E-Zec Medical Transport Services Ltd

E-Zec Medical Transport - Staffordshire

Quality Report

Conveyors House
Turner Crescent
Newcastle
Staffordshire
ST5 7LU
Tel: 01737822782
Website: www.e-zec.co.uk

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

Ratings

Patient transport services (PTS)

Summary of findings

Letter from the Chief Inspector of Hospitals

E-Zec Medical Transport - Staffordshire is operated by E-Zec Medical Transport Services Ltd. The service provides routine and high-dependency patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 24 and 25 July 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

At the time of this inspection; we regulated this service but did not rate it. This is because we issued a provider information request to gain data prior to the inspection before 2 July 2018. Inspections where provider information requests are sent to independent ambulance services after 2 July 2018 will be rated.

We found the following issues that the service provider needs to improve:

- Vehicles checked were found to be unclean; patient areas were dusty; with spilt liquids on seats and stretchers. We saw unsecured clinical waste on vehicles and a dirty, stained patient blanket behind a folded chair. Vehicle cleanliness was not audited by local managers.
- Medicines stored on the bases were not temperature controlled or monitored. The service medicine management policy did not specify this requirement.
- Mandatory training levels were below 50%. The service did not have a structured plan with set actions to achieve compliance.
- Incidents were not always reported in line with the provider's incident reporting policy.
- The service was underperforming in seven out of nine key performance indicators as of April 2018.
- Supervision and appraisal rates were poor; and the quality of appraisals was substandard.
- Staff morale was poor in areas; the culture of the service was one of fear to speak up. Staff team meetings were rare; and generally not formally recorded or structured.
- We found there was no overall service improvement plan. Learning from any feedback was not embedded and used to improve the service. Where ideas were generated; there were no formal action plans or objectives. Following the inspection; the provider gave us action plans for improving specific areas of business including renal patient key performance indicators.
- The risk register was outdated and missing key risks.

We found the following areas of good practice:

- Staff presented as passionate about their role in supporting patients; and were caring and respectful.
- Paramedic specific competencies were monitored and in date.
- Supervision and development of staff was being undertaken within the bookings team.
- The service sought to accept every booking made.

Summary of findings

- Staff were aware of their safeguarding requirements; and had the means and knowledge to report concerns. Concerns were dealt with appropriately.
- Feedback from staff indicated that the new local managers structure was already making positive changes with regards to staff engagement.
- During the inspection we observed effective teamwork and communication between staff.

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

Victoria Watkins
Head of Hospital Inspection (Central West) on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		At the time of this inspection; we regulated this service but did not rate it. This is because we issued a provider information request to gain data prior to the inspection before 2 July 2018. Inspections where provider information requests are sent to independent ambulance services after 2 July 2018 will be rated. We found the service was in breach of two regulations. These are: Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17: Good governance

E-Zec Medical Transport - Staffordshire

Detailed findings

Services we looked at
Patient transport services (PTS);

Detailed findings

Contents

Background to E-Zec Medical Transport - Staffordshire

E-Zec Medical Transport - Staffordshire is operated by E-Zec Medical Transport Services Ltd. The service has been operating in North Staffordshire since August 2016 and South Staffordshire since October 2016. Two new contracts have been recently awarded; and commenced in June 2018 across both North and South Staffordshire. These are high dependency contracts which involves the transfer of critical and non-critical transfers of patients from one hospital to another; and the Community Health Care contract which transports patients who are being treated for mental health conditions on either a voluntary or involuntary basis.

The service subcontracted staff from two local independent ambulance services, and subcontracted taxi drivers and their vehicles from two local taxi firms to cover shortfalls and to meet the needs of the contract.

The service primarily serves the communities of Staffordshire. In order to be eligible to use the service, patients must be registered with a GP within Staffordshire. Patients must also meet certain criteria which means their medical condition and mobility means the patient requires patient transport services.

Carers and or escorts from the sending locations (such as a care home staff member) may also be accommodated on the journey with the patient, should the patient require this due to a physical or mental health condition; or have some other vulnerability.

The service can transport patients of any age; however, those patients under 16 years old must be accompanied by a responsible adult. In circumstances where a responsible adult was not available; for example an urgent high dependency transfer from one location to another; either a member of the hospital staff or a member of the road crew would act as a responsible adult as per the service's policy on transporting children.

As well as local journeys, the service offers repatriation from other areas of the UK, assuming the patient meets the criteria set by the service.

We inspected the service on the 24 and 25 July 2018. The inspection was announced and we used our comprehensive inspection methodology for independent ambulance providers. We looked at the core service of patient transport services (PTS).

Our inspection team

The team that inspected the service comprised a CQC inspection manager, two CQC inspectors, and a specialist advisor with expertise in ambulance service provision. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The service is registered to provide the following regulated activities:

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

The service had one main location and three satellite bases. The main base was located in Newcastle, Staffordshire. The three satellite bases were located at Burton upon Trent, Hixon and Stoke on Trent; all Staffordshire. As of June 2018; the service had 93 vehicles in total and 237 substantive staff working across the four bases. There were also 54 bank staff and four voluntary drivers reported at this time.

During the inspection we visited the Newcastle base. In addition to holding the majority of vehicles here; the control room, bookings office, planning office and local senior managers were based at this address. This was the largest base.

We also visited the Stoke on Trent and Hixon bases as part of our inspection.

We spoke with 21 staff across the bases; including registered paramedics, patient transport drivers, control room staff and managers. We spoke with three patients and one member of staff working at a patient's residential home. During our inspection, we reviewed three sets of electronic patient records.

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

Activity (August 2017 to April 2018)

- There were 130,427 patient transport journeys undertaken.
- Of the above journeys, 693 were high dependency.
- As of July 2018, 13 registered paramedics worked at the service.

The service did not hold any controlled drugs.

Track record on safety July 2017 to April 2018

The service reported:

- Zero never events
- 31 clinical incidents were reported; however, the service did not break these down into harm categories.
- One serious injury reported to CQC
- 126 complaints; 20 directly from patients and 106 from hospital/ clinic staff

Patient transport services (PTS)

Summary of findings

We found the following issues that the service provider needed to improve:

- Vehicles checked were found to be unclean; patient areas were dusty; with spilt liquids on seats and stretchers. We saw unsecured clinical waste on vehicles and a dirty, stained patient blanket behind a folded chair.
- Clinical waste in collection bins was not labelled as per Health Technical Memorandum 07-01: Safe managers of healthcare waste. However, data provided by the service showed after the inspection, this concern was raised with the third party clinical waste collection company who confirmed they labelled the bags on behalf of the location upon collection.
- Medicines stored on the bases were not temperature controlled or monitored.
- Mandatory training levels were below 50%. At the time of the inspection, the service did not have a structured plan with set actions to achieve compliance. Since the inspection, managers provided a structured training plan.
- Incidents were not always reported in line with the provider's incident reporting policy.
- The service was underperforming in seven out of nine key performance indicators as of April 2018.
- Supervision and appraisal rates were poor; and the quality of appraisals was substandard.
- Staff morale was poor in areas; the culture of the service was one of fear to speak up. Staff team meetings were rare; and generally not formally recorded or structured.
- We found there was no overall service improvement plan. Learning from any feedback was not embedded and used to improve the service. Where ideas were generated; there were no formal action plans or objectives. Following the inspection; the provider gave us action plans for improving specific areas of business including renal patient key performance indicators.
- The risk register was outdated and missing key risks.

We found the following areas of good practice:

- Staff presented as passionate about their role in supporting patients; and were caring and respectful.
- Paramedic specific competencies were monitored and in date.
- Supervision and development of staff was being undertaken within the bookings team.
- The service sought to accept every booking made.
- Staff were aware of their safeguarding requirements; and had the means and knowledge to report concerns. Concerns were dealt with appropriately.
- Feedback from staff indicated that the new local managers structure was already making positive change with regards to staff engagement.
- During the inspection we observed effective teamwork and communication between staff.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- The service had no never events since registration. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death, have occurred in the past and are easily recognisable and clearly defined.
- Staff we spoke with were aware of the duty of candour. The duty of candour is a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We saw that following some incidents, patient welfare checks by telephone and in person were offered and undertaken. This was documented by E-Zec.
- Incidents were reported using a paper based system. If an incident occurred whilst staff were conducting a patient journey; the process was to contact the control room to update them and complete the paperwork upon return to base.
- Incident forms were given to the supervisor or manager on duty; who collated these and sent to head office weekly. The head of governance for E-Zec then reviewed the incidents and determined any actions or investigations required.
- During the inspection, we noted several incidents which were not reported using this method, including problems with vehicles and patient transport delays. We spoke with managers about this who reported that these types of incidents are reported through an alternative method. For example, where problems have occurred with vehicles the fleet manager would report this separately. However, we reviewed the policy for reporting incidents for the provider; which clearly stated that all incidents, including near misses, with the exception of safeguarding concerns should be reported using the company incident form.
- We saw that between July 2017 and April 2018, 31 incidents had been reported. Eleven of these related to patient falls. One of these falls which occurred in January 2018 was later found to be a serious incident (SI) due to the patient sustaining a fracture; and subsequently reported to CQC as per Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4). Incidents were reported as part of monthly quality meetings. However, we did not see that this serious incident was recorded in the quality report for either January, February or March 2018.
- The service provided a copy of the investigation report for this incident; we saw that a root cause analysis was conducted and the next of kin to the patient was contacted as per duty of candour regulations. However, the only sharing of learning documented was with the relevant Clinical Commissioning Group (CCG). Shared learning amongst the wider staff group was not documented.
- Another incident was highlighted as a SI in the quality reports; however, was not reported to CQC as the service did not recognise this as a reportable incident. In this incident; a patient sustained burns to a limb. We saw that following a complaint; this incident was investigated. Data from the service showed the clinical commissioning group (CCG) raised concerns regarding support for the patient involved; and also the lack of action taken following a similar previous incident that occurred in March 2017. We saw the patient was contacted via telephone as part of the duty of candour regulations.
- We saw that although incidents were recorded in the quality report; there appeared to be no follow up on these from month to month; and we did not see significant evidence of any shared learning or discussion in meeting minutes. However, we saw the CCG monitored investigations and root cause analyses of serious incidents where completed.
- Staff received informal feedback about incidents but this was inconsistent and irregular. We were given an example of where learning from an incident that occurred in a different location was shared in a staff bulletin. However, we were not assured that learning

from local incidents was shared with all staff as no formal staff meetings or communication opportunities were held, with the exception of the staff representatives' forum.

Mandatory training

- Staff were expected to undertake yearly updates of mandatory training. These included general data protection regulation (GDPR), safeguarding, consent, fire safety, conflict resolution, infection prevention and control and equality and diversity.
- Basic life support (BLS) was part of mandatory training; and provided this as part of staff's annual development plan.
- Bank staff were required to undertake the same mandatory training and initial induction as substantive staff.
- Due to the weight of vehicles; drivers were not required to possess a C1 driving licence. Instead a standard full UK driving licence was adequate. We checked staff records and saw all those working as a driver held a legal licence. We saw where staff received driving convictions or penalties they were expected to inform their employer. Drivers could be monitored using built in trackers; and were assessed by their supervisor following disclosure of a conviction.
- We saw that mandatory training levels were low at 48% during the inspection. All training modules were included in these figures. Staff and managers reported that staff had been expected to complete training on an unpaid basis if not able to fit into working hours in order to ensure it was completed. The majority of training was completed using e-learning. Staff had access to a shared computer at bases; however, were also given an online portal log on to complete training at home if they wished. At the inspection, managers told us they were looking into alternative ways of ensuring compliance with staff training including paying staff for their time. However, there were no set plans.
- Following the inspection; the service provided a spreadsheet containing staff training details; this highlighted out of date training modules and set dates for completion.
- The majority of new starters in June 2018, including staff who had transferred from a different provider to work on the high dependency contract and a contract to transfer patients with mental health conditions had not yet undertaken any mandatory training at the time of our inspection. Out of 48 staff, five had completed the mandatory training programme.

Safeguarding

- Staff working with patients were trained to level two in safeguarding children, and received training in adult safeguarding. All staff underwent a Disclosure and Barring Service check (DBS; a criminal record check) and we saw these were monitored on a yearly basis for any updates of information.
- Contact details for the provider safeguarding lead was on a key fob attached to vehicle keys. Staff could call for advice and support 24 hours a day. The national compliance manager also provided support with regards to safeguarding concerns raised. Data from the service reported that both the safeguarding lead and the compliance manager were trained to level four in safeguarding children.
- We saw that as of March 2018; 97.8% of staff were up to date with safeguarding training requirements. Those who had not yet completed this at this point were on long term sick leave.
- Patients under the age of 16 were expected to be accompanied by a responsible adult when being transported by E-Zec Staffordshire staff. We saw a standard operating procedure (SOP) which referenced the provider safeguarding policy outlining staff requirements when transferring children and young people under 18 years of age.
- Managers at the location reported that safeguarding referrals tended to relate to adult social care concerns; such as neglect. An example of a recent safeguarding referral that had been made was provided; whereby a patient of no fixed abode was discharged from hospital out of hours. Staff contacted the duty manager who came out to support them. The patient was re-admitted; and social services were contacted to provide additional support.
- Monthly quality reports sent to the contracting Clinical Commissioning Groups (CCGs) showed any safeguarding referrals made. For example, we saw between January to March 2018; three safeguarding

concerns were raised. All of these related to concerns about the patient being able to adequately care for themselves; and all were referred to social services. Follow up information was included; for example, where the patient had their social care packages increased.

- We saw the service's safeguarding policy which covered both adults and children. This was comprehensive; and included details on PREVENT; a national approach to managing the risk of radicalisation.

Cleanliness, infection control and hygiene

- We checked a sample of ambulances and vehicles (seven in total) across the bases. We found four vehicles, including the high dependency ambulance, to be visibly unclean. We saw dust over surfaces, a dirty patient blanket behind a chair, an unsecured clinical waste bag containing clinical waste left on the back of an ambulance, and spilt liquids across patient seats and beds.
- We reviewed cleaning records for ambulances and requested information relating to cleaning policies. An ambulance fleet attendant conducted a monthly deep clean per vehicle; and ambulance road staff were to clean down vehicles after each use. However, our visual inspection did not support the records. Furthermore, an external company conducted a monthly audit to identify how effective cleaning regimes were; the results of this are discussed below. We spoke with managers who reported they intended to initiate cleanliness audits for vehicles post inspection. However, we noted that cleanliness of vehicles and bases had been discussed within previous clinical governance meetings; with little action or improvement made by the time of inspection.
- The service used a third party contractor to undertake monthly cleaning and also to swab test areas of work including inside ambulances. We saw this company recorded swab tests before they cleaned; and after wards. Results showed that many areas were risk rated 'red' pre cleaning for number of microorganisms found. For example, in June 2018 the floor area, grab rail and driver steering wheel all scored red overall for all vehicles tested. This indicates that prior to the third party clean; cleaning by E-Zec staff may not have been effective. Post cleaning; swabs showed improvement in that microorganisms present were within the acceptable range for ambulances. We also noted that the patient trolleys tested; between February and July 2018 had a high number of microorganisms present pre clean. These results supported our findings on inspection.
- On one ambulance we saw ripped fabric on a seat which could impact on effective infection control and prevention. We also saw in a different vehicle, damage to the seams of a stretcher mattress.
- The service had an in date infection prevention and control policy which outlined procedures for ensuring appropriately clean and safe clinical areas of work. We saw an aspect of this policy reinforced the effective management and supervision of staff to ensure cleanliness was adhered to; however during the inspection we saw ambulance cleans were not audited. This policy had clear guidelines for vehicle cleaning.
- We saw plentiful supplies of hand gel located within ambulances and vehicles; and around the bases. Personal protective equipment including gloves and aprons were available to staff; however staff did not need to use these during our observations.
- We saw staff were issued with uniforms and washed these themselves. We saw an out of date code of conduct policy (due for renewal February 2018) which specified the uniform should be kept clean; however no guidance regarding the temperature at which to wash garments to prevent and control infections was given. Following the inspection; the provider produced a provider-wide staff bulletin dated May 2018 which did specify appropriate washing guidance.

Environment and equipment

- We saw fire safety checks were completed and up to date for all four bases.
- We saw that single use equipment on ambulances and patient transport vehicles was in date and stored appropriately.
- Ambulances and vehicles contained standard first aid kits, emergency breakdown kits and fire extinguishers. These were stored safely upon the vehicles. Apart from one cannister, we saw oxygen cannisters were secured safely; and had adequate levels of oxygen left.

- We saw on one ambulance; the sharps bin was not appropriately secured; the bin could be pulled upwards. As this was located above the patient stretcher; there was potential for patient harm should this become dislodged.
- A visual check of seven vehicles identified that they were maintained in a good external condition, with no worn tyres or excessive rusting. On one vehicle we saw broken armrests. All vehicles were allocated video cameras to record traffic and potential road incidents, and satellite navigation (sat nav) systems. We saw on occasion, a sat nav system was moved from a vehicle and not returned or replaced. This could cause delays for the incoming road staff who then had to source the equipment.
- Vehicle keys were safely secured within bases and had fuel cards attached for staff to use for fuel and toll road charges where needed.
- Local contracts were held with garages to ensure vehicle maintenance including MOTs and servicing. We saw that when a quick repair was required; these were undertaken in a timely fashion. Data provided by the service showed all vehicles were serviced regularly and had annual MOTs. We saw an in date vehicle maintenance policy which outlined staff responsibilities with regards to vehicle maintenance.
- E-Zec vehicles were fitted with trackers which identified the speed the vehicles were travelling at, their location, and how long was spent at each stage of a journey. Voluntary driver vehicles and any third party vehicles could not be monitored in this way.
- We saw the 'cab' areas of ambulances were unclean, with rubbish and food leftovers in compartments.
- We viewed the clinical waste collection bins located within two bases' garages and found no bags had been labelled in line with Health Technical Memorandum 07-01: Safe managers of healthcare waste. Data provided by the service showed this concern was raised with the third party clinical waste collection company after our inspection who confirmed they labelled the bags on behalf of the location upon collection. The bins were secured and locked during our inspection.
- Equipment to safely seat children was provided; such as child seats, harnesses and a paediatric stretcher. Specialist bariatric equipment was also available (equipment to support the transport of obese patients).
- We identified within minutes from a local managers team meeting held in June 2018, that building security required improvement. For example, doors to bases were left unlocked when there were no staff present. Discussion was held about managing this however no specific actions were set. During the inspection we found ground floor windows unlocked and open at one base with no staff members on site.

Assessing and responding to patient risk

- The vehicles used by staff were fitted with tracking systems; which meant any vehicle's location could be found quickly and easily in the event of an emergency. Similarly; when undertaking a patient journey, road crews were assigned an electronic device which acted as a mobile phone, tracker and provided information about each patient they were due to collect. This device also had an alarm button which could be pressed in the event of an emergency; and alerted the control room. However, we saw within meeting minutes; and staff told us, that the electronic devices could be unreliable; requiring frequent 're-boots' which resulted in road staff not having required patient information; or access to contact the control room in an emergency.
- Staff reported that they checked patient wrist bands for identification before leaving the hospital with a patient; in order to ensure they had collected the right person. Staff were also instructed to take patients to the designated home address. If patients wished to be dropped off elsewhere; staff explained this was not possible.
- We saw that, through the bookings process, certain risks were identified such as particular medical conditions, or patient behaviours which may require additional support from staff. For example, where patients were known to behave aggressively towards staff or other patients. This information was collated by staff taking bookings, who entered this onto an electronic patient record. When the journey was allocated to a road crew; this information was visible on a hand held electronic device. We were told of occasional incidents whereby information about patient risk had not been given or

collected, and subsequently communicated to road staff before staff arriving to collect a patient. In these situations; staff reported they made an onsite risk assessment in consultation with staff at the location and the on-call manager at E-Zec Staffordshire.

- Where patients were known to be a risk to other patients; they would be allocated lone patient transport which meant they would be the only patient on the vehicle. Where road staff had concerns about a patients' behaviour upon arriving to collect a patient; they called the control room for advice and support.
- The service had recently won a contract to provide transport to patients residing within a hospital for patients receiving treatment for mental health conditions. This included transporting patients who had been detained under the Mental Health Act. Where possible, staff making the bookings for these transfers requested that staff from the sending location provided staff escorts to support the road staff. However, we saw that when making longer journeys; for example, repatriating a patient from a mental health hospital several hours drive away, to a local hospital, generally no escorts were provided. However, patients who were detained under the Mental Health Act 1983 were required to be accompanied by a clinical escort.
- Staff told us that the service did not provide any 'break away' or other de-escalation training to manage patients with behaviour which may be unpredictable. Staff undertook conflict resolution training; and were provided with a booklet which detailed breakaway techniques. We saw that six members of staff who were working on the newly won contract transporting patients with mental health conditions had completed training that included breakaway skills in 2016 via their previous NHS employer.
- Some staff conducting patient transfers were lone workers; staff told us that patients who were less likely to require urgent medical support; or to display behaviour which may affect the journey were allocated to lone working road crews. We saw an in-date lone working policy which provided specific guidance to follow for lone working staff.
- Where staff identified a deteriorating patient; they would administer first aid and call an emergency ambulance where required. We saw a bulletin which was communicated to staff in April 2018 reminding road crews how to identify and deal with a deteriorating patient. Generally, the service transported patients who were generally fit to travel however a contract had been recently won to undertake journeys for high dependency patients. These patients were specifically transferred to locations within the same local NHS acute trust. These vehicles were staffed by registered paramedics who were equipped to support the patient. Patients who were critically ill were usually accompanied by a trust nurse or doctor to manage any deterioration.
- We saw 19 staff were trained to undertake 'blue light' driving; which included 13 high dependency crew staff members. Forms were completed in each instance where blue lights were used to transport a patient.

Staffing

- Within June 2018; the service reported they had 241 substantive staff and 54 bank staff employed. In addition, four volunteer drivers were in use by the service. Staffing needs were calculated based upon the numbers of journeys pre-planned; and the anticipated number of 'on the day' bookings. This information was predicted using daily reporting tools to compare previous days, weeks, months and where appropriate, years activity.
- We saw that staffing levels, including sickness was monitored by monthly quality reports. We saw minutes of reports up until March 2018 which detailed staffing numbers, vacancy rates and sickness rates. For example, in March 2018 we saw there were six vacancies across the Staffordshire locations; and sickness was 3.9%. We saw that the number of staff off with stress were monitored in order to explore this further if the levels rose over 30% of the total of those off work with illness. We saw that ongoing recruitment was recorded; and new starters highlighted. Staffing was discussed within meetings with the Clinical Commissioning Group (CCG) as an ongoing concern.
- Managers reported that staffing levels was a primary risk to the service. In order to mitigate this risk; staff from two other local independent ambulance services were subcontracted. In addition, the service used two local taxi firms to provide drivers and vehicles to conduct patient journeys. Staff told us, and we saw that the use

of these subcontractors was done regularly in order to accept all bookings made. Subcontracted staff did not undergo any induction; however, the service completed due diligence checks of the third-party companies before using them to ensure compliance to legal requirements; and to ensure policies and procedures were in line with E-Zec expectations.

- Staffing levels had recently increased; this was due to the service winning two contracts (a high dependency contract, and a contract to transport patients with mental health conditions) whereby existing staff from the previous provider were transferred over via Transfer of Undertakings (Protection of Employment) regulations (TUPE). Therefore staffing levels for the new contacts were sufficient.
- The control room was staffed 24 hours a day in order to take out of hour bookings; for example, for patients who had been to accident and emergency (A&E) out of hours.
- We saw that skill mix was considered when allocating staff to vehicles at the start of shifts. We also saw that staff could be moved round to support other staff where necessary. The control room staff managed this process as necessary.
- We saw that road staff were allocated break times to be taken where possible in between patient journeys. Shift patterns for substantive staff were set; so staff could plan outside of work. However, some staff told us their shift patterns were changed without warning.
- Staff did not conduct formal handovers at the end or start of their shift. Where handovers did occur, these were verbal with no record kept.
- Staff criminal record checks were updated yearly through the Disclosure and Barring Service (DBS). Bank staff and volunteer drivers also undertook DBS checks.

Records

- Patient records were kept electronically and were accessed by booking and control staff; and road staff undertaking journeys.
- An automatic electronic audit trail recorded any changes made to patient records.
- We reviewed three patient records and saw that information recorded included the patients' identifying information, next of kin or carer details, any disabilities or mobility requirements and any short-term information road staff may need to be aware of; such as if the patient had a temporary illness or injury.
- Patient records were monitored by the relevant supervisor weekly to ensure quality; however no formal audit was undertaken.
- Patient records contained spaces to record information that was helpful for the road staff to be aware of such as whether a patient had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place, and had space to relay 'special notes' to ensure any urgent information was communicated. For example, if a patient had fluctuating capacity to consent this could be recorded within the 'special notes' section.
- Road staff transported hospital and clinical records with patients where necessary. We saw one incident whereby a patients' hospital records went missing between discharge and arrival at the designated location. However, this was dealt with at the time and presented as an isolated incident.

Medicines

- Oxygen cylinders held within bases were kept in such a way which complied with the British Compressed Gases Society guidelines. We saw risk assessments for the managers and storage of oxygen cylinders were included in the medicine managers policy.
- Prescription only medicines, as carried or stored by registered paramedics, were stored securely on site and were all within expiration dates. However, staff did not monitor ambient room temperature therefore there was no assurance that medicines had not denatured due to being out of the safe storage temperature range. We checked the medicines managers and transportation policy which did not detail safe temperature for storage.
- Patients who carried their own medicines were expected to look after these whilst being transported. The service medicine managers and transportation policy outlined the transportation of patients' own controlled drugs.
- The medicine managers and transportation policy outlined safe storage, excluding temperature control,

disposal and access to medicines. The policy was clear that paramedics were the only individuals who could hold keys and administer medicines in line with their competencies.

Are patient transport services effective?

Evidence-based care and treatment

- Staff could access electronic policies and procedures using an online portal. Computers were located at bases for staff to access this information; and staff were also given personal log on details to access information remotely. Managers expected staff to familiarise themselves with updates to policies, procedures and guidance.
- We reviewed a number of policies as part of the inspection. The majority of policies we viewed, including the incident reporting policy, was based on national best practice, tailored to the service and was in date. However, some policies had not been reviewed in line with specified time scales. For example, the complaints policy was due for review in December 2017 and was therefore seven months overdue at the time of inspection.
- Booking staff used specific templates when taking bookings designed to ensure the most appropriately skilled staff; and vehicles were used for each patient. For new patient bookings; staff asked specific questions including the registered GP postcode to determine eligibility for the service.
- The service was not compliant with the Mental Health Act Code of Practice as they did not provide any form of restraint training to staff transporting detained patients. The code states: The main role for the ambulance service under the MHA is to provide transport (and immediate care of any physical/medical needs) for patients who have been detained (i.e. “sectioned”); this permits restraint if required.
- We saw the service followed some Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines where required; which are guidelines for clinicians working outside of hospitals such as paramedics. We saw the service followed guidelines relating to safeguarding.

Nutrition and hydration

- No food or drink was provided to patients for journeys of any length. The service did conduct journeys out of area, which could take several hours. Patients and/or carers were expected to provide food and drinks for the patients in these circumstances. Some patients received food from hospital before being discharged.
- Should a patient require regular food or fluids for a medical condition; the patient or their carer was expected to take responsibility for this. Journey breaks could be facilitated on long journeys for all patients being transferred, except those detained under the Mental Health Act.
- Bottled water was supplied where required.

Response times / Patient outcomes

- The service provided data outlining their key performance indicators (KPIs) between August 2017 and April 2018. This was monitored by the appropriate Clinical Commissioning Groups (CCGs) on a monthly basis.
- In total; nine targets were set for patient transfer services. Of these, as of April 2018 only two KPIs had met the required target. Please see ‘Well Led’ for details regarding actions to improve these.
- Inward arrivals at appointment (excluding renal) to arrive within 5 – 50 minutes of appointment time was set at a 90% target. The service, on average achieved 59.8% compliance against this target which ranged from 55.4% in December 2017 at the lowest, to 63.6% in April 2018 at the highest.
- Renal patient arrivals at appointments to arrive within 0-20 minutes before appointment time was also set as a target of 90% compliance. The average achieved rate was 66.9% of patients arriving within the required timescales to their appointment. This ranged from the lowest percentage of patients arriving on time (63.8%) in December 2017 to 72.6% of patients arriving on time in April 2018.
- For the KPI of outward journeys (excluding renal patients) to be collected within 60 minutes of request of agreed time at booking; the service achieved an average

of 68.2% against a target of 90%. The lowest month of compliance was March 2018, with 61.2%; the highest rate of compliance was August 2017 when 73.8% of patients were collected within agreed timescales.

- Outward renal patients to be collected within 45 minutes of their booked ready time was better; although still did not achieve the target of 90%. The average was 88.9% of patients being collected within the target time frame. The 90% target was achieved once between August 2017 to April 2018; and was seen in April 2018 when 91.1% patients were collected within 54 minutes.
- Time on the vehicle; up to 15 miles within 45 minutes was a target which required 90% compliance. On average 77% of patients spent 45 minutes or less on a vehicle when travelling up to 15 miles. This figure remained fairly static per month.
- The KPI of time on vehicle; within 15 to 20 miles within 85 minutes was met on average; with an average of 90.4% patients spending 85 minutes or less on a vehicle. However, it was noted that between December 2017 and April 2018 the service had consistently just missed the target; ranging between 87% compliance to 89.3% compliance.
- The KPI of time on vehicle within 20-30 miles being within 90 minutes was set at 90% of patients. On average the compliance was under KPI target at 88.5%; however, we saw that the target was met for three of the nine months monitored.
- The percentage of inward or outward journeys to arrive or be collected within 150 minutes had a target of 97%. We saw this target was consistently met from August 2017 to April 2018.
- Outward renal patients to be collected within 30 minutes of their booked ready time had a target of 90% of patients. The service consistently underperformed with this target; an average of 76.2% was achieved. This ranged from 72.2% of patients collected within 30 minutes in September 2017; to 80.7% of patients collected within the agreed time in April 2018.
- The service had been delivering the high dependency contract for just under two months at the time of our inspection. The service provided the set KPIs and data for June 2018 showed they had met these and achieved 100% for all targets.
- The KPIs were are follows:
- Critical, time critical category, and paediatric/ neonatal intensive care unit patients to be collected within ten minutes.
- Intensive category; all patients to be collected within 20 minutes.
- Stable and unstable paramedic patients to be collected within 30 minutes.
- Patient transfer Service discharges or transfers and mortuary transfers to be collected within 60 minutes.
- Internal outpatient and patient transport service outpatients to arrive for their appointments no more than 20 minutes before or 5 minutes after their appointment time.
- Internal outpatient and patient transport service outpatients to be collected after their appointments within 30 minutes.

Competent staff

- The company induction for road staff included corporate training, basic life support and dementia awareness. It was run over five days with 'on the job support' following this. Staff were then reviewed four, eight and twelve weeks after starting within their role. Following this; staff were expected to engage with a yearly review.
- Staff experience of the company induction programme varied. Some staff reported receiving a full induction and feeling competent to undertake their duties following this. Other staff reported that the induction programme had been shortened and they had been expected to commence normal duties quickly and with limited support. However; the majority of staff had worked for organisations providing the same service before working for E-Zec, therefore reported they did feel competent to undertake their roles.
- We checked personnel files for registered paramedics and found they were all registered with the Health and Care Professions Council (HCPC) in date with competency training updates including oxygen therapy, control of haemorrhages, and bariatric moving and handling training.

- We found that ongoing supervision of staff; and yearly personal development review meetings were inconsistently completed and generally of a poor quality; with no objective setting or personalisation. The exception to this was the bookings office; whereby calls were monitored weekly with developmental feedback provided to individual staff members.
- We checked a sample of road staff driving licences and found these enabled staff to undertake their driving duties and were checked annually.
- If bank staff had not undertaken a shift within a 12-month period; they were removed from employment.
- Data from the service showed that 19 staff were trained to drive under 'blue lights'.

Multi-disciplinary working

- E-Zec Staffordshire employed staff who were based at the local hospitals for which the service did the most transfers. These staff members acted as liaisons between the control room and the hospital to enable a more efficient service. We saw how road staff could contact the control room to discuss concerns, delays and issues. The control room then passed this on to the hospital liaison or rang a clinic or location directly to discuss this.
- A large proportion (approximately 60%) of patient transport was to and from dialysis appointments on a pre-planned basis. The control room supervisor and staff had built up positive relationships with staff at the renal services in order to co-ordinate care and resolve concerns. We also saw evidence of similar relationships with other local healthcare providers.
- When taking bookings; staff asked the person making the booking to provide information about the patient, such as whether the patient was receiving end of life care, or had any particular conditions road staff needed to be aware of. However, we were given examples where information had not been communicated either by the booking individual or the E-Zec booking staff which had resulted in issues and incidents. We saw that the electronic patient record used for making bookings had many options to record information; however, bookings staff tended to ask certain specific questions rather than the whole range. Therefore, specific issues such as access to property, language barriers and so on were not actively asked about for new patients on all occasions. This could then impact upon road staff who would require this information before undertaking the journey.

Health promotion

- We saw that booking staff did identify if a patient was at the end of their life at the time of requiring patient transport. If it was established a patient was at the end of life, booking staff asked further questions to ensure the road staff could promote the health of the patient and provide extra support where necessary.
- Where patients chose to not attend appointments; staff told us they tried to encourage the patient to attend for the benefit of their health, whilst still respecting the patients' right to choose.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- As of March 2018; 97% of staff were trained in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff told us about situations where patients chose to not take transport to their appointment or location. In these situations; staff respected the patients' right to refuse. Depending on the nature of the medical needs of the patient; staff could either terminate the journey or could wait and see if the patient changed their mind. Staff alerted the control room who contacted the end location. For example, if a patient due to go to dialysis refused to go; staff would encourage the patient whilst the control room liaised with the relevant renal department. However, appointments and transport could be rearranged at the patients' request.
- The service had an in date consent policy which covered the MCA and DoLS; outlining staff and manager responsibilities. A policy covering resuscitation for patients at the end of their life outlined staff responsibilities and procedures for respecting decisions made by or on behalf of the patient.
- We observed that patients gave implied consent to travel on patient transport.

Patient transport services (PTS)

Are patient transport services caring?

Compassionate care

- We observed staff undertaking their duties with patients; both in person and over the phone. All staff we observed were kind, friendly and caring towards both patients and carers.
- Patients were treated with dignity and respect throughout their time on vehicles.
- We observed that during patient journeys, staff sought to ensure patients were comfortable and settled at all stages during the transfer. Staff waited with patients when dropping patients off if necessary. For example, if no wheelchairs were available at the end location for a patient that required this; staff waited with the patient until one could be found.
- We observed warm but professional interactions between staff and patients. Many patients used the service on a regular basis and therefore staff were familiar with them; therefore promoting a welcoming environment.
- The high dependency service transferred deceased patients from one part of a large local hospital to another part of the hospital; this was to protect the dignity of the patient and their relatives as the alternative was for the deceased patient to be taken by a porter on a long journey through the hospital.

Emotional support

- Staff presented as understanding when working with patients; therefore, providing an environment that was conducive to a more relaxing journey.
- Staff were supportive to patients in distress or who were at the end of life. Where possible, the control room sent regular staff to work with patients who regularly used the service to maintain practical and psychological continuity.

Understanding and involvement of patients and those close to them

- Staff at the service undertook monthly phone calls to patients to ask about their experience of booking and using the service; including how they felt treated by the road crews. For March 2018, we saw that 60 patients were surveyed. We saw 100% of patients felt they had been treated with dignity and respect; and 88% of patients said they would recommend the service to their friends and family. However, as this feedback collection method was over the phone; it may have prevented some patients who were not able to take telephone calls from giving their opinions.
- We saw from incident reports that staff responded appropriately and kindly in response to patients' who described physical or emotional pain. For example, staff would take the time to examine the source of physical pain and support the patient to inform a suitable health care professional.
- Where patients expressed that they did not wish to attend their appointments; the staff sought to understand why this was; but respected the patients' final decision.
- Staff welcomed family escorts where appropriate to support the patient on their journeys.

Are patient transport services responsive to people's needs?

Service delivery to meet the needs of local people

- The patient transport service provided by E-Zec Staffordshire was provided to any patient who met the medical and situational criteria and had a Staffordshire GP registration. The E-Zec Staffordshire service did not have any set contract with specific hospitals; therefore, transported patients to any healthcare appointments including therapy sessions, opticians appointments and slimming club sessions. The exception to this was the high dependency contract (HDU) and the mental health contract which were both contracted to work at specific locations.
- The service had recently (June 2018) been awarded a HDU contract. This comprised providing two HDU crews/vehicles at one local hospital; and five at another local hospital; both from the same local trust. These appointments were unscheduled patient transfers for example; from one hospital high dependency unit to an intensive care unit at the other hospital. The service also transferred patients, including deceased patients, from one part of the larger hospital to other departments due the size of the hospital site.

Patient transport services (PTS)

- Approximately 60% of patient transport services was for the purpose of receiving dialysis treatment. In addition to pre-planned journeys; the service also took 'on the day' bookings. The service did not turn away any eligible booking.
- In order to meet the requirements of the contract; the service subcontracted staff from two local independent ambulance providers; and used two taxi firms to provide both drivers and vehicles for patients assessed as suitable for cars rather than ambulances. This was for the area of South Staffordshire only; transport delivered in North Staffordshire was provided solely by E-Zec Staffordshire. The registered manager undertook due diligence checks prior to using third party services.
- The service ran from four bases across North and South Staffordshire and in June 2018 had 93 vehicles; these were located strategically to be nearer to the more commonly used destinations such as local NHS hospitals.

Meeting people's individual needs

- Where patients required extra support, such as with communication, they could be accompanied by an 'escort'. The escort could be a family member, carer, or member of staff from the sending location. Although accommodating an escort on patient transport vehicles was permitted only for patients with a medical condition that required this; we saw that staff did make allowances where possible for example if a patient wanted extra support and space was available on the vehicle. If a relative or carer was unable to accompany the patient; staff explained this and suggested alternative transport to meet the patient at the end of the journey.
- We saw that where temporary notes had been added to patient notes on previous journeys, these were followed up at subsequent bookings to identify patients' health needs. For example, we observed staff clarify if a patient was still wearing a temporary cast before making a booking so the patient record could be updated; and appropriate road staff and vehicles deployed.
- Staff told us they tried to ensure the same staff undertook journeys with regular patients; such as patients being transported to and from dialysis three times per week. However, due to the nature of the work this was not always possible on every occasion.
- Staff received training in learning disabilities to gain a better awareness of patients who were diagnosed with these.
- Journeys were booked taking into account the needs of the patients where possible. For example, where patients requested staff of a particular gender due to cultural reasons; this was accommodated where possible.
- The service did not provide interpretation services for patients who did not speak English. Staff told us that where patients did not speak English, generally they would bring an escort with them who would translate. A whiteboard and pens were available on-board vehicles to help communicate with patients who were less able to communicate verbally.
- Staff taking booking calls had a proforma to follow which encouraged them to ask about patients' individual needs; whether these be medical or personal. We saw that staff asked certain standard questions such as the presence of a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order, and certain medical conditions. However, some questions were not routinely asked; such as ease of access to patients' homes. Staff told us that on occasion; incidents had occurred due to lack of information about patients' specific needs or situations which on occasion had led to a patient becoming re-admitted.
- The service had bariatric vehicles and equipment to support patients who required this.If necessary extra staff could be allocated to the vehicle to support the transfer of the patient onto and off the vehicle.
- We saw that patients were assessed to determine which form of transport was required for their needs; and how many staff members were needed to support the patient. For example, a patient who used their own wheelchair would be allocated to an ambulance rather than a car; and would be allocated either one or two staff members to that crew depending on the patient's medical needs.
- Staff told us they did not receive specific breakaway or restraint training to manage patients that displayed aggressive behaviour, including violence. We saw that six members of staff who were working on the newly

won contract transporting patients with mental health conditions had completed training that included breakaway skills in 2016 via their previous NHS employer.

Access and flow

- Between August 2017 and April 2018; the service undertook 130,427 patient journeys in total. Of this total; 693 journeys were from the high dependency contract.
- For the same time period; 6,649 journeys were aborted which comprised 5% of the total patient journeys.A total of 23,470 journeys were cancelled. This figure was broken down into journeys cancelled by the patient; 11,962, professional; 10,039 and system cancellations/ other; 1,478.
- During the time period referenced above; 19,636 escorts accompanied patients upon planned journeys. This was broken down into relatives; 11,050 and professionals, such as care home staff members; 8,586.
- Patients told us that although the service was generally good, waiting times after appointments could be significant. This was corroborated by complaints made to the service. We saw that control room staff sought to inform the staff at sending and receiving locations should any delays be expected. Road staff kept in touch with the control room to escalate any concerns regarding their workload.
- Bookings staff sought support from their supervisor and the control room to discuss when a new booking may need to be high priority.

Learning from complaints and concerns

- Between July 2017 and April 2018; 126 complaints were received. Patients had submitted 20 of these directly; and 106 came from hospitals and other health care locations who had raised concerns regarding E-Zec – Staffordshire.
- We saw the majority of complaints related to late collection of patients after appointments. The complaints were reported in a monthly quality report and appeared to be dealt with on an individual basis as required; however, we saw no longer term action plans or specific objectives to manage this issue and reduce the level of complaints.
- Managers confirmed during the inspection there was no specific plan to manage the themes of complaints such as late collections after appointments.
- We discussed patient and hospital complaints with managers. The process for managing complaints was to look at information provided and provide an apology where required. The complaints policy provided by the service was due for review in December 2017; therefore, was out of date at the time of inspection. However, the service also had a guide to responding to informal review as part of a standard operating procedure that was in date.
- Leaflets containing information as to how to make a complaint were located on vehicles.

Are patient transport services well-led?

Leadership of service

- The management structure at location level comprised a CQC registered manager who worked as the compliance manager, a contract manager and assistant contract manager. This management team oversaw the team leaders and supervisors; such as the fleet manager, the senior controller, the bookings team leader and the base supervisors. The local management structure was supported by provider level managers including the head of governance and compliance and training leads.
- Several local managers and supervisors had recently been promoted from within the service; following periods of time spent working in other areas of the business.
- The local leadership team was new; with the contract manager only having been in post for two weeks at the time of our inspection. Before this, we saw there had been significant changes within the managers structure including changes to the registered manager.
- Staff reported that leadership was not visible or accessible at all satellite bases and that escalating concerns and issues was difficult. The new managers told us of plans to have a structured approach to managers presence across all four bases.

Vision and strategy for this service

- The overall service vision and values were displayed on walls within bases.
- There was no specific vision or strategic plan for the Staffordshire location. However, the company wide mission statement was 'to provide the very best care for each patient on every occasion'. Staff were generally aware of this; and those we observed sought to promote patient care.
- When conducting interviews with managers during the inspection; it was apparent that there was no business sustainability strategy for this location. When asked about plans to develop and grow the business; nothing was identified and no action plans had been generated or were in place.

Culture within the service

- Morale within the service was low. We were told, and we saw that there had been several middle and upper managers changes within the service over the past six to 12 months. Staff, although presenting as committed to their role, described an environment with inconsistent support or communication. We spoke with managers regarding this who reported plans to engage more consistently with staff.
- We received information from different sources both before and during the inspection which reported that the service promoted the achievement of key performance indicators (KPIs) over patient dignity or staff wellbeing. This information, from a variety of sources, also reported that staff felt if they spoke up about their concerns they would be punished. However, other staff told us they felt they could raise concerns safely with their managers.
- The appraisal and supervision provided to staff was inconsistent and of a poor quality for the majority of staff who experienced these. This led to some staff feeling undervalued. We saw within minutes of a local managers meeting held in June 2018 that appraisals took on average, 20 minutes per staff member.
- Senior managers at the service were working to improve this through staff engagement; staff spoke positively of this change. However due to the newness of the managers structure in place at the time of the inspection; consistent change had not yet been achieved.
- Staff described some conflict between road staff and control room staff at times with regards to instructions given to undertake patient transfers. We were told of actions taken to resolve this; such as staff shadowing each other's roles and learning more about different aspects of colleague's departments.
- We saw staff were allocated time to have breaks from work. However, we saw within meeting minutes that staff were struggling to take annual leave due to staffing reductions. We saw no evidence of specific plans to mitigate this concern.

Governance

- At the time of our inspection, managers reported there were few regularly scheduled and structured local managers meetings to monitor the quality of the service. Managers reported this was largely due to significant managers changes over the previous six months; including changes to the registered manager.
- We saw a provider level meeting had been held in July 2017 with discussions around how to adhere to CQC requirements. Actions were set; however, as no names were recorded except apologies; it was not possible to identify if any managers from the E-Zec Staffordshire location had been present. We saw subsequent clinical governance meetings were held in conjunction with provider level managers in January and May 2018. The minutes of these meetings showed discussion around CQC inspection requirements; sharing of incidents and complaints from different locations. We noted internal complaints had been raised regarding the attitude of the out of hours control room staff at E-Zec Staffordshire. We saw a discussion on actions already taken was held; however, no actions were set for monitoring improvement.
- Managers of the service reported that much of the day to day running of the service was conducted verbally; with very limited recording of any managers duties or decisions taken.
- Local managers meetings held were minuted. We saw minutes from meetings held in May and June 2018. During these meetings general issues and risks were discussed; however, we noted specific action plans were

not set. Issues previously discussed were raised again at subsequent meetings however it was difficult to identify progress made in resolving these concerns due to lack of formal monitoring systems.

- Plans were in place to formalise the governance; and we saw minutes from a meeting held in July 2018; before our inspection showing a managers meeting had been held. Furthermore, monthly meetings to discuss performance were held with the Clinical Commissioning Groups (CCGs) on a monthly basis. Minutes from meetings with the CCGs showed that complaints and incidents were closely monitored and the service was challenged where it was felt they had not responded adequately.
- Reports from the control room were sent daily to the service managers team both at location and provider level and the local hospitals and clinics who used the service. This comprised of the number of journeys made day by day; and where the journeys had been to. These reports enabled the managers team to identify busier days and to plan staffing accordingly.We saw staffing was discussed at CCG meetings with regards to meeting key performance indicators; including use of sub-contractors. We saw the CCGs wished to adapt the staffing model used by E-Zec in order to facilitate a more effective service.

Managers of risk, issues and performance

- The service risk register was out of date and did not reflect all current risks. We saw that where risks had been identified; such as pot holes within bases; although permission had been granted to resolve this issue; there were no timescales or specific actions set. We also saw some risks which were resolved by the time of inspection however the risk register had not been updated to reflect this. For example, a lack of fire warden trained staff had been identified in October to November 2017. This had since been rectified with six staff trained to undertake this role. However, the risk register had not been amended. Therefore, this was still outlying as a risk to the service. We saw that risks had been added following feedback after the CQC inspection; for example that of staff engagement. An action had been added for a manager to arrange engagement meetings; however this was not allocated to a named individual and there was no deadline for this action to be completed. Another example was of clinical waste bags not being labelled prior to collection. We saw this risk had been addressed and resolved with the waste collection company.
- Staffing was a primary risk identified both before and during the inspection by senior managers. However, this risk did not appear on the service risk register. Managers recognised that both recruitment and retention of staff was problematic; and were continuing to recruit to vacancies. Managers reported no specific plan for retaining staff and linked problems with retention to employees either retiring or becoming trainee paramedics elsewhere. Exit interviews were not completed with leaving staff; therefore, no analysis of actual reasons for leaving the company had been undertaken. However, we saw that staffing was monitored as part of monthly quality reports; which detailed staff leaving the service, sickness rates, training and appraisal rates.
- The service had sub-contracts with two local independent patient transport services (PTS), and two local taxi firms to meet the requirements of the contract. The local PTS providers provided staff only; whereas the taxi firms provided vehicles and a driver. Taxis were used for stable patients who would be very unlikely to require emergency treatment. Due diligence checks had been carried out with all agreed sub-contractors before them being used.
- A risk identified by the service was the low compliance with mandatory training. At the time of inspection, training levels were 48%. Staff and managers reported that staff; although provided with remote log on access to the online training portal, were expected to complete training on an unpaid basis; and often outside of working hours in order to ensure it was completed. This had not worked as an effective strategy; therefore, the managers team were considering other options including paying staff for their time to attend training. We saw this had been discussed in a recent governance meeting and a date of August 2018 had been set to achieve 90% compliance. However, at the time of inspection there was no set action plan to achieve this target. In addition, we were not assured that the risk of staff having not kept up to date with mandatory training was fully recognised. For example, should an incident occur whereby it was found some cause could be linked

to a lack of staff training; this would be a breach at provider level, not the individual staff level. When discussing this with managers; we saw that this issue of training was assumed to be the staff members' sole responsibility; rather than a shared responsibility. Following the inspection; the provider produced a training database that highlighted mandatory training needs and specified dates for completion by individual staff members.

- Monthly quality reports were completed for the location. These included key performance indicator (KPI) figures for the month, incidents reported by staff, complaints made by patients, complaints made by professionals, and patient satisfaction survey results. We saw that incidents and complaints were discussed; and informal actions highlighted to prevent reoccurrence. However; no review of incidents was recorded month on month; and where themes were identified with incidents or complaints; no longer term action plans were developed to manage these. Safeguarding referrals were also reported monthly; these clearly detailed actions taken by staff including contact with social services where appropriate.
- KPIs were not met for the majority of targets set by the Clinical Commissioning Groups (CCG) who commissioned the service. We discussed this with the managers team who reported some targets were missed by a few minutes; such as arriving too early for appointments, or collecting patients too late. Some actions to mitigate this were underway; such as communicating with dialysis providers to discuss scheduling of transport. The managers team also had plans to dial into local hospital 'bed meetings' in order to identify and plan for discharged patients on a daily basis. This issue had been added to the service risk register in July 2017. An action of identifying specific KPIs to focus on was set and allocated to the previous registered manager who has not been actively working for the majority of 2018. There was no review date; and the risk was sitting as open.
- We saw minutes of meetings held with the CCGs who commissioned the service. In February 2018, it was highlighted that there were no set plans to improve KPI performance. A collaborative improvement plan was set up at this meeting in order to rectify this; and was a standing agenda item in meetings following this. This plan was due to end in July 2018; however within June meeting minutes it was highlighted that the plan would stay in place to support KPI improvement for a longer period of time.
- Following the inspection; the provider sent us data which showed plans to improve the KPIs in relation to renal patients on a month by month basis between February 2018 and July 2018. However; this data did not show which of the set actions had been completed and which were outstanding. The provider also sent evidence that improvements were being sourced; such as obtaining wheelchairs to use at hospitals to positively impact on patient transport targets.
- KPI information was shared with staff on staff noticeboards; however staff feedback was not sought for ideas to improve performance.

Information Management

- Information for staff was displayed on office walls. This included information on duty of candour, the Mental Capacity Act and associated consent guidelines.
- Staff undertaking patient transfers used electronic devices to receive patient information for booked journeys; and were able to use these to make calls to the control room. Generally, relevant patient data was recorded such as whether the patient had a No Not Attempt Cardio Pulmonary Resuscitation (DNACPR) agreement, or any conditions which may require managers during transport. On occasion relevant information was not given to staff which resulted in delays such as access problems on return to a patients' house. Also, staff told us the electronic devices could at times be unreliable and required restarting.
- When undertaking bookings for patients that had used the service previously; we saw staff requested patients' surnames in order to find the patient record. However, rather than asking the caller to confirm the patients' first name or date of birth to confirm they had found the right patient file; staff told the caller the first name and asked them to confirm. In order to protect personal information; best practice is for staff to actively ask the caller to provide identifying information in order to confirm full patient identity. Where bookings were taken for new patients; data protection was adhered to.

- We saw within local managers meeting minutes held in May 2018 that staff at one base were breaking into a private filing cabinet. Whilst this issue was discussed and some ideas generated to manage this; it appeared no formal action had been taken to address this potential breach of data protection laws; or to manage the staff conduct. Post inspection, the provider told us that this filing cabinet did not contain confidential information.

Public and staff engagement

- Managers of the service had recently commenced a more active level of staff engagement including a more structured approach to team meetings; and plans to have a more visible presence at satellite bases.
- Staff representatives held quarterly meetings to discuss concerns and questions raised by the wider staff group. We saw within minutes that one topic discussed within February 2018 was the lack of action taken following the previous meetings; which resulted in no resolution of concerns. For example, a previously raised concern was a lack of wheelchairs at certain NHS locations which meant staff stayed longer with the patient until wheelchairs could be found. Therefore, key performance indicators (KPIs) were affected; and onward patient journeys delayed. However; we saw during inspection that this was still an ongoing issue impacting upon performance. Although control room staff did manage these incidents on a case by case basis; there was no long-term solution being actioned. Meeting minutes suggested that E-Zec Staffordshire intended to provide wheelchairs for hospital use; following the inspection we were sent emails demonstrating that the sourcing of wheelchairs was underway.
- Two staff comment boxes had recently been introduced to the main base. One was for general staff comments to be read by managers, and the other was for staff to make comments and suggestions to staff representatives. Staff representatives read these and raised any concerns during staff representative meetings.
- Patient feedback was sought monthly to identify themes and trends. Whilst there were many positive comments within this feedback; we also saw themes of patients reporting delays to be collected and spending long times on vehicles. This was corroborated with complaints data received from the service, and key performance indicator results. The managers team at the service reported plans to engage more with patient groups to develop solutions; however, this had not been initiated at the time of our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that vehicles are kept clean. The provider must also ensure shortfalls in cleanliness are monitored and immediate action taken to rectify shortfalls.
- The provider must ensure that systems are established to effectively monitor and take action to improve shortfalls in the following: infection prevention and control, mandatory training, incident reporting, investigations and shared learning, staffing and staff appraisals.
- The provider must use feedback provided by key performance indicators, patients, clinical stakeholders and staff in order to develop the service.
- The provider must manage medicines as per national guidelines; specifically with regards to temperature monitoring of medicines.
- The provider must ensure that staff are aware of, and follow, the provider incident reporting policy.
- The provider must notify CQC of serious incidents as per Care Quality Commission (Registration) Regulations 2009 (Part 4).

Action the hospital SHOULD take to improve

- The provider should explore reasons for low staff morale and take action to engage staff effectively.
- The service should instigate regular supervision of staff to promote performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents 18.— (1) Subject to paragraphs (3) and (4), the registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. (2) The incidents referred to in paragraph (1) are— (a) any injury to a service user which, in the reasonable opinion of a health care professional, has resulted in— (i) an impairment of the sensory, motor or intellectual functions of the service user which is not likely to be temporary, (ii) changes to the structure of a service user's body, (iii) the service user experiencing prolonged pain or rolonged psychological harm, or (iv) the shortening of the life expectancy of the service user; (b) any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent— (i) the death of the service user, or (ii) an injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a)

This section is primarily information for the provider

Requirement notices

The service investigated an incident which was categorised as serious but failed to inform CQC.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance