E-Zec Medical Transport Services Ltd

E-zec Medical Transport - Cornwall

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	Good
Are services safe?	Good
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We carried out a comprehensive inspection of E-Zec Medical Transport Services Cornwall as part of our inspection programme. We inspected and rated all of our key questions: safe, effective, caring, responsive and well led.

Our previous inspection of this provider was completed in April 2021. However, this did not result in a rating as the Care Quality Commission did not have the legal powers to rate independent ambulance services at that time.

Following our inspection in April 2021, the provider was issued with 2 requirement notices, one under Regulation 17 (Good Governance) and the other for Regulation 19 (fit and proper persons employed). We found that the service had made improvements to meet those requirement notices.

Before the inspection, we reviewed information that we had about the provider, including intelligence and data provided to us.

We rated this location as good because:

- 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 collected safety information and used it to improve the service.
- Managers monitored the service provision and 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. They provided emotional support to patients, families and carers.
- 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:

- The service did not meet all agreed response times. Some patients were subject to long waits for transport which placed patients at risk of harm.
- Not all patients could access transport when they needed it, which impacted on their access to care and treatment with other healthcare providers.
- There had been improvements with the recruitment practices of new staff, but systems and processes to investigate gaps in employment history was not effective.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	We rated this service as good because: See above for details.

Summary of findings

Contents

Summary of this inspection

Background to E-zec Medical Transport - Cornwall

E-Zec Medical Transport Cornwall is operated by E-Zec Medical Transport Services Ltd. The service provides non-urgent, planned transport for adults with a medical need who need to be transported to and from NHS funded services, who are registered with a GP. Patients need to meet the eligibility criteria agreed with the Integrated Care Board (ICB) to access the service. They are commissioned by the ICB to serve the communities of Cornwall.

The service started to provide secure mental health transport services in February 2023 under a contract with the local Integrated Care Board (ICB). We were advised that 5 short journeys had been completed at the time of our inspection.

E-Zec Medical Transport Cornwall's fleet consists of 42 vehicles, including cars, vehicles for transporting patients on stretchers, and transport vehicles with wheelchair access. The service has a dedicated patient transport vehicle for mental health transport which is fitted with a secure cell if required to ensure patient and staff safety. The service has a main base in Redruth, their call centre is in Bodmin with a satellite base in Saltash. We visited all 3 locations as part of this inspection.

This service has had a registered manager since 2019. Registered Managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The service is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

The service completed approximately 38,400 patient transport journeys in the last year.

How we carried out this inspection

We carried out a short notice, announced comprehensive inspection on 28 February and 2 March 2023. We announced the inspection so that the registered manager was present and enabled them to make arrangements for the inspection team to speak with staff and patients.

The inspection team comprised of 2 CQC inspectors and a specialist advisor with expertise in patient transport services.

During our inspection, we visited locations in Redruth, Bodmin and Saltash. We completed 6 vehicle checks. We spoke with 13 members of staff including the registered manager, senior managers and ambulance care assistants. We spoke with 4 patients and 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.

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The provider and location were looking at ways to reduce their carbon footprint and the effect on the environment. They were using eco-friendly cleaning products and encouraging staff to drive more economically to reduce fuel consumption and their carbon footprint. Future plans included the use of electric vehicles.

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that patients are not subject to long waiting times either to be picked up or returned home from appointments or treatment to reduce the risks of harm. Regulation 12(2)(a)

Action the service SHOULD take to improve:

- The service should ensure that they investigate and accurately document gaps in employment history during the recruitment process. Regulation 17(2)(a)
- The service should ensure that the toilets in the Redruth location are properly maintained and safe for use. Regulation 15 (1)(a)
- The service should ensure that the risk register reflects all current risks. Regulation 17(2)b)
- The service should provide communication aids and patient information leaflets in different languages in their transport vehicles.
- The service should continue to recruit new staff to fill their vacancies.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Patient transport services

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

Is the service 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. The service held an annual skills development day for staff to complete yearly mandatory training. Overall training compliance was 95% against their own target of 85%.

Staff completed training required for their roles in health and social care. This included learning on how to interact with patients who had autism or a learning disability.

Additional training was provided to staff who undertook secure mental health transport including increased safeguarding, verbal de-escalation and physical restraint.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were sent reminders by email and line managers monitored training compliance for their staff.

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.

Staff received in-depth training specific for their role on how to recognise and report abuse. Staff with regular patient contact were trained to level 2 in safeguarding adults and children. Safeguarding leads for the provider were trained to level 4 in adults and children. Training compliance was at 91.2% for level 1 and 89.2% for evel 2, which was above the provider's target of 85%.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Good

Patient transport services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. If children were being transported, staff ensured they were escorted by a parent or another responsible person.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were supported by a safeguarding team who were available 24 hours each day for initial queries and help with raising concerns. Local managers were available to help staff with safeguarding queries, including out of hours.

We reviewed recruitment checks which showed full compliance with Disclosure and Barring Service (DBS) checks for all staff, alongside an automatic process to review every 3 years with an alert system for any offences in the interim period.

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.

All areas were visibly clean and had suitable furnishings which were regularly cleaned and well-maintained.

Cleaning records were consistently maintained and demonstrated that all 3 satellite premises were cleaned regularly. Following our previous inspection in Saltash, an external provider was introduced to improve cleaning and we observed significant improvement during this inspection.

Cleaning records were up-to-date at Redruth, Bodmin and Saltash which demonstrated that all areas were cleaned regularly. Cleaning products were correctly risk assessed in accordance with Control of Substances Hazardous to Health (COSSH) requirements.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff said they cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Every vehicle was scheduled for a deep clean every 12 weeks. We reviewed evidence of this and ongoing monitoring of this process. Ambulance care assistants cleaned vehicles at the end of their shift and told managers if vehicles needed a deep clean earlier than planned.

Ambulance care assistants had access to mobile devices which held details of any patient infection risks so that actions could be taken to maintain safety.

Ambulance care assistants training compliance for infection, prevention and control (IPC) was confirmed as 88.2% against a target of 85%.

Environment and equipment

The design, maintenance and use of premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all areas of the premises were always well maintained.

Good

Patient transport services

During our inspection we checked 6 vehicles at Redruth, they were all roadworthy, had enough equipment and were well maintained. The service had a dedicated patient transport vehicle for mental health transport, this was fitted with seats and a secure cell for patients who presented as high risk. The cell had not been used as ambulance care staff recognised the use of seats as the least restrictive option.

Ambulance care assistants carried out daily safety checks of vehicles and reported any concerns or defects for immediate investigation. This information was tracked electronically and on a local whiteboard for all staff to see actions taken. Each vehicle was fitted with a tracker to enable journey monitoring and completion of welfare checks if staff were unexpectedly delayed.

Ambulance care assistants said they were trained in use of equipment including stretchers and wheelchairs. The service had enough equipment to help them to safely care for patients.

Ambulance care assistants disposed of clinical waste safely. The service had a contractor to remove clinical waste at regular intervals with provision to increase collections if required.

The environment across their premises in Redruth, Bodmin and Saltash were designed for their use. However, we found that the toilet seat in the female toilet was loose and the bin was broken. Following our inspection, the registered manager told us that these issues had been resolved.

Assessing and responding to patient risk

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

Ambulance care assistants responded promptly to any sudden deterioration in a patient's health. All patient transport vehicles were double-crewed with one member of ambulance care assistant with patients at all times. Ambulance care assistants told us the actions that they would take if a patient became unwell unexpectedly and this was in line with the provider's policy we reviewed following the inspection.

All patient referrals were made through the call centre in Bodmin. This process included a risk assessment to ensure safety was maintained and included information such as mobility requirement and any infectious diseases. Ambulance care assistants completed risk assessments for each patient using the information loaded to their mobile device by call centre staff and raised incidents where appropriate.

Following our inspection, we reviewed the referral process for mental health transport which included a safety risk assessment of the patient, any previous known risks and number of ambulance care assistants required.

Ambulance care assistants shared key information to keep patients safe when handing over their care to others, including family members, hospital and care home staff.

Staffing

Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction. However, the service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The manager could adjust staffing levels daily according to the needs of patients and demands of the service, this fluctuated from day to day and was dependant on the number of discharges from local hospitals.

The service had reducing turnover rates. Senior managers said that they were working hard to retain ambulance care assistants. Staff turnover had reduced but was at 30% at the time of our inspection. Senior managers had improved pay for staff and recognised the importance of staff retention. New ambulance care assistants completed a 12 week induction programme, including mandatory training and driving assessment before starting their first shift.

The service had low sickness rates of 3.9% in January and February 2023 against a target of 4.5%. If ambulance care assistants sickness increased to over 4.5%, senior managers would report this to the Integrated Care Board (ICB) as agreed within their contract.

Managers made sure all bank staff had a full induction and understood the service.

However, the service did not have enough ambulance care assistants to keep patients safe. Senior managers told us they needed 86 full time equivalent of ambulance care assistants and had 79 at the time of our inspection. The service used bank staff as a short term measure. Senior managers told us of recent successful recruitment which resulted in the recruitment of 10 new employees who were due to start by the end of March 2023 and would fill their current vacancies.

Records

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

Patient notes were comprehensive and all ambulance care assistants could access them easily. Ambulance care assistants had access to patient notes on mobile devices and included patient risks such as poor mobility or travel sickness before collecting any patient.

We reviewed 4 patient records on the provider's computer system and found accurate documentation which included an assessment by control room staff and further consideration by ambulance care assistants.

Records were stored securely, all mobile devices were password protected. Patient notes were updated by ambulance care assistants and downloaded to their patient record through the mobile device.

Medicines

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

Patient transport vehicles were stored and equipped with oxygen cylinders, which were only used in an emergency. No other medicines were held on vehicles.

If a patient was discharged from hospital with medicines, they were retained by the patient and not held by any members of ambulance care assistants.

Any medicines that were being transferred with a mental health patient would be stored securely within the patient transport vehicle and given to clinical staff upon arrival at their destination. Local managers said they had not transferred any patients with medicines at the time of our inspection.

Good

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.

Ambulance care assistants knew what incidents to report and how to report them. Ambulance care assistants described the incident reporting process and received feedback with any learning. When ambulance care assistants reported incidents from their mobile devices, a senior manager would be aware of this immediately and enabled them to start an investigation and provide support to ambulance care assistants.

Managers closely monitored and reviewed incidents and shared learning with their local ambulance care assistants and across the service. Managers developed a staff newsletter which included learning from local and national incidents within the E-Zec group.

Ambulance care assistants understood the duty of candour. They were open, transparent and gave patients and families a full explanation if and when things went wrong. Senior managers reinforced this and encouraged ambulance care assistants to be honest and focused on learning from incidents that happened. Senior managers took ownership of incidents that required duty of candour and had a system to follow if an incident met the threshold for duty of candour.

Ambulance care assistants received feedback from investigation of incidents, both internal and external to the service. Incidents were discussed at regional meetings and managers communicated themes and learning from other areas. Learning from incidents was communicated to staff by monthly leaflets, emails and posters in staff rooms.

Is the service effective?

Requires Improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and providers policies. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Ambulance care assistants followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All staff rooms had noticeboards with relevant updates. This information was loaded to mobile devices and managers had oversight of ambulance care assistants who had reviewed new policies and guidance.

Call centre staff assessed every referral to check patient eligibility for the service and described awareness of the NHS England eligibility criteria for patient transport service to ensure they transported appropriate patients.

Good

Patient transport services

Ambulance care assistants were made aware of any patient specific needs such as mental health or disability by reviewing notes on their mobile device. Ambulance care assistants also received a handover when collecting patients from hospitals or care homes.

Ambulance care assistants protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

Patients had access to water during the journeys.

Ambulance care assistants planned all journeys to account for patient's hydration, nutrition and toileting needs. Ambulance care assistants ensured that patients with long journeys had been to the toilet before leaving. Patients had access to water on vehicles if required.

Response times

The service monitored agreed response times so that they could facilitate good outcomes for patients, however they did not always meet them. They used the findings to help make improvements.

The service monitored their performance against Key Performance Indicators (KPI) that were agreed under their contract with the Integrated Care Board (ICB).

Senior managers said the service completed approximately 38,400 patient transport journeys in the last year.

The Key Performance Indicator (KPI) for patients to arrive at their outpatient or dialysis appointment was up to 45 minutes before their appointment time. Information provided by the service following our inspection from January and February 2023 confirmed that 18% (229 out of 1241) of outpatients and dialysis patients arrived late for their appointments. Data showed that 2 patients were delayed by between 90 mins and 2 hours, with 2 patients delayed by over 4 hours. Senior managers said they were recruiting 10 ambulance care assistants in March 2023 and they hoped patient experience would improve as a result.

The KPI for patients to be collected from outpatients and dialysis appointments was within 45 minutes of their completed appointment. Information provided by the service following our inspection covering January and February 2023 confirmed that 81% (1158 out of 1430) of patients were collected within 45 minutes.

The service collected end of life patients from all areas of local hospitals including emergency departments and dialysis units. Data from November 2022 showed 4 end of life journeys were completed with waiting times that ranged between 2 hours and 20 minutes to 3 hours and 30 minutes. The longest delay happened because the patient needed a second patient transport crew.

During our inspection we reviewed data which demonstrated that response times were being closely monitored and an improvement was observed in delays from September to December 2022 with a slight decrease in January 2023 where 25 patients waited over 6 hours and 10 patients waited over 10 hours for transport. This placed patients at risks of harm when experiencing long delays to get to, and from appointments especially those who were more vulnerable such as end of life patients.

Good

Patient transport services

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.

Ambulance care assistants were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Ambulance care assistants received appropriate training for their roles. The service provided dedicated staff for mental health transport, they received additional training such as dealing with violence and aggression.

Managers gave all new ambulance care assistants a full induction tailored to their role before they started work. Ambulance care assistants completed a structured induction plan including classroom learning and driving assessments. New call centre staff completed a detailed induction programme that included scenarios, job shadowing of existing colleagues and spent time with ambulance care assistants. All new ambulance care assistants had regular probation reviews and were supported by a mentor.

Managers supported staff to develop through yearly, constructive appraisals of their work. Information provided by the service following our inspection confirmed appraisal rates of 99%.

The service found it difficult to arrange full staff meetings due to differing shift patterns and potential negative impact on patients. Staff representatives met with senior staff at regular intervals and records were shared with all staff. Senior managers made sure staff received key messages by different methods to provide updates such as newsletters, posters in staffroom and email.

Ambulance care assistants had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The service encouraged staff development. Senior managers said several ambulance care assistants have enrolled onto the provider-wide apprenticeship scheme with a pathway towards a paramedic qualification.

Managers identified poor staff performance promptly and supported staff to improve. Managers described an emphasis on informal conversations where appropriate.

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.

Ambulance care assistants worked with local hospitals, care homes and other agencies to discuss incidents and improve patient care. Ambulance care assistants were made aware of any patient requirements or other important information such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

The service employed a patient transport liaison officer at the local NHS acute hospitals to provide support with transport bookings and to improve the patient discharge process through communication with ward staff.

The service held monthly review meetings with local NHS hospitals and were keen to strengthen their relationship to learn from incidents and improve the patient experience.

Health promotion

Good

Patient transport services

Staff gave patients practical support and advice to lead healthier lives.

Ambulance care assistants signposted patients to information that promoted healthy lifestyles, however we did not see this information in their patient transport vehicles.

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.

Ambulance care assistants understood how and when to assess whether a patient had the capacity to make decisions about their care. The service had 4 dedicated ambulance care assistants for mental health transport and provided additional consent, Mental Capacity Act (MCA), Mental Health Act (MHA) and Deprivation of Liberty Safeguards (DoLS) training. This included the process for patients without capacity to consent.

Ambulance care assistants gained consent from patients for their transport in line with legislation and guidance. Following our inspection, we reviewed the provider's policy for obtaining patient consent and transporting children which covered the key information and regularly reviewed.

When patients could not give consent, ambulance care assistants made decisions in their best interest, taking into account patients' wishes, culture and traditions. Patients with dementia or learning disability were often supported by family members or carers.

Ambulance care assistants understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Ambulance care assistants could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Ambulance care assistants training compliance for combined consent and Mental Capacity Act training was 97.1%, which was above the provider's own target of 85%.

Is the service caring?

Good

Compassionate care

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

Ambulance care assistants were discreet and responsive when caring for patients. Ambulance care assistants ensured that patients were adequately dressed before starting journeys and patient transport vehicles were equipped with blankets to maintain patient dignity if required.

Good

Patient transport services

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed several interactions between staff and patients which were kind and compassionate.

Patients said staff treated them well and with kindness. Ambulance care assistants were provided with detailed handover information for each patient such as sight loss and travel sickness and made appropriate adjustments. Patients were very happy with the standard of care provided.

Comments received from patients in February 2023 included:

- "The lift at home broke so they took me all the way around without any problems very pleased."
- "Absolutely brilliant could not have been more helpful."
- This service is invaluable I would not manage without it thank you."
- "I would recommend your service to anyone."

Ambulance care assistants followed policy to keep patient care and treatment confidential. Patient information was stored on mobile handheld devices that were password protected. No patient records were used during the transfer process.

The provider actively requested feedback from patients to measure and improve their service. Information we reviewed following our inspection showed that from 71 responses, 100% of patients felt that they were treated with dignity and respect.

Ambulance care assistants demonstrated awareness of how to challenge any inappropriate behaviour and would raise an incident for managers to investigate and consider appropriate action to take.

Emotional support

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

Staff gave patients, families and carers help, emotional support and advice when they needed it. Patients told us that staff were very kind, even when they expressed frustration towards them.

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. Patients said staff showed awareness they were often being collected later than planned and were often tired after treatment.

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.

We observed how staff interacted with patients, families and carers in a way they could understand. They spoke with patients in a very caring and patient way.

Patients and their families could give feedback on the service and staff supported them to do this.

Good

Patient transport services

Senior managers closely monitored patient feedback and contacted patients who responded with any unsatisfactory feedback to make improvements.

Is the service responsive?

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. Journeys for regular patients were planned to meet the contract with the Integrated Care Board (ICB). In addition, the service accepted short notice transport bookings from local NHS hospitals to facilitate patient discharges. This resulted in patient transport vehicle journeys being recalculated throughout each day, minimising impacts on patients were possible.

Ambulance care assistants followed the process for cancelling journeys if patients were not at home but reported this to the call centre and attempted telephone contact with the patient before cancelling.

Senior managers had expanded the service to include secure mental health transport and completed 5 short journeys in February 2023 and had planned to further expand their service to include high dependency transport.

Facilities and premises were appropriate for the services being delivered. The main site was in Redruth, the call centre was in Bodmin and a satellite depot was in Saltash.

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.

Ambulance care assistants were aware of the provider's policy on meeting the information and communication needs of patients with a disability or sensory loss for care funded by NHS, however we did not see communication aids on vehicles. Any patient communication or disability information was recorded in patient notes. Patients could be accompanied by a family member or carer to support them.

In addition to the patient liaison officer located at Redruth hospital, managers have increased support to patients waiting for transport by recruiting for a patient liaison administrative role. They will identify patients at risk of being delayed, provide them with food and fluids until transport has arrived.

The service did not have information leaflets available in different languages. However, senior managers were aware of this and planned to make improvements.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Ambulance care assistants had access to interpreter services and call centre staff arranged this for pre-booked journeys. Ambulance care assistants could access interpreter services from their mobile device.

The provider had improved their mandatory training to include autism and learning disability awareness. Dedicated mental health transport ambulance care assistants received additional training such as physical restraint.

Access and flow

Patients could not always access the service when they needed it, however the service monitored and rescheduled journeys to meet patient needs.

Managers monitored waiting times but could not ensure patients could access services when needed and often did not receive transport within agreed timeframes. Senior managers reviewed the service performance against Key Performance Indicators (KPI) with the local Integrated Care Board (ICB). This included concerns related to delays in patients arriving for and being collected after treatment.

The service provided transport for all areas of local NHS hospitals, including emergency departments. We reviewed information that we requested following our inspection in relation to patient delays. From 13 February to 24 February 2023, the service did not meet the KPI on 31 occasions, 19 patients waited between 2 to 3 hours, 5 patients waited for between 3 to 4 hours and 7 patients waited over 4 hours. Staff and managers worked hard to reduce delays for patients. Following our inspection, the service has improved efficiency by using single-crewed staff to collect appropriate patients.

Call centre staff proactively contacted patients to advise them of delays and rescheduled patient journeys to be more efficient where possible and reduce impact on patients.

The service had 20 last-minute cancelled journeys in December and 31 in January, these were mainly due to local care homes being unable to accept patients after 6pm. Control room staff proactively contacted ward staff and transport was re-booked for the next day.

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. Patients used different ways such as direct to ambulance care assistants, through the call centre or to the local hospital.

All vehicles showed information about how to raise a concern or give feedback.

Ambulance care assistants were provided with information about how to deal with complaints. They understood the policy on complaints and knew how to handle them. Managers were available for support when required.

Good

Patient transport services

Managers investigated complaints and identified themes. Information provided us to after the inspection confirmed that 1 complaint was received in December 2022 and 5 complaints received in January 2023 and related to journey delays and equipment use. The service received a total of 39 complaints for 2022, 36 were upheld with 3 not upheld.

Complaints were allocated to senior managers to investigate before a response was provided in line with their policy. Complaints were recorded on a tracking system which provided reminders to ensure that final responses were provided to comply with their policy. Managers explored different ways of dealing with complaints such as by telephone and home visits. If patients or families were unhappy with the response provided, they were signposted appropriately to escalate further.

Managers shared feedback from complaints with staff and learning was used to improve the service. Senior managers distributed a monthly learning document which covered incidents and learning from the previous month. The bulletin from December 2022 referred to an incident where a patient fell out of a wheelchair and raised the importance of using safety belts. The monthly documents included other information such as number of complaints with identified themes.

The service highlighted any particularly long patient delays and patient complaints by recording them on their 'service recovery board'. These patients were closely monitored by a centralised team to improve the patient experience and to measure if the service had improved.

Is the service well-led?

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. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge and experience to run the service. The local management team had been established since 2019. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. There was a clear management structure for this area and the provider.

Ambulance care assistants told us leaders were visible and approachable and spoke of site visits from senior managers. All staff were aware of and felt fully supported by their managers.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and a leadership strategy and development programme, which included succession planning.

Leaders understood the challenges to quality and sustainability and 10 new ambulance care assistants due to start before the end of March 2023 to help address these.

Vision and Strategy

Good

Patient transport services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and a set of values throughout the Cornwall service and their wider service called “We Listen, We Learn, We Adapt”. Staff demonstrated awareness of these and this was discussed during team meetings and uploaded to the staff portal.

Senior leaders were aware of the local challenges which included staffing and patient response times. There was a realistic strategy for achieving the priorities. Recruitment and retention of staff was a key theme.

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans was monitored and reviewed with the ICB and local hospitals.

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.

Staff felt supported, respected, valued and were positive and proud to work in the organisation. The culture was centred on the needs and experience of patients who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

Leaders and staff understood the importance of being able to raise concerns without fear of retribution. Learning and action taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including patients who used services, and in response to incidents. Senior managers and staff were keen to work together to improve the patient experience and were honest when things did not go as planned.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Senior managers encouraged ambulance care assistants to gain further qualifications. There was a strong emphasis on the safety and well-being of staff. Support was available by formal counselling or an informal chat, and managers adapted their approach accordingly.

Governance

Leaders operated governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, not all governance processes were effective and staff did not have the opportunity to meet as a team to discuss and learn from the performance of the service.

Good

Patient transport services

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. We reviewed evidence of meetings at local and regional level which showed discussions around performance and potential areas of concern. The service used computer systems to monitor data and performance and shared this information during monthly performance review meetings with the local Integrated Care Board (ICB).

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Staff felt supported through their line manager, allocated mentor. Local managers had an open door policy. The service did not provide meetings for all ambulance care assistants as this would be difficult to facilitate without having a negative impact on patients.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care in discussion with local hospitals and care providers.

All levels of governance and management functioned effectively and interacted with each other.

During our inspection, we reviewed 8 employment records and found that 4 applications with gaps in employment history had not been fully explored. In 3 of the 4 records, the interviewing panel had not identified several employment gaps ranging between 3 to 11 months. The remaining employment record was updated to advise that a discussion had taken place during the interview but no further information was documented. This was discussed with the registered manager during our inspection. We did not find any concerns with the remaining 4 records that we checked.

Following our inspection, local managers confirmed a provider-wide change to the recruitment process and improved oversight to improve compliance. From mid-February 2023, all applications were reviewed by human resource (HR) teams to check elements such as employment gaps, disclosure and barring service (DBS) and references before a position was offered to an applicant. Files were returned to the recruiting manager if any of the recruitment elements were missing. The service had not employed any new members of staff since the process changed.

An audit of all existing staff files had started, to provide assurance that recruitment processes have been fully complied with.

Management of risk, issues and performance

Leaders and teams used systems to manage performance and had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, they did not identify and escalate all relevant risks and issues and identified actions to reduce their impact.

The service had comprehensive assurance systems and performance issues were escalated through clear structures and processes. There were processes to manage current and future performance which were reviewed internally and with the ICB.

Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. However, these processes did not address the concerns that we found with the employment process during inspection but have been resolved since. Reports demonstrated action was taken when required and improvements monitored.

Good

Patient transport services

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. Staff and managers identified one of their biggest concerns as patient delays, but this was not documented on the risk register provided following our inspection. No new risks had been added since November 2021.

Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

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.

Quality and sustainability both received coverage in relevant meetings at all levels.

Staff had sufficient access to information and challenged it when necessary. There were clear service performance measures, which were reported and monitored with effective arrangements. This ensured the information used to monitor, manage and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

Engagement

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

Patient's views and experiences were gathered monthly and acted on to shape and improve the services and culture.

In January 2023, 46 patients responded to the patient feedback survey as follows:

- 93% were very likely to recommend the service to friends and family.
- 98% were very satisfied with their experience in the patient transport vehicle and the ability of staff to meet their needs.
- 96% were very satisfied with the standard of driving by ambulance care assistants.

Local managers contacted patients who responded with dissatisfaction to gain further information and to make improvements. The surveys were random and included patients in a range of equality groups and those close to them. Staff were actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture.

All staff were asked to complete a yearly staff satisfaction survey. Areas for improvement were identified such as wellbeing and contact with managers. Senior managers have introduced bi-monthly open meetings with the Chief Executive and implemented a quarterly check-in between managers and staff to improve engagement. The service issued a newsletter to staff to highlight good news stories and financial incentives such as Blue Light Card.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Senior managers said that they had increased their service to include secure mental health transport to improve their support to the local community. Ambulance care assistants were supported by senior managers to begin apprenticeship roles.

In addition to the existing patient transport liaison officer, the service planned to introduce a hospital liaison role based at a local NHS hospital to improve patient flow and support patients whilst waiting for transport.

Local managers had identified several errors during the transport booking process and had started to use a computer programme to review referrals and improve efficiency. Local managers said national training was amended to include material designed by control room staff in Cornwall.

Leaders reduced the carbon footprint of the service by use of eco-friendly mist with less environmental impact and planned to introduce electric powered vehicles.

The service used a driver monitoring system to improve driving standards, patient experience and carbon emissions with a financial incentive each month.

Staff had access to a reward and saving scheme. Other incentives included retail discount, £20 gift voucher at Christmas, legal assistance and free drinks through a wellbeing mobile phone application.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(a) Patients experienced long delays when waiting to be collected or returned home from appointments or hospital treatment.