provider recognised the need for patients to have positive experiences and maintain a high level of satisfaction

The culture encouraged openness within the organisation, including with patients, in response to incidents. Staff and crews told us they were encouraged to report any incidents. We were told the outcome of these incidents was fed back to patients and with any actions/learning to prevent it from happening again.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Staff had access to forums where a representative from their staff group fed back issues to service leaders. We saw details about this on staff notice boards. Senior managers told us staff could come to them to report any concerns or issues as they operated an 'open door' policy.

Patient transport services

Prior to this inspection and within the previous year, we had received three whistle blowing concerns from three staff members. These were anonymous shared concerns about Covid-19 precautions. We fed the concerns back to the provider and local management team. They were aware of some of these issues as staff had also fed this back to them. Some of the concerns were beyond the remit for the local management to change as they related to the terms of their contracts with the local Clinical Commissioning Groups (CCGs). For example, the number of patients they could transfer in one journey.

Mechanisms had been introduced to provide all staff at every level with the development they needed to meet their own training needs and included appraisal and career development conversations. The appraisal and staff supervision figure were 64%. The service did not set a target for completion of appraisals.

The provider had placed emphasis on the safety and well-being of staff. A new provider for occupational health needs of staff had been appointed. Staff could access them with any health concerns that impacted on their role, and this included physical and mental health support. One member of staff told us they had their role altered to meet their needs following a period of ill health.

Staff wellness packages were being distributed to show staff they were appreciated. Senior staff told us other wellness packages were sent out at different times of the year.

The provider recognised April was national stress month and staff had access to support to help them manage stress throughout the year. Some members of the leadership team at this location had completed mental health first aid training to help support staff. This was rolled out across the company.

The provider had a duty of candour policy, and a risk matrix was used to assess all incidents to see if they met this criteria. They had limited incidents that required this to be implemented. Senior staff at this location had an understanding of duty of candour.

The leadership team had access to policies and procedures to address behavior and performance that did not meet the providers vision and values. Support could be obtained from the human resources team if needed.

Governance

There were governance processes for leaders to use, but these were not always followed and so, could not provide assurance of safe service provision. Staff at all levels were clear about their roles and accountabilities. There were opportunities for leaders to meet to discuss the performance of the service.

The provider had some structures, processes and systems of accountability to support the delivery of their services. We saw auditing of some areas of the service which was not accurate enough to provide enough assurance. For example, vehicle checklists and recruitment. The provider was in the process of installing a new quality and compliance-focused software. This would include for example, event reporting, audits, risk registers and a live dashboard. This system would also enable the provider to have a corporate oversight of the quality of the service being provided.

Some areas of monitoring were not sufficient to be an accurate reflection of the overall service. Weekly vehicle checklists we saw were up to November 2020 and were completed by crews. The Registered Manager reviewed and tracked two vehicle checks per location each week, which was approximately 10% of the fleet. Each location was required to send different call-signs each week until entire location fleet were reviewed. Call signs is the individual vehicle identifier. Each vehicle is marked with letters and numbers. The letters identify the type of vehicle for example;

Patient transport services

EW16 is WAV (wheelchair accessible vehicle). This system is a more informative identifier for the crews rather than just the vehicle registration number. Feedback on non-compliances was returned immediately to operational management and confirmation of actions completed was required by return of e-mail and kept as evidence. However, we did find equipment on vehicles crews were not trained to use and were not required for their service.

Auditing of incidents, safeguarding, complaints and feedback from patients was undertaken monthly. The report on incidents was shared with the head of compliance at quarterly meetings attended by the registered manager for the location. Monthly reports of complaints, incidents and safeguarding were sent to the board and shared with the local CCGs as part of their contract monitoring.

Outcomes were reviewed and shared across the company. A monthly report was completed of all incidents, and this was shared with the providers at board level and the Clinical Commissioning Group (CCG) as part of their contract arrangements. All incidents across the company were discussed at the quarterly compliance meeting where there was representation at local level and board level. Any lessons that needed to be shared across the company were discussed and actions agreed.

There were gaps in the governance of the recruitment process which could put patients at risk. Most of this recruitment of new staff was undertaken centrally at the providers head office by their human resources team. Senior staff at each main location would undertake the interview. Managers at the locations did not have access to all the information required about their staff to ensure risk assessments and safety management strategies could be implemented. We reviewed the recruitment records of four randomly selected new members of staff from a list of new staff. Two had commenced employment and the other two were due to start work after our inspection. The providers application form only requests five years employment history and not a full employment history as required under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). This would not provide enough employment history to enable a full review of staff skills and employment experience. Each member of staff had gaps in their employment history with only one providing evidence of these gaps. The computer system used flags when there was a gap of more than 30 days, but no record of the actions taken from this. The interview record sheet asks the interviewer to follow up gaps in employment history but in the two records we saw there was no evidence of this.

The E-Zec recruitment policy stated, “any gaps in employment history must be explored and any explanation given by the candidate must be noted on the interview notes”. Their recruitment policy also states, “we require applicants to outline their full employment and/or training history covering the previous 3 years”. This does not meet the regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) as it must be a full employment history as stated above.

The Disclosing and Barring Scheme (DBS) checks had been returned before staff started work. We saw that for three staff the check had been returned prior to them starting work. The fourth member of staff had not started work and their DBS check was waiting to come back before they started. We saw evidence of a police caution many years previously in one employment record. There was no record that consideration had been given to managing any risks associated with this. The provider told us a risk assessment was completed, but was not provided for us to review.

The provider recruitment policy relating to references does not provide details about requesting evidence of conduct from previous employment with children or vulnerable adults. Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) states; “Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to (a) health or social care, or (b) children or vulnerable adults. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended”.

References had been requested for each new member of staff but not all been returned. We saw these were followed up by the provider. For two members of staff who were yet to start work these checks were ongoing. We saw one had two references returned prior to starting work and this included one from their last employer. The other member of staff who started work we saw three references had been requested but only one had been returned. The registered manager asked the human recourses department (HR) about these missing references and was told that after six months if they had not been returned a risk assessment would be completed. No risk assessment had been completed prior to this member of staff starting work to make sure any risks to patient had been assessed and a decision made on their suitability. Senior staff who recruited new staff had access to their references on their computer system. The provider told us a risk assessment had been completed, however we have been unable to review this.

Health questionnaires were sent to new staff members. One was waiting to be returned for one new member of staff who had not started working for this provider. One new staff member had added in two concerns with their health. There was no record to state this had been reviewed by anyone or additional information obtained. Local management had not seen this health questionnaire so were not aware of the concerns raised. They told us they do not get to see these and so could not ensure that health related risks would be safely managed. Human Resources (HR) told us during the inspection all health questionnaires were reviewed by a HR administration assistant who if concerned would pass to the medical director. The provider told us staff at locations who recruit staff would be made aware of any concerns that need following up to prevent patients being put at risk. The provider told us this had been reviewed and no concerns identified. The provider told us they would send evidence of this after our inspection. We have not been sent this.

The recruitment process did not follow E-Zecs own recruitment policy. We were not assured the provider was undertaking auditing of their recruitment process both by head office and the locations. Following our feedback to the provider after the inspection they sent us evidence of the changes they had started to make to meet the regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) in relation to recruitment.

Arrangements with partners and third-party providers were governed and managed effectively to encourage interaction and promote coordinated, person centred care. For example, the Clinical Commissioning Groups (CCGs) monitored key performance indicators (KPIs) and Commissioning for Quality and Innovation (CQUINs) regarding the service's performance. CQUINs are extra quality improvement goals that services can agree to aim for, there is a financial incentive to achieve those aims. The CQUIN framework is intended to reward excellence, encouraging a culture of continuous quality improvement, whilst delivering better outcomes for patients. A monthly report was sent to the CCGs and senior staff met with representatives from the CCG on a frequent basis.

Policies and standard operating procedures were accessible in on the company's electronic system called the hub. Staff had access to them to support them in their roles. However, not all policies were regularly updated and followed. For example, the policies relating to oxygen management and the human recourses recruitment policy.

Risk Management

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

There were arrangements for identifying, recording, managing and mitigating risks, including those to keep patients safe. The registered manager was able to show us their risk register for the Gloucester location. We saw risks were reviewed and updated. For example, at one of the satellite locations there was an issue with the roof. We saw records which showed this had been reviewed and actions agreed and when the issue was addressed. This was shared with the local Clinical Commissioning Group.

Inspected but not rated

Patient transport services

The registered manager was able to explain to us the highest risks to their service provision. For example, Covid-19, and the extra demands this had placed on them with changes to their contract with the each of the local Clinical Commissioning Groups (GGC's). Having enough, staff to keep the service running and meet their contract with the local CCG's. The risk register evidenced these risks were assessed, mitigated and managed by the service.

The provider had a risk register where each of their locations could add their highest risks to share with the board members. This provided the board with an overview of their service risks. We saw a risk for this location which was about parking vehicles too close the fire door. Actions were seen for example, yellow marks were painted by the door to warn drivers not to park there.

Senior managers told us about the actions they had implemented in relation to keeping staff and patients safe through the Covid-19 pandemic. This included cleaning of vehicles, PPE for staff, and managing clinical waste and cleaning in line with company policies.

There was a programme of some internal audits to monitor quality, operational processes, and systems to identify where action should be taken. Some checks were not carried out correctly and an appropriate safety response taken. At the Lydney satellite location two vehicles had been identified as having an issue where the rear door would not open from the inside. This was written on the white board in the staff room. Both vehicles were still in use; however, one had been involved in a minor accident that morning so had been removed for a repair. The other vehicle was still being used. When we pointed this out to the management team the crew were contacted to bring the vehicle back to the base. We were concerned this was not identified and actioned immediately when written on the white board, as this could potentially place patients at risk.

The service understood and managed foreseeable business risks. A business continuity plan had been devised to manage for example, loss of facilities or infrastructure. To manage demand the provider had a daily meeting where demand and capacity was discussed across all locations. The registered manager said at this location they were able to move around vehicles and staff to meet the needs of the service if required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed