E-Zec Medical Transport Services Ltd

E-zec Medical Transport - Bristol

Quality Report

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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.

Summary of findings

Letter from the Chief Inspector of Hospitals

E-zec Medical Transport Bristol is operated by E-zec Medical Transport Services Ltd. The service is contracted to provide non-emergency patient transport services. They are commissioned by the clinical commissioning group to serve the communities of Bristol, North Somerset and South Gloucestershire. E-zec Medical Transport Bristol had been awarded the patient transport contract in April 2017, therefore at the time of inspection had been operating in Bristol for under one year.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 and 21 March 2018, and held a drop in session with staff on the 19 March 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.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

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

- There was a basic governance structure. This was not effectively used to monitor service performance and identify areas for improvement.
- There was a lack of evidence of the responsibility, overview and scrutiny by the board.
- There was no local management meeting.
- There was no assurance third party providers, who were providers completing patient transport work on behalf of E-zec, had appropriate recruitment checks or training. There had been a reliance on these third party providers, to include other independent ambulance providers and taxi firms, to help deliver the patient transport contract.
- There was no evidence staff references had been received and reviewed when recruiting new staff.
- There was not a strong or positive culture. There was a disconnect between management and staff, and between staff groups. The mechanisms to engage staff were ineffective.
- Staff were not suitably trained and assessed to carry out driving duties safely. Staff told us driving assessments were completed at the point of interview, which involved a short drive, they did not feel this prepared them for the role.
- There was not a culture of learning from incidents. Staff told us they did not receive feedback or the lessons learnt from the incidents they reported. This was discouraging staff from reporting incidents, and therefore there was a risk staff would not report incidents.
- The provider was unable to tell us their compliance against mandatory training, and did not hold a local record to report on performance. However, the managers were informed by the human resources department when staff training was due to expire.
- Staffing recruitment and retention had been a challenge since the start of the patient transport contract. Although the provider was nearly at full staffing, the staff were mostly new and inexperienced.

Summary of findings

- The provider did not consistently provide a good service. They measured their effectiveness of delivering a timely patient transport service using measures set by the commissioner called key performance indicators. These key performance indicators were not always being achieved.
- Staff were not aware of the available translation and interpretation services which could be used to meet peoples individual needs. Staff told us escorts were used to translate for the patient, this is not best practice.

However, we found the following areas of good practice:

- Staff were observed to provide good care to patients, which was kind and respectful.
- Safeguarding was well understood by staff and they were confident about how they would respond if there was a safeguarding concern.
- The provider maintained good working relationships with stakeholders to ensure coordinated working.
- Patient transfer liaison officers were a valuable role to link between E-zec and hospitals to support the flow of patients.
- Information was clearly recorded so staff could access special notes and patient needs.
- Standards of cleanliness and hygiene were well maintained and there were systems to prevent and protect people from infection.

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 two requirement notices that affected the patient transport service. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South), 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)		The provider had faced capacity and resource issues since the start of their patient transport contract in April 2017. This had impacted on a number of areas, however improvements had been seen as the provider approached full staffing establishment, and there was a realistic vision for the future. Delays and timeliness of patient transport was a regular complaint and poor performance was reflected in the key performance indicators, which measured the effectiveness of the service and timeliness of patient transport. Key performance indicators were monitored, and the service was adapting where possible, with patient experience kept at the forefront. There was a basic governance structure, which did not enable the full scrutiny and analysis of data and information to drive service improvement. There was no local management meeting to discuss quality, risks and service improvement, and there was a lack of evidence of the board's overview and scrutiny. There was a disconnect between staff and management, and between staff groups, with no proactive engagement undertaken by the management team. The provider was not always able to evidence how staff had completed recruitment checks, on-going checks and training, particularly in relation to third party providers. Third party providers are other organisations who carry out work on behalf of E-zec Medical Transport Bristol. They had been relied on to deliver the patient transport contract.

E-zec Medical Transport - Bristol

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Detailed findings

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Background to E-zec Medical Transport - Bristol

E-zec Medical Transport Bristol is operated by E-zec Medical Transport Services Ltd. The patient transport contract was awarded to E-zec Medical Transport Bristol in April 2017 and they completed registration with the CQC in May 2017. E-zec Medical Transport Bristol is an independent ambulance service providing non-emergency patient transport services. The service primarily serves the communities of Bristol, North Somerset and South Gloucestershire. Service users have an established medical need requiring transportation to and from hospital. As well as local journeys, they complete repatriations and long distance transfers across the country.

The service's current registered manager, Mr Nick Gibson, registered in November 2017. 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.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,two further CQC inspectors, and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Daniel Thorogood, Inspection Manager, and Mary Cridge, Head of Hospital Inspection.

Facts and data about E-zec Medical Transport - Bristol

E-zec Medical Transport Bristol is part of E-zec Medical Transport Services Limited (the corporate provider). They work with clinical commissioning groups and hospital trusts to provide non-urgent patient transport between people's homes and healthcare locations.

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

The fleet consisted of 49 vehicles including cars, stretcher-equipped vehicles including three high dependency/bariatric vehicles (bariatric refers to a patient with a BMI over 40), and vehicles with wheelchair access.

There were three bases: the main hub at Avonside with 25 vehicles and operating 24 hours a day, and two satellite depots in Yate and Nailsea both with 12 vehicles and operating 6.30am to 9pm. The Avonside base had a control room, which took on the day bookings and had

an oversight to manage vehicles on the road. A corporate control room was also based at Stoke, where there was a dedicated staffing resource to take Bristol bookings and cover out of hours.

In total, approximately 118 staff were employed across the office and road-based teams. Some staff were transferred across from the previous provider for the contract, under Transfer of Undertakings Protection of Employment (TUPE) regulations, while others had been employed since E-zec took on the contract.

E-zec Medical Transport Bristol sub-contracted some of their work to third party providers. This means other providers completed patient transport work on behalf of E-zec. There were five third party providers, these included three independent ambulance providers and two taxi firms.

The level of activity was approximately 100,000 journeys per annum. This was mostly pre-booked journeys, with 16% of the activity booked on the same day.

During the inspection, we visited all three bases. We spoke with approximately 30 staff including patient transport drivers, a patient transfer liaison officer, control centre staff, a fleet supervisor, team leaders, the head of patient transport service, operations manager, operations director, head of governance and compliance, and clinical support. We spoke with four patients. We looked inside eight vehicles and observed two patient transport journeys. We also spoke with stakeholders to gain their feedback on the service provided.

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.

Track record on safety

- The service reported no never events between June 2017 and February 2018
- The service reported 128 incidents between June 2017 and February 2018
- The service reported no serious injuries between June 2017 and February 2018
- The service reported 29 complaints between June 2017 and February 2018

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Summary of findings

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

- There was a basic governance structure. This was not effectively used to monitor service performance and identify areas for improvement.
- There was a lack of evidence of the responsibility, overview and scrutiny by the board.
- There was no local management meeting.
- There was no assurance third party providers, who were providers completing patient transport work on behalf of E-zec, had appropriate recruitment checks or training. There had been a reliance on these third party providers, to include other independent ambulance providers and taxi firms, to help deliver the patient transport contract.
- There was no evidence staff references had been received and reviewed when recruiting new staff.
- There was not a strong or positive culture. There was a disconnect between management and staff, and between staff groups. The mechanisms to engage staff were ineffective.
- Staff were not suitably trained and assessed to carry out driving duties safely. Staff told us driving assessments were completed at the point of interview, which involved a short drive, they did not feel this prepared them for the role.
- There was not a culture of learning from incidents. Staff told us they did not receive feedback or the

Patient transport services (PTS)

lessons learnt from the incidents they reported. This was discouraging staff from reporting incidents, and therefore there was a risk staff would not report incidents.

- The provider was unable to tell us their compliance against mandatory training, and did not hold a local record to report on performance. However, the managers were informed by the human resources department when staff training was due to expire.
- Staffing recruitment and retention had been a challenge since the start of the patient transport contract. Although the provider was nearly at full staffing, the staff were mostly new and inexperienced.
- The provider did not consistently provide a good service. They measured their effectiveness of delivering a timely patient transport service using measures set by the commissioner called key performance indicators. These key performance indicators were not always being achieved.
- Staff were not aware of the available translation and interpretation services which could be used to meet peoples individual needs. Staff told us escorts were used to translate for the patient, this is not best practice.

However, we found the following areas of good practice:

- Staff were observed to provide good care to patients, which was kind and respectful.
- Safeguarding was well understood by staff and they were confident about how they would respond if there was a safeguarding concern.
- The provider maintained good working relationships with stakeholders to ensure coordinated working.
- Patient transfer liaison officers were a valuable role to link between E-zec and hospitals to support the flow of patients.
- Information was clearly recorded so staff could access special notes and patient needs.
- Standards of cleanliness and hygiene were well maintained and there were systems to prevent and protect people from infection.

Are patient transport services safe?

Incidents

- There was a system to report and investigate incidents. Staff completed a paper incident form and the management team were then responsible for investigating each incident. A record of incidents was held and presented monthly within a quality report, which was shared with the clinical commissioning group.
- Staff were aware of the processes to record and report incidents, however there was a risk staff were not reporting all incidents. Talking to staff, they understood what constituted an incident and how to report it. Staff said they understood how to report incidents and were encouraged to do so by the management team. However, staff felt once reported the incident was often forgotten about and they never received any feedback. This was disengaging staff from reporting incidents and therefore there was a risk staff would not report incidents.
- Lessons learnt from incidents were not clearly shared with staff. The provider could demonstrate to us the actions and learning which resulted from incidents. However, this did not appear to be communicated with staff to ensure a culture of learning from incidents.
- We reviewed incidents in the quality report where 128 incidents were reported between June 2017 and February 2018. We saw common themes of patient transfer delays due to service failure, booking errors, and issues where there were incorrect vehicles, equipment or staff.
- The system to monitor incident trends and themes needed improvement. During the inspection, we did not see evidence of the incident trends locally for E-zec Medical Transport Bristol or a wider corporate view of trends and themes for learning purposes. At the end of the inspection this was fed back to the provider. In response to our concerns, the head of governance and compliance sent an incident trending document for January and February 2018. This only looked at basic trends within one month of incident reporting.
- E-zec Medical Transport Bristol retained the responsibility for investigating incidents when they

occurred using third party providers, sub-contracted to deliver their regulated activity. We were told the sub-contracted providers were expected to follow E-zec's incident reporting policy and report incidents. We saw examples of incidents, which involved third party providers, entered on the incident log, and actions taken following the incident.

- Staff we spoke with were aware of their responsibilities regarding duty of candour. They were aware of the regulation and how and when it would be used. They understood the importance of being open and transparent with patients when things go wrong. Staff were able to show us folders in the staff room informing them of the duty of candour regulations. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The provider appropriately applied the duty of candour when investigating and responding to incidents and complaints. There was a corporate duty of candour policy, and a lead within the E-zec organisation. We saw evidence of duty of candour application when responding to incidents and complaints, with a written explanation and apology to the patient or family concerned.

Mandatory training

- Systems did not enable local management to manage training proactively. There was no local record of staff compliance with mandatory training, therefore compliance figures could not be provided to us at the time of inspection. However, we did see a process where the human resources department emailed the head of patient transport service (contract manager) with training gaps where staff training modules had expired or were due to expire. We also saw one team leader had their own spreadsheet recording which staff members had provided their certificate for training. On review of 14 staff files, only two had complete evidence of training certificates for mandatory training.
- Mandatory training was delivered face to face at induction, with online and face to face training updates periodically. Induction training was based around the care certificate to develop staff skills and was delivered over five days. This included basic life support, safeguarding adults and children level two, infection prevention and control, mental capacity act, conflict resolution, moving and handling, health and safety, duty of candour, and duties of care for patient safety and caring. An emergency first aid at work one day course was also provided to staff.
- Staff had mixed opinions about the quality of mandatory training delivered. Some staff felt well prepared for their role, but others had concerns about the quality of mandatory training for assisting patients with additional needs, such as those requiring wheelchairs and stretchers. They felt training was rushed, with not enough hands-on time to be confident with the equipment used. They also felt the emergency first aid at work course did not prepare them fully to deal with the frail and sick nature of the patients they transported.
- Some staff told us they could not access policies and on line training. Staff told us they could not log into the system despite having requested new passwords. Staff had reported this and managers were aware but it had not been resolved at the time of our inspection.
- There were no assurances that staff who were employed by third party providers sub-contracted to complete work had up–to-date training. The third party subcontracted providers confirmed their staff were up-to–date by completing a due diligence document, but there was no evidence obtained by E-zec to confirm this.

Safeguarding

- There were reliable systems, processes and practices to safeguard people from abuse and avoidable harm. Staff understood their responsibilities and adhered to safeguarding policies and procedures. The same processes were followed for sub-contracted care.
- Staff were confident in recognising a safeguarding concern and the action they would take to ensure the patient's safety. Staff were able to provide us with examples of situations where a patient was at risk or there were concerns with their welfare, and how they responded to ensure the patient was safe and the concern reported.

Patient transport services (PTS)

- Staff received appropriate levels of safeguarding training. All staff received level two safeguarding training in line with the recommendations for ambulance staff in the intercollegiate document 'Safeguarding children and young people: roles and competencies for health care staff' (2014). The provider reported 100% compliance with safeguarding training. The operations director and head of governance and compliance were the named professionals trained in level four safeguarding.
- Staff had access to a designated telephone hotline to report safeguarding concerns and all staff were aware of this number. However, some staff told us they were not always able to get through on this line. Some staff also said they had been asked to leave the details on the answerphone, which would breach confidentiality. The provider told us this had been resolved and there was no longer an answerphone function. There was also some confusion from staff about how this hotline could be used. Some staff thought this line could be used to discuss safeguarding concerns and get advice; however, the main purpose of this line was to report safeguarding so a referral could be made. The person responsible for taking this information and making the referral was not trained to offer advice and support to staff. This would need to be referred to the level four trained named professionals.
- Safeguarding incidents which had been reported were appropriately identified as safeguarding concerns. We reviewed the nine safeguarding incidents reported in the monthly quality reports between June 2017 and February 2018. We found these referrals and the action taken to be appropriate.
- Oversight of safeguarding concerns was led by a senior manager within E-zec. We were told the contract manager would feedback to staff following a referral. However, staff we spoke with told us they did not receive any feedback about safeguarding referrals they made.
- Patients at risk for safeguarding were identifiable. Information could be recorded on private notes and accessed by phoning the control centre to be made aware of information or previous safeguarding concerns.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were well maintained and there were systems to prevent and protect people from infection. The provider had an up-to-date infection prevention and control policy and staff we spoke with knew how to access it.
- Vehicles and equipment were observed to be appropriately and safely cleaned and ready for use. We inspected five vehicles and found them to be visibly clean and free from contamination. It was the responsibility of staff to clean their own vehicle in line with guidance. This was recorded on their handheld device once completed. Should a vehicle become contaminated it would be pulled off the road for cleaning.
- There was a programme for deep-cleaning vehicles. The provider had a contract with an external cleaning company who carried out a quarterly deep-clean of the vehicles. Part of this service involved the swabbing and identification of areas which were missed by staff, which were presented in a report. Team leaders shared this information with the staff for learning and improving the cleanliness of the vehicles.
- To maintain the cleanliness of vehicles staff had access to cleaning equipment and materials. All the ambulance bases we visited had clear colour-coded vehicle cleaning stations. All mops were single-use and the chemicals used for cleaning were dispensed automatically. This reduced the risk of staff coming into contact with the cleaning chemicals and ensured the correct strength of mixture.
- Personal protective equipment was readily available to staff. This included gloves, aprons and protective glasses, which we observed staff using when required.
- We observed staff carrying out good infection control practice. This included good hand hygiene practice when caring for patients. Staff had personal hand sanitisers and used them before and after contact with patients. Staff also had clean uniforms, which they were responsible for maintaining.
- Linen was well-managed, disposed of and replaced in agreement with the local hospital. There were appropriate stocks of clean linen, and all dirty linen was bagged and tagged accordingly for collection. Any

heavily contaminated linen would be disposed of immediately on arrival at the hospital. There was not a formal contract document but the hospital invoiced the provider on a weekly basis.

- Staff were made aware of specific infection and hygiene risks associated with individual patients. Any information relating to patient infection was relayed by the ward at the point of booking. This was then added as a 'flag' on the patient details and staff were made aware in advance. However, some staff reported to us that on occasions this was not always the case and they had to double check when taking a patient to know their infection status.

Environment and equipment

- The station environment at all three bases was properly designed and maintained in a way which kept people safe. Each base was lockable and secure, with vehicle keys stored securely and vehicles locked when not in use. Where staff used motor oils and other engine fluids we found safety information displayed. This meant staff would be aware of potential health issues when using them or what personal protective equipment to use.
- The fleet supervisor ensured all vehicles had a current MOT, service and were insured. We reviewed records of vehicle maintenance and schedules based on mileage or time, in line with manufacturer recommendations. As the service had been running for one year all vehicles were coming up to their dates for MOTs. Managers told us a rota had been created to ensure all vehicles would have an MOT without causing any disruption to the service. However, they also expressed concern about minor damage to vehicles which needed fixing, such as damaged wing mirrors, having an impact on the availability of vehicles.
- Monthly safety audits were completed for vehicles, which were comprehensive. Any faults were reported to the fleet supervisor to enable them to be rectified.
- Daily checks were completed and recorded for vehicles and equipment. We saw staff starting their shift completing and recording vehicle and equipment checks on their handheld device. The team leader then completed monthly spot-checks of the vehicles and also a spot-check to ensure staff were recording daily checks.
- Overall, vehicles and equipment were well-maintained. However, on one vehicle we found the fire extinguisher to have no pressure showing in the gauge and the large oxygen bottle at the rear of the vehicle to be empty. We brought this to the attention of the fleet supervisor who told us the previous staff were responsible for checking this and logging any defects on the handheld system. We looked at their previous report and they had not reported either issue. This was rectified by the staff who took the vehicle out on the next shift.
- The service managed the restocking of vehicles, equipment and supplies. We inspected a storage area for the service where we saw staff uniforms and various consumable items. All items were in date. Consumables included personal protective equipment such as gloves, gowns and facemasks. Relevant equipment was available for both adults and children.
- Equipment was of good repair and held securely on vehicles. We saw evidence equipment had been serviced and was monitored to ensure safe use. We observed staff using equipment correctly and safely, and patients being safely secured whilst being transported. A supply of child car seats was available in two sizes for the transport of younger children.
- Equipment faults were managed by the fleet supervisor. If faulty equipment was identified on front line vehicles a decision would be made whether the vehicle needed to be taken off the road or if the equipment could be replaced immediately.
- Waste was well-managed to ensure it was appropriately segregated, stored and disposed. We observed good waste management at each station and on vehicles. Staff would bag and bin clinical waste appropriately and an approved waste management company collected clinical waste regularly.

Medicines

- Medicines were safely managed and medicines were administered in line with the provider's policy. The service only stored and administered oxygen.
- Medical gases were stored safely and securely at all three bases. Storage was compliant with guidance from

the British Compressed Gases Association. There were large and small cylinders in use, all of which were in date. Empty and full cylinders were stored separately and away from fire risks.

- Oxygen was available on vehicles and all cylinders we inspected were in date and safely secured. However, we did find one vehicle where the oxygen cylinder was empty, which was resolved immediately by the provider. Each vehicle was equipped with oxygen, which staff were able to administer to patients if a doctor had already prescribed it. Staff were not allowed to adjust the flow rate of the oxygen and could not administer more than four litres per minute, in line with company policy.
- Patients' own medicines were their responsibility, and staff were not responsible for any administration of these medicines.

Records

- Patients' records were mostly accurate, complete, legible, up-to-date and stored securely. All records were held electronically and control shared information to staff via information technology platforms. Staff could access the information on their personal digital assistant (PDA).
- Staff were made aware of special notes to alert them to patients with pre-existing conditions or safety risks. Patient special notes were created at the control centre and received by staff on their PDA. Control room staff collected relevant information during the booking process about the patient's health and circumstances. For example, any information regarding the patient's mobility and access to their property. The process was designed to ensure staff were informed about any needs or requirements the patient may have during their journey.
- Up-to-date information on do not attempt cardiopulmonary resuscitation (DNACPR), was recorded and communicated to staff when patients were being transported. We saw evidence this was recorded on patient information and available to staff on their handheld device. We observed updated information being passed to the control room when it was found a patient's DNACPR had been updated.
- Risk assessments completed for patients were held securely at the bases. Once a risk assessment was completed the information was stored electronically and the original signed paper copy was filed.

Assessing and responding to patient risk

- Risks were assessed to ensure they could be managed, and plans were made to deliver a safe service to patients. Risk assessments were completed for patients ahead of a patient journey. These were completed by team leaders or patient transfer liaison officers, or information was obtained at booking.
- Staff were reliant on risk assessments and information gathered by the control centre team at the point of booking to obtain as much information as possible. This would identify such things as equipment to use or the weight of the patient. The provider completed a patient movement plan based on this information, which included how many staff were required to move the patient and how to gain access to the property. Staff told us there were times when they were given insufficient or inaccurate information from other healthcare providers. This would be incident reported.
- Staff were confident to dynamically risk assess a patient. When talking to staff they told us how they would dynamically risk assess a patient and deem whether or not it was safe to transport. We saw an example of a staff member dynamically risk assessing and deeming it was not safe to continue with the transfer of the patient. The patient therefore remained in hospital and this was incident reported.
- Staff were confident about how to manage and respond if a patient's health deteriorated or there was a medical emergency during a journey. In line with the provider's resuscitation policy, staff would pull over their vehicle and phone the emergency services, or return to the hospital's accident and emergency department if they were in close proximity. Staff had received basic life support training and were able to provide compressions to a patient if required while they waited for the support of the emergency services.
- We were told by other providers how sometimes patients were collected by E-zec staff without

communicating with the ward or discharge lounge staff. This posed a risk patients could be taken home without medicines or the staff not being fully informed of their individual needs and any risks.

- Staff were able to tell us how they would deal with violent or aggressive patients. They felt their training in conflict resolution helped them to deal with these situations, although this was rare.

Staffing

- The provider's biggest challenge was the recruitment and retention of staff. Since the start of the patient transport contract staffing had been below establishment, with a high turnover of experienced staff, and not enough management capacity. This meant there was high reliance on third party providers to deliver enough staff.
- When the contract began in April 2017, 85 of the existing 144 staff transferred from the previous contract provider under the Transfer of Undertakings Protection of Employment (TUPE) laws. There were a further 16 staff who later left E-zec and returned to their previous employer for job role progression, which resulted in a significant loss of experienced staff.
- There was a high level of new and inexperienced staff. There had been 95 new staff recruited since the start of the contract, which meant the majority of staff had less than 12 months experience. Due to the shortages with staffing this meant new and inexperienced staff were not provided with the opportunity to shadow staff. Where possible staffing was arranged so new staff worked with an experienced colleague. This meant there was an additional pressure on experienced staff to deliver the day-to-day service to patients and support the new members of staff.
- At the time of our inspection staffing was almost at full establishment. Staffing levels (versus full planned establishment) were:
- Eight managers and supervisors.
- 96 whole time equivalent (WTE) ambulance care assistants and solo drivers (98 WTE full establishment).
- 25 bank ambulance care assistants.
- Three WTE planner dispatchers (four WTE full establishment)
- Four WTE control call handlers.
- Six WTE booking office call handlers were based in Stoke but were dedicated to the Bristol service.
- Staffing levels were planned to meet the demands of the patient transport contract and ensure people were safe. Core staffing was planned based upon historical demand and then monitored through the review of forecast activity to determine staffing levels. Rosters were completed four weeks in advance. Unfilled shifts were made available for overtime, offered to bank staff or covered by an agency or third party provider if they could not be filled. At the time of inspection, agency usage had been stopped as staffing was approaching full establishment.
- During a shift, staff were responsible for ensuring they had adequate breaks. This was not always possible for some staff when trying to meet the demands of the booked journeys.
- There had been a high sickness rate, which also impacted on staffing. The January 2018 quality reported identified a 6.1% sickness rate since the start of the contract, with six staff currently on long-term sickness.
- Disclosure and Barring Service (DBS) checks were completed for all employed staff to ensure they were safe to work with patients. Staff who did not come into direct contact with patients received a basic disclosure check, and staff who came into direct contact with patients received an enhanced check. A spreadsheet was held to record this information and the human resources department would contact managers to inform if any were due to renew their DBS. We saw evidence this was complete for all staff and records were maintained.
- Driving licence checks were completed for all staff at recruitment and on a six-monthly basis. There was a record maintained on a spreadsheet that confirmed all staff had received a six-monthly check of their licence.
- Staff files were incomplete. In particular, references were not held to confirm staff conduct in their previous employment. This was not in line with the provider's recruitment policy. We reviewed 14 staff files, eight of which were for staff who were part of the TUPE process and reference information had not been handed over by the previous employer. For these eight staff, there were

six staff who had a scanned copy of their driving licence and passport on file. Two staff did not have this information on file, which included a team leader and an ambulance care assistant. The six new staff all had driving licence and passport evidence on file, five had a driving assessment and one did not. Only one person had two references on file. The remaining five new staff did not have any references on file. We raised this as a concern with the provider. The provider told us references were obtained and checked in line with the recruitment policy, however not all had been retained and copies placed on file. The provider was implementing a process to ensure all staff newly employed since the start of the contract would have evidence of two references, whether this was confirmed within files or a reference was requested again. For any new staff employed the provider would ensure references were obtained and on file before they commenced employment.

- There was no assurance sub-contracted staff were fit and proper to provide a safe service to patients. Third party providers used for sub-contracted work included three independent ambulance services and two taxi firms. E-zec completed some checks for each third party provider. However, these checks relied on the third party provider completing a self-assessment. E-zec did not seek any assurance or evidence the staff were appropriate to work and that relevant checks had been completed.

Anticipated resource and capacity risks

- The service understood how they would manage foreseeable risks, for example the impact of adverse weather or disruption to staffing. Shortly before our inspection the winter pressure and snow plan procedure had been used due to several days of snow and cold weather. The provider told us they co-ordinated with hospitals to make early decisions, focussing on resources for patient flow and identifying the patient groups to prioritise. However, we were also told by a stakeholder they felt the plan had not been well–implemented, due to low numbers of staff and no 4x4 vehicles provided.

Response to major incidents

- A corporate business continuity policy outlined the arrangements for emergency preparedness.
- A 'standard operating procedure major incident plan for patient transportation services' provided the response to a major incident or disaster, and explained how the patient transport service would assist the emergency and urgent operations of the 999 ambulance service. This plan would be initiated by the NHS ambulance service responsible for alerting, mobilising and co-ordinating the response.
- A senior manager told us the service would provide a supportive role to any major incident in the area, and would be commissioned to undertake work by the clinical commissioning group. A major incident exercise in Bristol and Somerset had been undertaken in September 2017, including a senior manager from E-zec, but no learning from this had been shared with local managers or staff of E-zec Medical Transport Bristol.

Are patient transport services effective?

Evidence-based care and treatment

- Policies and procedures were based on relevant and current evidence-based guidance, standards, best practice and legislation. This included the National Institute for Health and Care Excellence (NICE) guidance and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). Staff knew how to access these policies electronically at the stations.
- Patient eligibility was determined at the booking stage. Control centre staff followed flowcharts to assess the eligibility of patients for transport.

Assessment and planning of care

- Staff were made aware of a patient's condition or special needs to enable transport to be planned accordingly. However, this was reliant on accurate information being provided on booking. Where information was found to be inaccurate this was incident reported.
- Technology and equipment was used to enhance the delivery of effective care, however it was not always fully functioning. We reviewed the systems used and confirmed information was clearly recorded and available to staff to aid the assessment and planning of care.. There were IT issues affecting personal digital assistants (PDAs), senior management told us this was

being addressed. Staff said PDAs were often unresponsive to commands, such as the ability to log arrival and departure times from locations. Staff felt frustrated as they were trying to be time efficient. New members of staff told us they did not get to see or use a PDA until they were out on their first job.

Response times and patient outcomes

- The provider was not consistently meeting some of their standards to measure the effectiveness of the patient transport service. The commissioners set standards and measures (key performance indicators), this included picking patients up in a timely manner, ensuring patients arrived at their appointment on time, and that patients were not on vehicles longer than required. The capacity issues and traffic in the area meant key performance indicators were not being achieved, however with the improvement of staffing levels the key performance indicators were also improving.
- Key performance indicators were reviewed on a daily basis and captured in a monthly activity report. Shortfalls were reviewed to determine how the service could be improved, for example additional staffing to meet the demands of the service.
- At the end of 2017 the commissioning support unit, on behalf of the clinical commissioning group, wrote to E-zec Medical Transport Bristol sharing concerns regarding performance and operational issues. Important key performance indicators had not been met and the acute trusts had raised concerns regarding availability and timeliness of transport. E-zec recognised these concerns, had started an improvement plan to deliver performance, and were working with commissioners to address performance issues.
- There was no corporate or wider benchmarking of key performance indicators. Managers we spoke with told us they did not routinely benchmark themselves against other providers, as they stated they provided a bespoke service that was different to other independent ambulance providers. They told us it was difficult to get comparative information because of market pressures.

Competent staff

- The levels of experience of staff in their role was variable, with a high number of new staff. Some staff were particularly knowledgeable about their role and this came from experience. For example assessing patient risk. New staff were still learning and were not as confident in their decision-making. Effective support mechanisms were not available for these staff.
- All new staff completed a five-day induction programme based on the care certificate. New staff felt this provided them with appropriate information before they started the role, but recognised they would continue to learn from experience and from their experienced colleagues.
- Staff were not being assessed as competent in their role during their probationary period. The provider had not been completing all four, eight and 12-week assessments for new staff. With the increased numbers of new staff there was not the management capacity to complete these assessments. This was identified on the risk register. Staff were being identified if there were performance concerns, but this was reliant on other staff feedback or receiving incidents or complaints.
- Staff received appraisals, however staff felt the quality of these was poor compared to experience of appraisals from previous employers. All staff said their appraisal did not last for very long and someone who did not know them sometimes completed them. This did not allow the opportunity to support staff development or identify learning needs.
- There was no formal training programme for junior managers and supervisors. This had been added to the provider's risk register in December 2017. We were told training for team leaders and other management roles was being explored to enable them to be better equipped and skilled to support their teams.
- Staff were not suitably trained and assessed to carry out driving duties safely. Staff completed a driving assessment, lasting between 30 minutes and one hour, at the time of interview. During this assessment the candidate's driving ability was assessed. We reviewed five completed driving assessments and found all five included areas the candidate was required to improve. Comments on driving assessments included "bad habits, one handed steering", "need to practice", and "not using mirrors". We identified one new ambulance care assistant did not have evidence of a driving assessment on file. Following the driving assessment, and on commencement of their role, staff were not provided with any training for their driving. Staff

consistently told us this was an area they would have liked further support and training. There was also no process at the time of our inspection to reassess driving skills and ability on a regular basis. This was only done when there was cause for concern.

- A safety analytics report by vehicle was sent to the head of patient transport service (contract manager) periodically. This identified any concerns with driving behaviour. We reviewed an example report which identified the vehicle being driven but could not identify the staff member. We were told this report was in development to capture more meaningful data and allow staff who required additional driver training to be identified.

Coordination with other providers

- Care was delivered in a co-ordinated way by ensuring relationships were built with other providers of healthcare. Best practice meetings were held bi-monthly with hospital trusts where E-zec Medical Transport Bristol were working in partnership. This enabled feedback to be shared, ideas to be discussed and actions identified to improve the service.
- Other providers were positive about the relationship they maintained with E-zec. However, some comments were made about the difficulties in accessing the control centre, or how messages were not being passed on from control to the provider.

Multi-disciplinary working

- All relevant staff across different teams and services were involved in assessing, planning and delivering people's care and treatment. However, information was not always successfully or accurately shared between different people and providers.
- The patient transfer liaison officer roles helped to encourage multidisciplinary working. There were two patient transfer liaison officers who were based at two local hospitals. The patient transfer liaison officers provided a positive link between E-zec and the local hospitals, co-ordinating with wards, discharge lounge and transport offices, and the E-zec Medical Transport Bristol staff. The patient transfer liaison officers were new roles. It was hoped they could educate wards and the transport booking staff in hospitals, to help the provider achieve the key performance indicators and improve patient experience.
- The culture within E-zec Medical Transport Bristol did not always help promote multidisciplinary team working. There was negativity from road staff with regards to some of the control centre staff, and vice-versa. At times, road staff felt they were requested to carry out unsafe practices as the control centre staff did not have an awareness of the ambulance care assistant role. There was also a slight divide between the staff who had transferred under the TUPE law and those newly employed for E-zec, which did not promote multidisciplinary working. There was no forum within E-zec Medical Transport Bristol to bring these staff groups together to help improve the multidisciplinary working.

Access to information

- Staff had access to the information they needed, for example special notes or information about do not attempt cardiopulmonary resuscitation (DNACPR).
- There were accurate and up-to-date satellite navigation systems to enable staff to navigate their journeys. The control centre was able to locate a vehicle at any given time.
- There was no system for identifying which staff member was driving a vehicle at any one time. When staff started a shift, they were required to use an electronic system to 'log on' to a vehicle via their hand held device. However, this did not record who was driving the vehicle, and there was no other means of capturing this information. The provider therefore did not have the information to know who was driving if there was an incident or complaint related to driving, or if a driving penalty was received.
- Policies and forms were accessible to staff and located in the staff room at the base and were easily accessible to staff. These included safeguarding, infection control, DNACPR, incident reporting and lone working. A folder was kept on each vehicle which contained forms and information.

- We saw staff taking basic handovers from nurses and checking details, including medicines and DNACPR information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the importance of gaining patient consent. We observed staff obtaining consent from patients, for example to move them.
- A corporate 'capacity to consent policy' provided guidance to staff who were involved in the care, treatment and support of people who were incapable of making some or all decisions for themselves at a specific time.
- Staff were provided with training in the Mental Capacity Act (2005) in relation to capacity testing and applying best-interest decisions.
- A 'Do not attempt cardiopulmonary resuscitation policy' clearly set out to staff their responsibility in following this order when transporting patients.

Are patient transport services caring?

Compassionate care

- People were treated with kindness, dignity, respect and compassion. We observed positive staff and patient interactions. Staff greeted patients in a friendly manner and engaged and showed interest in how their day had been.
- Privacy and dignity was maintained during transport and when moving a patient into or out of a vehicle. Blankets were available to help maintain dignity as required. Staff were respectful of patient dignity.
- We spoke with one patient who was very complimentary about the staff and their manner while using the service. They spoke of the hard-working staff with a kind and open nature.
- We observed staff reassuring patients and taking time to explain what they were doing, such as securing wheelchairs. They warned of sudden noises, for example a closing door, to those who were anxious. Staff spoke clearly and slowly ensuring the patient understood.
- Excellent patient care was witnessed from the staff. Patients were engaged, stimulated and included in their care.
- Staff explained how they would ensure a patient was warm, comfortable and safe before leaving them at home.
- Patient survey feedback was mostly positive. Patients regularly commented how staff were "helpful and polite".

Understanding and involvement of patients and those close to them

- Staff communicated with people so they understood the care they were receiving. We saw staff made sure patients understood what they said and what was happening. They gave updates on potential delays when in transit and demonstrated an understanding when patients expressed their frustrations with these delays.
- Staff were caring and attentive when we observed them engaging patients in conversation. This included informing them of transport details, and asking questions and showing interest in the patient's care.

Emotional support

- Staff understood the impact a person's care, treatment or condition could have on their wellbeing and on those close to them, both emotionally and socially. They told us whilst they were not always aware of the patient's condition, they ensured they did their best to be sensitive to the patient's needs.
- Staff were not provided with any education or support to prepare them for patients who die in their care to then enable them to support the patient, relatives or other parties. There were two examples provided by staff where they witnessed a patient death. The staff found this distressing and were not provided with any support from the provider.

Supporting people to manage their own health

- Staff provided examples of how they would encourage patients to manage their own health. Staff told us they had limited input on how a patient chose to manage their health, but they offered encouragement where possible and checked when patients wanted additional support, for example assistance with walking.

Patient transport services (PTS)

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The provider was not consistently meeting the standards of service required by the commissioners. However, the commissioner had raised concerns with performance and the provider was responding well. Improvement had been seen in meeting the standards.
- The service only provided non-emergency planned transport for patients, for example transport to hospital clinics or appointments, and discharges from hospital. Repatriations (transferring someone a longer distance to return home) were also carried out. The roster was flexed based on the service demands.
- Staffing and resources were planned to meet the differing demands of the acute trusts. For example, there had been a large increase in evening activity for discharges and transfers so rosters were altered and late vehicles were put on to ensure the service could be delivered. The provider had also seen an increase in patients who need a stretcher over the winter, they would put on more stretcher equipped vehicles to deal with this demand.
- The geography also impacted on capacity and there was an awareness of this when reviewing performance. For example, Bristol had significant traffic delays, which outside of London were reported as being the worst nationally.
- The patient transport service was available 24 hours a day, seven days a week. The Avonside base operated 24 hours a day, but with reduced fleet overnight and weekends when demand was less. Yate and Nailsea bases operated from 6.30am to 9pm.

Meeting people's individual needs

- The service was planned and delivered to take account of the needs of different people. There was a system to flag where people had complex or specific needs, for example dementia and learning disabilities. Reasonable adjustments for people were reviewed on a case by case basis and special requirements were discussed and agreed as part of the booking process.
- Control room staff told us the majority of patients with dementia had their own escort to accompany them on their journey. However, if a patient with dementia did not have an escort, the ambulance staff would prioritise that patient to ensure they were dropped off first. This ensured the patient was not left on an ambulance either on their own or with other patients.
- Vehicles were equipped to meet people's individual needs. For example, there were three bariatric (for patients with a BMI over 40) capable stretcher multi-purpose ambulances, nine stretcher multi-purpose ambulances, 25 sitting/wheelchair ambulances and six wheelchair accessible solo vehicles. Staff received bariatric training.
- Translation support was available for staff when caring for people who could not speak English, but staff were not always aware this was available. A corporate interpretation and translation services policy outlined the requirement for suitable interpreting services to be arranged where required. An approved service provided interpretation and translation, or a private interpretation agency could be arranged with director approval. Control room staff were not aware of the availability of translation services for patients whose first language was not English. Staff we spoke with told us escorts would often translate on behalf of patients. This is not in line with best practice.

Access and flow

- People were able to access the patient transport service; however, the service provided was not always timely. Common themes from complaints and incidents, stakeholder feedback and key performance indicators identified service timeliness could be improved.
- The service could be accessed 24 hours a day, seven days a week via telephone. Calls were taken at the Bristol office between 7am and 7pm from Monday to Saturday. Outside these hours calls were directed to the main office in Stoke.
- E-zec Medical Transport Bristol completed approximately 100,000 journeys a year. This was mostly pre-booked, with just 16% of activity being booked on the day. The patient booking office located in Stoke,

which had a dedicated Bristol resource, managed patient journeys booked in advance. The Bristol call handling office managed on the day bookings with between 40 and 60 booked each day.

- The service took action to ensure resources were where they needed to be at the time required. Vehicles were allocated by the service depending on which staff were free or were completing journeys close to the area where the service was required. We observed the call handling staff in Bristol reviewing resources and re-allocating to meet the demands of the service or when unpredictable changes arose. However, control centre staff were unable to track journeys taken by third party providers, and relied on staff or taxi drivers to report into the control centre.
- Eligibility for patients was assessed at the time of booking to reduce the risk of patients being booked incorrectly. If patients were incorrectly booked staff would raise an incident report.
- Traffic in the Bristol area provided a challenge for staff and impacted on the timeliness of patient transfers. Staff started shifts on time but journeys were dictated by traffic within the area. Staff were often late collecting patients as reflected in incidents, complaints and key performance indicators.
- Staff in the control room were able to track all E-zec vehicles through a bespoke planning and dispatch system, and could monitor on-scene and turnaround times.
- The patient transfer liaison officer's role was thought to have reduced the number of aborted journeys for patient discharges, which helped with patient flow. By liaising with the wards to ensure medicines were ready for the collection time, as an example, staff were able to transport the patient promptly. However, there had been no qualitative or quantitative data to evidence this.

Learning from complaints and concerns

- People's concerns and complaints were listened and responded to, however due to capacity issues the provider told us they were not meeting their own complaint response targets. This was included on the risk register. Data was not captured to analyse how many complaints were not meeting targets. A corporate complaint policy indicated timelines for responding to complaints. Acknowledgement of the complaint must either be sent in writing or communicated verbally within 36 hours of the complaint being received. A final written response, or a satisfactory verbal explanation, should be sent within 25 days. The provider included on their risk register the inability to respond to complaints in line with the policy timescales as a result of staffing and management capacity issues.
- The head of patient transport service (contract manager) and operations manager were responsible for investigating complaints. All complaints were sent to the head of governance and compliance to generate a monthly quality report for commissioners. Complaints were also discussed as a standing item at the contract meeting with commissioners, including learning and actions.
- There were no systems to audit the quality of responses to complaints and monitor all actions or learning. The contracts manager showed us a complaint tool which was required to be completed. Once completed, a monthly report was generated and this was delivered to the local clinical commissioning group as part of the quality and performance agreement. It was of note the number of complaints received and recorded by the head of patient transport service (contracts manager) in a month was higher than the number of complaints reported to the clinical commissioning group via the quality report. This meant not all complaints were shared.
- Complaints were reviewed and investigated. We reviewed three complaints and followed through the complaint process. For the three complaints reviewed the response to the complainant was timely. Face to face meetings were held with complainants, and resolution and transparency was apparent.
- Between June 2017 and February 2018 there were 29 complaints received. The most frequently complained about category was transport being late.
- Feedback leaflets were available on vehicles should a patient want to provide feedback or raise a complaint.

Are patient transport services well-led?

Leadership of service

- Local leadership for E-zec Medical Transport Bristol was provided by the head of patient transport (the contract manager and CQC registered manager), who was supported by the operations manager. Team leaders were also in post at each station.
- The senior management team (corporate leadership team) included; an operation directors, operations manager, senior compliance manager and clinical governance lead, HR director, HR manager, regional operations manager and national fleet manager. This team provided support to the local management team.
- The board consisted of the managing director and commercial director who were the two executive directors. The operations director also sat on the board as a non-executive director. We were unable to evidence the scrutiny and overall responsibility at board level. There was no formal board meeting to discuss and minute operational risks. The board discussed financial and shareholder topics, which included confidential and sensitive information. We were told decisions were made and operational risks managed in real-time and each person had an action tracker. We saw examples of how this was managed, but this was sometimes reactive rather than proactive.
- Leaders had the knowledge and experience to lead effectively but did not have the capacity. The local management team for E-zec Medical Transport Bristol were aware of the challenges for the service and could identify the actions needed to address these, however had not had the capacity to implement change.
- Management were not always visible or approachable to staff. Some staff were unable to name, or said they would be unable to recognise, corporate senior staff and their local management staff who were responsible for the leadership of the service. Staff said they rarely saw any senior or middle management whilst at work, but spoke positively about their relationships with their team leaders.
- There was a disconnect between management and staff. What leaders were telling us, staff were not aware of. For example leaders told us messages were relayed to staff via the staff representative, however some staff did not know who their staff representative was. Staff did not always feel supported. They felt they were sent from person to person with nobody providing an answer or a solution to the problem raised.
- Staff did not have access to any leadership when working out of hours. Instead support was provided by the control centre.
- Leaders were not encouraging appreciative, supportive relationships among their staff. The management team, due to capacity, had not spent time engaging with their staff or promoting a positive culture.

Vision and strategy

- There was a realistic vision for the future. The management team were aware of the key pressures and risks. They could describe the goals and plans for the service, locally and corporately, to help improve the quality of the service and care provided. The key drivers for providing an effective patient transport service were understood by management staff. However, there was not a strategy for progress to be monitored.
- Staff were not engaged with vision and were unsure of the goals and plans for E-zec Medical Transport Bristol.
- There were no established values for staff to work to.

Governance, risk management and quality measurement

- There was not an effective governance framework. The governance framework required review and improvement to ensure it was working effectively.
- There were basic systems to monitor and manage quality and performance. However, the provider could develop how they analysed and reviewed data and information to help improve quality and performance.
- There was no local meeting or forum for the managers of E-zec Medical Transport Bristol to discuss quality, performance and risks.
- The head of patient transport service attended quarterly corporate clinical governance meetings. These meetings had recently been introduced and were not yet embedded to support the delivery of high quality care. We reviewed the minutes of the first three meetings in July 2017, October 2017 and January 2018. The meeting minutes did not follow a formal agenda and there was no governance specifically around E-zec Medical Transport Bristol. The July 2017 meeting was mainly setting out corporate processes, and the October 2017 and January 2018 meetings discussed these processes further and any concerns or issues.
- There were arrangements for recording and manging risks on a local risk register; however, we were unable to see this being reviewed and escalated within the

governance framework. We were provided with a risk register ahead of the inspection, which was last updated in December 2017 and included 10 risks. This risk register did not record when a risk was added. We did see risk mitigation and actions were included on the risk register. We were provided with a risk register following the inspection which included 12 risks. This had been updated to include the date the risk was added and showed reviews took place on a regular basis.

- Performance was well-understood and regularly reviewed. Key performance indicators (KPIs) were used to monitor the service's performance and information was shared and discussed with commissioners.
- Governance was discussed monthly at contract meetings with the commissioners and monthly quality reports for E-zec Medical Transport Bristol were produced. These covered safeguarding, complaints, incidents, workforce information and training, key performance indicators and family and friends scores. We were concerned the provider was not always being transparent when reporting in quality reports. During our inspection, we were told some complaints held on the local E-zec Medical Transport Bristol complaint spreadsheet were not always included in the quality report. We saw the spreadsheet and found the number of complaints held by the head of patient transport did not always correlate with the number of complaints in the quality report. We were unable to confirm why this was.
- There was a programme of clinical and internal audit being carried out. These were planned to be undertaken quarterly but were reliant on staff being available to complete the audit. We were shown an 'audit overview', which showed regular audits were undertaken at the bases we inspected. These included infection prevention and control, and vehicle safety. Information from the audits was collected by management, but we did not see evidence of, and managers could not explain, how audits were used to share learning and improve performance.
- Working arrangements with third party providers were not well-managed. There were limited systems or processes to be assured these providers and their staff were competent and appropriate to work.

Culture within the service

- The culture was difficult to capture and describe. There was not a familiarity between management and staff, for example we observed when managers were in the crew room they did not engage well with their staff. There were also sub cultures with conflict between new and TUPE staff, and on the road staff and control room staff.
- The culture did not encourage collaborative working amongst operational staff, or between operational staff and management. Although staff and management were all focussed on providing good quality care to patients, there was not a sense of team work across all staff groups to enable this to be achieved together. There was also no forum for team meetings to improve team morale.
- Staff felt they were not regularly involved in service developments or informed of information.
- Staff we spoke with felt there was a culture of "us and them" in relation to the TUPE transferred staff and newly employed E-zec staff. The differences in pay and conditions had created a rift between employees. New E-zec staff were unlikely to do extra hours due to the pay deficit.

Public and staff engagement

- There was limited staff engagement. Monthly staff representative meetings were held, however the majority of staff were not aware of who their representative was or that monthly meetings existed. This forum was therefore not being used effectively to engage staff and keep them informed. Two representatives from each ambulance base would attend the monthly staff representative meetings. There was an open floor with all representatives being encouraged to speak. There was an action planner and assigned actions, which were discussed and updated every month.
- Staff were not actively engaged. Staff did not feel they were always informed about decisions that affected them directly. Staff told us they would like to be more involved to help improve the service. Staff did not feel they were regularly asked for feedback.
- Patient experience was captured on a regular basis and was mostly positive. Five patient journeys were selected randomly every week and these patients were telephoned and asked a specific set of questions in relation to their patient transport experience. Vehicles also held patient feedback forms and there was the capacity to leave feedback on the provider's website.

- Staff told us positive feedback received from patients was not shared with them. They were made aware of positive feedback from the patient themselves, but there was no evidence this was celebrated by management.

Innovation, improvement and sustainability

- Management was considerate of sustainability when discussing how improvements could be made to the service. At the time of the inspection, the service was concentrating on recruitment to ensure staffing was at full establishment and they were able to deliver quality and perform in line with key performance indicators. There was therefore no capacity for looking at ways to innovate at this time.
- There was a longer term plan to expand the Bristol control hours so the control function could be brought in house.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure there is evidence of systems and processes to measure the quality and safety of the services provided, with effective oversight, scrutiny and responsibility from the board.
- Evidence appropriate checks have been completed for employees as per the recruitment and selection procedures, and ensure these checks are complete before staff begin employment.
- Have their own assurances and be able to evidence third party providers, delivering regulated activity for E-zec Medical Transport Bristol, have had the appropriate checks and training to ensure they are safe to work with patients.

Action the hospital SHOULD take to improve

- Review and evidence how information and data can be analysed so quality and performance can be improved.
- Consider a local forum for E-zec Medical Transport Bristol management meetings to review the quality and safety of the service, and to feed in to the corporate clinical governance meeting.
- Embed the governance processes and ensure this is captured within the clinical governance meeting.
- Engage with staff and promote a positive culture.
- Consider how support can be provided to staff to train and educate them in their driving skills, particularly on starting in their role, and to assess on a regular basis and provide any further training as required.
- Ensure lessons learnt from incidents are shared with staff to promote a culture of learning and to encourage staff to report incidents.
- Hold a local record of staff compliance against mandatory training modules for E-zec Medical Transport Bristol so the management team and staff are aware of performance so this can be evidenced.
- Remind staff how to access translation and interpretation services so this can be effectively used to meet patient individual needs.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17(1) Systems and processes must be established and operated effectively to ensure compliance with the requirements.** There were limited systems and processes to measure the quality and safety of the services. It was not clear how the board had overall responsibility, oversight and scrutiny of the governance, safety and quality of the service.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **19(1) Persons employed for the purposes of carrying on a regulated activity must –** **(a) be of good character** **(b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them** **19(2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in 19(1)** The provider was unable to evidence full recruitment and selection checks had been completed for staff in line with schedule 3, for satisfactory evidence of conduct in previous employment. Files did not all contain two references for an employee's previous employment, and the references were not always obtained before the commencement of employment.

This section is primarily information for the provider

Requirement notices

The provider was not assured third party providers had the appropriate checks and training. For example DBS checks, driving licence checks and checks at recruitment. Due diligence documents were completed by the third party provider, and therefore was reliant on a self-judgement with no check process to ensure each staff member used from third party providers was appropriate to work with patients and carry out the role.