

E-Zec Medical Transport Services Ltd

# E-zec Medical Shropshire

## Inspection report

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

### Ratings

#### Overall rating for this location

Good



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Inspected but not rated



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

## Overall summary

We rated it as good because:

- The service had mostly enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. Staff told us they provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all vehicles were clean inside.
- Some fixtures and fittings of vehicles were damaged and not all staff reported this.
- Not all staff were up to date with mandatory training.
- Not all staff understood the duty of candour.
- Not all staff understood the Mental Capacity Act.
- The service could not evidence what competencies had been assessed when ambulance care assistants were undertaking their post-training supervised work.
- Not all staff had access to team meetings.
- Not all staff understood the service's vision and values, and how to apply them in their work.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good 	

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# Summary of findings

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# Summary of this inspection

## Background to E-zec Medical Shropshire

E-zec Medical Shropshire is run by E-zec Medical Transport Services (E-zec). E-zec Medical Shropshire was awarded the non-emergency patient transport service (NEPTS) contract to supply services across Shropshire by the local Clinical Commissioning Group (CCG) and for Powys residents accessing hospital services in Shropshire in October 2021.

E-zec Medical Shropshire's contract is to provide 95,000 patient journeys for children and adults each year across Shropshire and Powys. The types of journeys patients undertake includes: renal dialysis, outpatients appointments, discharges, admissions, transfers, oncology, palliative care, paediatric transport, bariatric transport, and GP transfers, In addition to standard patient transport services, E-zec provides a dedicated renal manager to provide enhanced support for dialysis patients across the region, a shuttle service linking the two acute NHS hospitals in Shropshire, plus a support service to facilitate the discharge of long-stay patients and their equipment.

The service is registered to deliver the following regulated activity:

- Transport services, triage and medical advice provided remotely

The service had a registered manager in place at the time of our inspection. The regional manager was applying to take over the role as registered manager at this time.

The service delivered one core service:

- Patient transport services

As this service commenced in October 2021, we have not previously inspected it. We inspected this service as part of our inspection priorities at the time. There were no risks, outstanding compliance actions or enforcement associated with this service at this time.

## How we carried out this inspection

We inspected this service on 10 May 2022. This was an unannounced comprehensive inspection looking at all aspects of the service. We visited the main base of this location in Shrewsbury. We did not visit the satellite location in Newcastle-Under-Lyme in Staffordshire. We did not visit the site in Powys, Wales as this was funded by Welsh authorities which we do not inspect.

The inspection team comprised a lead CQC inspector, a CQC assistant inspector and a specialist adviser with expertise in managing independent patient transport services.

During our inspection we spoke with 14 staff members including ambulance care assistants, control room staff, supervisors and managers. We checked eight vehicles, reviewed five patient records and six staff records. Due to the ongoing Covid 19 pandemic, we did not accompany any ambulance crews who were transporting patients. Therefore, we did not observe any patient care or speak with any patients as part of this inspection.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

# Summary of this inspection

## Areas for improvement

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

### **Action the service MUST take to improve:**

- The service must ensure that all vehicles are fully cleaned prior to use and any damaged fixtures or fittings are reported and addressed.

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

### **Action the service SHOULD take to improve:**

#### **Patient Transport Service**

- The service should ensure that all staff are up to date with mandatory training. In addition, the service should consider refreshing learning for staff in the areas of the Mental Capacity Act and duty of candour. The service should consider a training module which focuses on consent.
- The service should consider developing a way to identify what aspects of care staff have been signed off as competent in during their post training supervised period.
- The service should ensure contact details for Shropshire safeguarding services are within the safeguarding policy.
- The service should ensure it is meeting requirements under the Accessible Information Standard so people who have a disability, impairment or sensory loss get information about their transport that they can access and understand.
- The service should ensure all vehicles carry information about how patients can give feedback including making a complaint.
- The service should consider implementing an interpretation option for patients who do not speak English.
- The service should consider implementing opportunities for all staff to meet, discuss and learn from the performance of the service.

# Our findings

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires Improvement	Good	Inspected but not rated	Good	Good	Good
Overall	Requires Improvement	Good	Inspected but not rated	Good	Good	Good

# Patient transport services

Safe	Requires Improvement 
Effective	Good 
Caring	Inspected but not rated 
Responsive	Good 
Well-led	Good 

## Are Patient transport services safe?

Requires Improvement 

We rated safe as requires improvement.

### Mandatory training

**The service provided mandatory training in key skills to all staff. Not all staff were up to date although plans were in place to manage this.**

All staff recruited since October 2021 were up to date with mandatory training. Not all staff from the previous contract were up to date with their mandatory training (18 out of a total of 92 staff); however, we saw the service had provided familiarisation training for the different vehicles, equipment and processes. We discussed this with managers at the inspection who said this was due to focusing on operational aspects of getting the service up and running. A focus on ensuring mandatory training and compliance was the next step in ensuring compliance with all key lines of enquiry and a recovery plan for this was in place. We saw a document which showed training dates scheduled for throughout 2022 to ensure all staff would be compliant by the end of the year. The provider target for mandatory training compliance was 98%.

Staff took part in an annual skills development (ASD) day whereby they completed their yearly mandatory training. This comprised a mix of face-to-face training such as basic life support and time to complete e-learning modules.

Staff we spoke with were familiar with the mandatory training modules and told us they had completed them.

The mandatory training was comprehensive and met the needs of patients and staff. We saw modules included conflict resolution, health and safety, moving and handling, infection prevention and control, dementia for ambulance services and the Mental Capacity Act.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Ambulance care assistants were trained in dementia care.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they got reminders to complete their training if due.

# Patient transport services

## Safeguarding

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

Operational staff received training specific for their role on how to recognise and report abuse. The ambulance care assistants and control room operators were trained to level two in safeguarding adults and children. Local managers were trained to level three and the provider wide safeguarding lead was trained to level four. Staff also received training in preventing radicalisation. Staff could access the national safeguarding lead for further advice and support.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of where they had raised safeguarding concerns. Staff were familiar with the process of reporting via the electronic system used by the provider.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff at the service had access to a 24-hour safeguarding telephone line which they could call to report concerns. Staff would also report safeguarding concerns through the personal digital assistants (PDA, handheld electronic devices) which they took on each shift.

The national safeguarding lead reviewed all safeguarding concerns raised. Where appropriate, concerns would be reported to the local authority. If the safeguarding lead was not available, for example out of hours, staff contacted an on-call manager for support and guidance.

We reviewed the safeguarding concerns reported since the service opened. We saw these were appropriately actioned to keep patients safe.

The service transported children, either as the patient who required transport or as a passenger accompanying a parent who needed transport. Children were always required to be accompanied by a parent or carer.

The service conducted Disclosure and Barring Service (DBS) checks on all operational staff prior to starting. We reviewed six staff records and found a DBS check had been done in all cases. Staff records also highlighted when they should be re-done. The service policy was to re-do these checks every three years.

We saw a safeguarding policy was in place at the service. The safeguarding policy had local authority contact details for Staffordshire and Norfolk, but not for Shropshire at the time of the inspection. However, we noted staff would not generally contact external safeguarding teams directly themselves as they would refer this to the safeguarding lead or the on-call manager out of hours.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Some vehicles were not visibly clean in clinical areas.**

Clinical areas were not always clean. However, we saw all areas of the base were visibly clean and tidy including the garage which housed vehicles.

The vehicle garage had a 'make ready' area where vehicles were cleaned by ambulance fleet assistants (AFAs). All cleaning equipment was colour-coded to ensure staff use the correct equipment on the correct part of the vehicle. The

# Patient transport services

service used disposable mop heads to avoid any contamination. Cleaning products were risk assessed as required in line with 'Control of Substances Hazardous to Health (COSHH) requirements. The service had recently started using an environmentally friendly cleaning product which did not need to be risk assessed as it was not hazardous to health but had the same cleaning efficacy as other products used.

During our inspection we checked seven vehicles. All vehicles had a good supply of personal protective equipment (PPE), clean linen and hand cleansing gel. We found plentiful supplies of decontamination wipes.

However, we found three of the seven vehicles to be dirty in the patient area. For example, dirty flooring. We also found some of the fixtures and fittings in the vehicles to be damaged such as a tear in the material of a patient trolley. This meant the trolley would not be able to be cleaned effectively in line with infection prevention and control guidance. A patient stretcher in one vehicle was dirty. We raised this with managers at the time of inspection who reported they would seek to gain more oversight of daily cleaning and vehicle checks. The service confirmed that the ambulance fleet assistant immediately cleaned the ambulances found to be dirty were on site after the inspection; and booked these in for a deep clean.

The service generally performed well for cleanliness. We saw the service used daily check sheets to monitor the base cleaning levels.

Cleaning records were up-to-date and demonstrated that all areas of the base were cleaned regularly. Deep cleans were undertaken by third party provider. The deep cleaning was done every twelve weeks. At the time of our inspection; all vehicles were compliant with the deep clean schedule. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff we spoke with were familiar with how to use PPE. Staff driving the vehicles had access to antibacterial gel in the cab areas.

## Environment and equipment

**The design and use of facilities, premises, vehicles and equipment kept people safe. Some vehicles had damage to fixtures and fittings. Staff managed clinical waste well.**

The design of the vehicles followed national guidance. At the time of our inspection the service had 53 vehicles which had been used as part of a contract in a different area. All of these vehicles were approximately 6 to 7 years old. The service had commissioned 53 new vehicles to be built to replace this older fleet. These new vehicles were due to be rolled into the service over June, July and August 2022.

During our inspection we checked seven vehicles. We found that vehicles were well stocked, and the majority of equipment was working and well-maintained. However, we found damage to some areas of the vehicles. In five out of seven of the vehicles we checked we found torn material or damage such as a broken side panel, torn trolley material and a torn patient seat. We noted that one of these vehicles was off the road at the time of our inspection. We found some of the vehicles to be dirty for example one vehicle had a dirty floor in the patient area, one vehicle's external body was dirty, and we saw rubbish had been left in the cab areas of two vehicles. We also saw a stretcher had tears in it on one vehicle and was not visibly clean.

Data supplied following the inspection showed one vehicle found to have a defect had been swapped out for an incoming new vehicle as soon as these arrived; and another vehicle had parts replaced. All vehicles identified during the inspection were due to be replaced as above.

# Patient transport services

Staff completed a vehicle checklist at the start of their shift which required them to report stock, mileage, and any issues with the vehicle. However, these did not always reflect damage to vehicles or equipment. In addition, staff completed weekly vehicle checks. However, whilst checking vehicles we found a number of defects which had not been reported. Data from the service showed an in-date defect reporting process was in place and staff had access to forms to complete when they identified a defect. Staff told us they reported defects however the examples provided tended to be equipment defects rather than damage to the fixtures and fittings of the ambulance itself.

At the time of our inspection, supervisors checked vehicle checklists and defect forms that staff completed but did not perform their own checks or audits. We discussed this at the time of the inspection and the fleet supervisor recognised this was an area which could be improved to gain greater oversight. The service sent us three defect forms completed in May 2022; two were completed after our inspection visit.

Staff used personal digital assistants (PDA, handheld electronic devices) to obtain patient details, be directed to their patient pick-ups and to communicate with the control room. Staff could also use these devices to report incidents, safeguarding concerns or complaints. Each vehicle had a PDA assigned.

The fleet supervisor could track vehicles using an electronic tracking device on each vehicle.

When vehicles were off the road for example if they needed repair, the fleet and operation supervisors remove the keys, attached a red tag to the keys and stored them in a lockable cabinet so no staff could accidentally take that vehicle out.

The base had CCTV recording at all times to maintain security.

Staff carried out safety checks of specialist equipment. Staff checked equipment such as consumables and oxygen cannisters weekly.

The service used local garages to carry out repairs to vehicles. The fleet supervisor at the time of the inspection was a trained mechanic and able to quickly identify faults.

Data from the service showed regular maintenance of equipment.

The service had enough suitable equipment to help them to safely care for patients. High dependency vehicles had additional equipment such as pull out chairs and additional harnesses for patients.

Staff used paediatric equipment to safely support children who travelled on the vehicles.

Staff disposed of clinical waste safely. Clinical waste was stored and disposed of appropriately. The clinical waste bins were kept inside the compound so they could be locked away when not in use. A third-party company collected the clinical waste.

## Assessing and responding to patient risk

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

The majority of the service provided by this location was patient transport services delivered by ambulance care assistants for patients who were not acutely unwell. A small proportion of the work was transferring patients from one

# Patient transport services

healthcare location to another in a high dependency (HD) vehicle. The service had a policy in place clearly outlining the criteria for patients using the HD service. All patients using this service was required to be 'stable' in their clinical condition at the time of transfer. Clinical escorts from the sending hospital accompanied patients where necessary and E-zec staff delivering this service were trained to Level 3 First Response Emergency Care (FREC3).

Staff responded promptly to any sudden deterioration in a patient's health. Staff did not take routine observations of vital signs for standard patient transport journeys but were aware that if a patient became unwell on a journey, they contacted the ambulance service by ringing 999. When staff transported patients on the high dependency vehicles, they took clinical observations of vital signs to identify any deterioration using the National Early Warning Score (NEWS2). This service did not undertake any emergency journeys, including those using blue lights and as with standard PTS journeys, would call 999 for an emergency ambulance if required.

Staff completed risk assessments for each patient on booking and reviewed this regularly for patients who undertook regular journeys. ACAs knew about and dealt with any specific risk issues. Control room operators recorded any potential risk factors such as if a patient had additional needs, used specialist equipment or was Covid-19 positive.

Ambulance care assistants (ACAs) reviewed the electronic patient records prior to picking patients up to identify any potential risks or areas of additional needs. This enabled ACAs to review risk assessments and notes about the patient.

The booking staff triaged all patients to assess whether they were suitable to travel with other people in terms of clinical vulnerability.

The service, as part of its contract, the service transported patients undergoing treatment for mental health conditions on a voluntary basis (not detained under the Mental Health Act). The senior leadership team told us at the time of the inspection the service did not transport patients who were detained under the Mental Health Act. Some staff told us they did not feel comfortable working with patients whose primary health condition was related to mental health due to a lack of training and felt this posed a risk. The service required that these patients using the service were accompanied by an escort (such as a member of staff from the sending establishment) or carer. We saw staff had access to training on caring for patients with a mental health diagnosis.

If ambulance care assistants were undertaking a long journey, they were required to take turns at driving to mitigate the risk of tiredness.

Where patients did not attend for their journey, particularly if being collected from their own home, ACAs escalated this to ensure the safety and wellbeing of the patient.

Staff shared key information to keep patients safe when handing over their care to others. ACAs spoke with staff, family or carers when collecting a patient to gain a handover and ask relevant questions. When dropping patients off, ACAs escorted patients into the building. If ACAs were taking a patient to their own home, they entered the home with the patient to ensure the environment was suitable and safe, particularly if the patient had spent some time in hospital.

## Staffing

**The service had mostly enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Supervisors regularly reviewed and adjusted staffing levels and skill mix.**

# Patient transport services

The service did not have a full complement of ambulance care assistants (ACAs) at the time of the inspection. Some staff had been TUPEd from the organisation who previously held this contract. TUPE stands for 'Transfer of Undertakings (Protection of Employment)'. However, not all of these staff had chosen to move to E-zec Medical Shropshire meaning the service had to recruit.

At the time of our inspection, managers showed they had consistently recruited ACAs since the contract had started, running regular induction courses. Plans were in place to have a full complement of ACA staff within 12 months of opening.

Data submitted towards the end of May 2022 showed the vacancy rate was low. There were four vacant positions (3.8%) against 106 total number of operational positions. However, sickness rates were high at 10.1% as of May 2022. Turnover rates had reduced; by May 2022 this was just under 6%.

To mitigate the gaps in staffing, the service had used a third-party independent patient transport provider. As the staffing numbers rose, this company was required less. The service also had volunteer drivers who transported patients. Volunteer drivers selected the hours they wanted to work. Volunteer drivers underwent the same checks as paid staff such as Disclosure and Barring Checks (DBS).

Control room supervisors allocated ACAs to shifts. New staff were not permitted to work alone until signed off as competent and were allocated to work with staff who had worked in the role for a longer period of time.

The control room had enough staff to cover all shifts.

## Records

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

During our inspection we checked five patient records. Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. Patient records were electronic and initiated by the control room operatives when taking a booking. Ambulance care assistants (ACA) could access these via personal digital assistants (PDA, handheld electronic devices) which they took on each shift.

The records contained relevant information to enable ACAs to safely transport patients. This included details of the patient and their journey, details of any vulnerabilities, risks and the patients' Covid-19 status.

Control room operatives clearly recorded if the patient had a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). This enabled ACAs to know whether to resuscitate a patient if they went into cardiac arrest.

## Medicines

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

Oxygen was the only medicine used at the service. Staff stored and managed this safely. Full and empty oxygen cylinders were stored separately in locked cages. A system was in place to check the oxygen cylinders and ensure they were in date.

## Patient transport services

Staff followed systems and processes to prescribe and administer medicines safely. Staff were trained in administering oxygen. Oxygen was only given to patients travelling on high dependency vehicles; unless patients were transported with their own oxygen. This was prescribed by clinicians from the sending establishment.

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

### Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy, including serious incidents. Staff reported incidents electronically using the personal digital assistants (PDA, handheld electronic devices) which they took on each shift. Managers were able to immediately view the incidents once these had been reported.

Not all staff understood the term 'duty of candour'. However, they were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff we asked were not familiar with the duty of candour; although we saw staff received training in this. Supervisors and managers apologised when things went wrong and where appropriate in complaint responses. Managers exercised the legal duty of candour in line with the CQC regulations.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers emailed staff to alert them to any learning following incidents. Staff and managers were aware of incidents that had occurred, and staff told us they got feedback after incidents.

Staff did not meet to discuss the feedback and look at improvements to patient care. At the time of our inspection, team meetings were not embedded with all staff therefore staff did not meet to discuss incidents. Managers discussed incidents at a more senior level internally and externally to the service.

There was evidence that changes had been made as a result of feedback. For example, we saw a 'lessons learnt' document, and safety bulletins, highlighting recommendations for staff following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. During our inspection we reviewed a sample of incidents reported and investigated since the service started in October 2021. We saw managers had to follow a structured process to ensure incidents were investigated depending on their severity. Root cause analysis reports were produced for serious incidents.

### Are Patient transport services effective?

We rated it as good.

# Patient transport services

## Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had electronic access to the provider policies to support their roles.

Staff followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines when administering oxygen.

When handing over care, staff routinely referred to the psychological and emotional needs of patients. Staff spoke with hospital and care home staff, carers and family when collecting or dropping off patients. They shared information about the patient relevant to the patients' needs.

## Nutrition and hydration

**Staff provided water for patients on board vehicles.**

Due to the nature of the service food and drink was not routinely served to patients during journeys. However bottled water was available for patients going on longer journeys. Staff also liaised with carers and hospital staff to check if there were any special requirements in relation to nutrition or hydration.

## Response times

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

Managers monitored performance against five key performance indicators (KPIs) set by the CCG which included response times.

KPI One: Planned journey arrival time. Patients arriving on time for their appointment. The target was 85%. As of April 2022, the service had achieved 88.6% compliance.

KPI Two: Planned journey collection time (excluding discharges and transfers) – patients should be picked up within 60 minutes of their collection time. The target was 85%. As of April 2022, the service had achieved 78.4% compliance. This was an improvement on the previous two months.

KPI Three: Collection time of planned discharges/ transfers: Patients should be collected within 60 minutes of the service being informed the patient is ready. The target was 85%. As of April 2022, the service had achieved 81.1%. This was much improved from all previous months since the service started operating.

KPI Four: Collection time of unplanned discharges/ transfers: Patients should be collected within 120 minutes of the service being informed the patient is ready. The target was 75%. As of April 2022, the service had achieved 68.3%. This was an improvement from all previous months since the service started operating.

KPI Five: Collection of unplanned admissions (e.g. hospital admissions/ nursing home admissions) - Patients should be collected within 240 minutes of the service being informed the patient is ready. The target was 75%. As of April 2022, the service had achieved 100%.

# Patient transport services

KPI Six: Call answering time – calls should be answered within 120 seconds. The target was 85%. As of April 2022, the service had achieved 86%.

Managers identified reasons for not achieving KPIs which included restrictions due to Covid-19 (such as only having one patient per vehicle/ not being able to transport renal patients with non-renal patients, staff sickness due to Covid-19).

The service did not have a key performance indicator for the time patients spent on vehicles.

The service discussed performance monthly with the Clinical Commissioning Group (CCG) and identified areas of improvement.

## Competent staff

### **The service made sure staff were competent for their roles.**

Staff had the right skills and knowledge to meet the needs of patients. Staff employed by the service were trained to carry out their roles. Where staff had transferred from the previous contract holding organisation; they had undertaken their initial induction training already.

Managers gave all new staff a full induction tailored to their role before they started work. Ambulance care assistants (ACA) who were new to the service underwent an induction training which comprised five days of classroom-based induction and two days of driving training. The classroom training was a combination of face-to-face training such as basic life support, and e-learning. Following this, new staff members were allocated to shifts with more experienced ACAs. New crew members were not permitted to work alone until they were signed off as competent. Senior ACAs signed new staff off as competent following assessment shifts. At the time of our inspection we found there was no formal recording process to show that staff were competent in all required areas. Instead the senior ACAs emailed leaders to inform them that new staff had been signed off. We discussed this at the time of the inspection and managers reported they would review the need to create a competency checklist for new starters.

Two staff we spoke with told us the induction training was not adequate for their needs. We reviewed the modules provided by the service and found the topics covered were suitable for the grade of ACA.

Some staff told us they were allocated to work with other new team members when they had started with the service. We explored this during the inspection and found this occurred where new starters were put with staff who had started before them but since the service opened. As this service had only been operating for just over seven months at the time of the inspection, some of the more experienced staff was still reasonably new to the organisation. The control room operators told us they considered staff skills and competency when pairing staff to work together.

New starters underwent probationary periods of six months to ensure they were performing in line with the service requirements.

All vehicles used by the service were under 3.5 tonne at the time of our inspection. This meant they could all be driven on a standard UK driving licence. We checked a sample of staff records and found that driving licence details were checked prior to ambulance care assistants starting in the role. The service used an electronic system which monitored staff driving licences therefore if staff accrued points or convictions relating to their driving, the service would be made aware. Staff were expected to disclose if they received any driving convictions whilst in the role. The service also required ambulance care assistants to undertake a driving assessment as part of the interview process to ensure they have the necessary skills to undertake the role.

# Patient transport services

Managers supported staff to develop through yearly, constructive appraisals of their work. The provider target for appraisal rates was 95%. Staff had received annual appraisals whilst employed by the previous provider. Staff had not yet received their annual appraisals whilst employed by this service as appraisals were undertaken on a yearly basis from the start date of each staff member. Therefore, any staff members recruited since the start of the service were not yet due an appraisal. The service had planned future appraisals for all staff within a year of starting with this service. The service held records which showed when appraisal dates were scheduled to ensure all staff would be compliant by the end of the year.

Control room supervisors supported control room operators to develop through regular, constructive supervision of their work. The supervisors listened to phone call recordings and used a structured feedback form to identify strengths and areas of development. Staff were encouraged to also listen to the same calls and score themselves to develop understanding of expectations when taking a call. Supervisors listened to four calls per month.

We reviewed feedback from January and February 2022 where areas of improvement had been identified. We saw supervisors recorded their discussion with the staff member which was presented as collaborative and supportive process enabling development of skills. Clear action plans and outcomes were created with staff for future development.

Provider wide trainers delivered annual skills development (ASD) days to support staff completion of mandatory training. The trainers included registered paramedics.

Some staff had access to team meetings. Control room supervisors held team meetings and tried to time these to maximise attendance. Supervisors emailed information to inform staff of updates or changes. ACAs did not have team meetings at the time of our inspection.

Managers identified poor staff performance promptly and supported staff to improve. All phone calls taken by the control room operators were recorded. This meant supervisors could listen into calls where any concerns or complaints have been identified.

Where poor performance was identified with ambulance care assistants; the senior ambulance care assistants or supervisors could observe shifts to provide supervision and support.

Managers recruited, trained and supported volunteers to support patients in the service.

## Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had two desks at each of the local NHS acute hospitals. Staff worked at these desks daily to liaise with hospital staff and the service control room to ensure patients being discharged were collected as responsively as possible.

Managers worked with clinical team leaders at the local NHS acute trust to determine who the trust had identified as priorities to be collected when the demand for the service outweighed the available vehicles and crews.

# Patient transport services

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to consent to being transported. However not all staff had a full understanding of the legislation around capacity to consent.**

The Deprivation of Liberty Safeguards are not applicable for this service.

Staff gained consent from patients for their journey in line guidance although did not receive any specific training for this. Staff had access to an up to date policy on consent. Where patients with capacity to consent declined to go on the transport, staff respected this decision although did try to encourage patients to make the journey.

The service transported patients who were voluntarily attending treatment for mental illness. Staff engaged with hospital staff and escorts to ensure the patients' rights were upheld.

Staff received training in the Mental Capacity Act however, staff we asked during the inspection were not familiar with this legislation.

Staff gained consent from escorts or carers if they deemed a patient to not have capacity. We acknowledged that patients with more severe dementia who were less likely to have capacity were usually supported by carers on the journey therefore asking registered carers in the best interests of the patient was appropriate.

Not all staff understood the legislation regarding how and when to assess whether a patient had the capacity to make decisions about their care. Staff were not always sure of how to gain consent for patients who may lack capacity or patients under 18 years.

Staff told us they would gain consent from parents for under 18s to be transported. However, some young people (for example competent 13-17 year olds) could decide if they wanted to attend their health care appointments for themselves. Staff did not receive training on consent in relation to children and young people.

## Are Patient transport services caring?

Inspected but not rated 

Unable to rate due to not observing patient care.

## Compassionate care

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

Based upon written patient feedback, staff were discreet and responsive when caring for patients. Staff described how they worked with patients who had additional needs such as dementia or learning disabilities. Staff told us they would speak to patients in a calm and caring manner to ensure the journey went as well as possible.

Within written feedback, patients said staff treated them well and with kindness.

# Patient transport services

Staff followed policy to keep patient care and treatment confidential. Staff accessed patient records electronically therefore maintaining other patients' confidentially.

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff showed understanding of equality and diversity and how this applied to working with patients.

## Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw an example of relative feedback following the death of a patient. The relative praised staff for good empathy, communication skills and enabling dignity in distressing and challenging circumstances.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. A large aspect of the service was transporting patients to and from dialysis several times per week. Staff were able to build supportive professional relationships with regular patients and understood how having long-term health conditions impacted upon a person's life.

## Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand. We observed a call where a control room operator took a booking. The operator introduced themselves by name and spoke politely throughout. They reconfirmed all details with the patient to ensure a full understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Managers actively sought feedback from patients.

Patients gave positive feedback about the service. Data from the service showed 356 patients provided feedback as part of a survey held from October 2021 to April 2022. The survey showed 324 (91%) patients were very likely to recommend the service to their friends or family, and 17 (5%) were likely to recommend the service. Three hundred and forty-seven patients (97%) reported they were treated with dignity and respect.

## Are Patient transport services responsive?

# Patient transport services

We rated it as good.

## Service delivery to meet the needs of local people

**The service planned and provided transport in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the changing needs of the local population. At the time of our inspection the service had been running for just over seven months. E-zec Medical Shropshire started in October 2021 following a successful bid for a contract from the local clinical commissioning group (CCG). The service was planned according to the requirements set out in the contract designed by the CCG. Eligibility criteria included being registered with a GP in Shropshire, although on occasion the service went outside this by exception to support patient needs.

Senior leadership of the service had future plans to expand the service if supported by the CCG into specific areas to support the needs of the local population.

Facilities and premises were appropriate for the services being delivered. The base was spacious, modern and had an adequately sized vehicle garage. Staff had space to clean vehicles, store equipment and consumables and to take breaks. There was space for training rooms, hot-desk work and staff facilities such as lockers. Patients did not visit the base.

The service had equipment to suit the needs of different types of patients including paediatric and bariatric patients.

Managers ensured that patients who did not attend appointments for transport were contacted. Staff would first try to contact the patient, or next of kin. If they could still not contact the patient and were concerned for their safety; staff escalated this so that managers could ensure welfare checks took place.

## Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Control room operatives requested that patients with additional needs, including children, be accompanied by an escort to ensure the patient was supported throughout the journey.

The service did not provide additional communication tools to support patients who did not communicate verbally or who had cognitive impairment. The service did not provide an interpreting service or use communication cards for patients with a disability or sensory loss who could not communicate verbally. However, the control room operators recorded information about any communication needs for patients so that staff are aware of this and could liaise with family or carers as appropriate.

A staff member gave an example of supporting a visually impaired patient to their appointment where they guided the patient to ensure they were safe.

# Patient transport services

The service ensured space was available for assistance dogs if required.

The service did not use foreign language interpreters due to the nature of the patient journeys undertaken. As above they liaised with families or carers to support patients who did not speak English. Where they were taking a patient to an NHS hospital, it was expected that the NHS hospital would provide an interpreter for that patient on arrival.

Patients could request gender specific crews for cultural reasons if required, although at the time of our inspection this had not been requested.

## Access and flow

**People could not always access the service when they needed it and sometimes experienced delays. Managers continually reviewed access and flow to improve this for patients.**

At the time of our inspection, 97% of the patient journeys undertaken were on the day discharges rather than pre-booked appointments. This was due, in part, to pressures within the local system with regards to patient flow through hospitals. Senior leadership attended silver command meetings daily with the CCG and the local acute NHS trust to maximise patient flow.

Managers told us that the control room operators scheduled patients in advance where possible, for example patients who were attending a prearranged outpatient appointment. However often, due to the demands of the NHS trust, the clinical lead at the trust prioritised patients needing to be discharged over pre-booked outpatient journeys. The reason for this was to ease the flow of patients moving through acute NHS hospitals. However, this meant some patients experienced additional delays before being collected before or after an outpatient appointment. The service discussed this regularly with the CCG and the trust.

The service aimed to collect patients identified at the end of life within one hour of the booking to support the patients to get to their destination as quickly as possible.

The service monitored the number of aborted journeys. We saw that reasons for staff aborting a journey included patients not being ready to travel at the time of collection and the wrong mobility being booked. The crews did wait for 15 minutes where possible for delayed patients, and longer in exceptional circumstances, before aborting. Data around aborted journeys was collected and reported to the CCG. We saw the service aborted relatively few numbers of journeys compared to the overall number. For example, in April 2022, 351 journeys were aborted. Of these five were aborted by E-zec staff. Patients aborted 206 and professionals aborted 136 of the overall figure. The remaining four were aborted due to reasons relating to Covid-19.

## Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. If a patient, family member or professional rang to complain, the control room supervisors supported staff to take the call.

## Patient transport services

The service did not display information about how to raise a concern in patient areas. The service had complaint leaflets which staff could provide if a patient wished to complain however we saw there were not any of these in the vehicles at the time of our inspection. Staff had access to an electronic QR code that patients could scan if they chose to leave feedback on a mobile phone or tablet.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes, and patients received feedback from managers after the investigation into their complaint. Complaints were collated on an electronic system. Managers reviewed each complaint and investigated as necessary. The service complaints policy specified that managers should respond to patient complaints within 25 working days. We saw examples of complaints which had been investigated and where a response had been provided.

Responses we saw included an apology and an explanation of the situation.

Staff knew how to acknowledge complaints. People that contacted the service by phone to complain spoke with control room operatives who were familiar with addressing concerns.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with told us they did not always get feedback or learning following a complaint. However, managers sent out updates and learning following complaints via emails and bulletins.

### Are Patient transport services well-led?

We rated it as good.

#### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The service had a clear leadership structure in place. The regional manager for the service worked alongside the registered manager to oversee the service. The regional manager was in the process of applying to take over the registered manager responsibilities at the time of inspection. They were supported by an operational manager, quality, health and safety manager and a compliance manager. Supervisors included the fleet supervisor, operations supervisor and control room supervisors; these oversaw the day to day running of the service and worked directly with staff.

Due to the service being newly opened, some management positions had either been recently recruited to such as the HR manager role or were actively being recruited to such as a deputy operations manager role. We saw succession planning was in place to ensure leadership recruitment was successful.

All local leaders we spoke with presented as competent and able to run the service. All were able to describe the service priorities and any risks or concerns.

# Patient transport services

Leaders and staff told us that the managers had an open-door policy. On the day of our inspection we saw that leaders were visible and accessible to staff. Local leaders made efforts to introduce themselves to new staff starting during the training programme.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.**

The provider had recently introduced a new vision and strategy across all their sites. Not all staff we spoke with were familiar with this although we saw it was displayed clearly in staff areas.

The vision was 'to be the leading provider of patient transport by embracing change and innovation through a culture of continuous improvement'. The values included:

- Compassionate Care – we deliver care with empathy, kindness, respect and dignity
- Achieving Excellence – we strive to achieve excellence in everything we do
- Collaborative teamwork – we work as one team to deliver success.

## Culture

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

Not all staff felt valued by the service. The senior leadership team were aware that staff who had been TUPEd were not all happy with this change. TUPE stands for 'Transfer of Undertakings (Protection of Employment)'. A TUPE transfer happens when a service is transferred to a new provider, for example when another company takes over the contract for patient transport services. Concerns raised by staff included working from a new site which meant for some staff they had a longer travel time and higher travel costs to attend work. Senior leadership had attempted to retain the site used by the previous contract holders; however, this had not been possible at the time. Managers told us about planned listening events to gather staff views.

Some staff told us they did not get adequate breaks throughout their shifts. We saw in the control room that staff could have breaks scheduled into their working day and some staff chose to build their own breaks in between patient journeys. We requested data from the service which showed that staff should receive breaks in line with the EU Working Time Directive; the length of the break varied depending on the staff member's contract.

Other staff told us they felt valued by the service, were able to go to managers if they had concerns and felt that changes were well managed.

Staff told us they worked as part of a team to support each other such as in the event of a vehicle breakdown.

The service worked with staff who had health conditions to support them to continue working. There were opportunities for staff to progress for example from an ambulance care assistant (ACA) to a senior ACA.

# Patient transport services

Patients and those who were around them were able to complain to the service. We saw feedback was reviewed openly and learning shared as necessary.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.**

Leaders operated effective governance processes. We saw there were clear lines of governance to enable effective monitoring of performance and quality. An operations manager, quality and health and safety manager and a compliance manager oversaw incidents and complaints.

As the service at Shropshire had only recently commenced, supervisors and managers told us of a fast-paced approach which enabled the service to be up and running quickly. Supervisors and managers were aware of their roles and accountabilities. They understood the service requirements and worked to provider wide standards.

The provider had a robust recruitment process to ensure ambulance care assistants and other operational staff were suitable for the roles they were to undertake. We checked a sample of six staff records and found that the service ensured proof of identity, a disclosure and barring service check and driving licence checks were completed prior to starting. The service also required ambulance care assistants to undertake a driving assessment as part of the interview process to ensure they have the necessary skills to undertake the role.

Not all staff had the opportunity to attend team meetings; in particular the ambulance care assistants. However, listening events were planned to gather the views of staff since the contract had started.

## Management of risk, issues and performance

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

Leaders met with the Clinical Commissioning Group (CCG) monthly to review performance. We saw meeting minutes for February to May 2022. Agenda items included performance against key performance indicators (KPIs), complaints, incidents, liaison with CQC and other ongoing issues or concerns. The minutes reflected feedback provided to the service from the CCG.

The service worked with partner organisations to support the local system and improve patient experience. Leaders attended daily system silver command meetings. A renal manager worked with dialysis units and the service had placed two desks in each of the local two acute hospitals. Operational staff worked from these to create a more effective working relationship between the service and the trust.

In addition to monitoring performance as set by the CCG, the provider had internal quality performance indicators which enabled locations to be benchmarked. The internal KPIs reflected the CQC domains (safe, effective, caring, responsive and well led) and included targets such as 98% staff to be compliant with mandatory training, less than 8% of vehicles to be off road at one time and over 5% of patients to be encouraged to complete the patient survey.

The service had a regional risk register and also fed into a provider wide risk register. Identified risks matched those discussed during the inspection such as an older fleet. Risks were regularly reviewed at provider level.

# Patient transport services

The service used an electronic system to report, investigate and monitor incidents, complaints, and safeguarding referrals. We reviewed this system and found it enabled supervisors and managers to undertake appropriate investigations where necessary. We reviewed a number of entries on this system and found that each had been well reviewed and escalated if required.

There were audit systems in place, and we saw examples of these being effectively carried out and the results acted on.

To support the business the service used a third-party independent ambulance provider and a local taxi service. Managers told us about the due diligence checks completed on both organisations prior to using these. As staffing for this service was getting better the third-party providers were being used less.

The service had business continuity policies in place to cope with unexpected events.

## Information Management

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

The service collected reliable data using the electronic system as described above. This allowed managers to review performance, risk and quality and to produce clear reports for the Clinical Commissioning Group (CCG) and provider.

Information such as patient details was kept securely on electronic systems. All operational staff could access the information they needed to do undertake their jobs.

At the time of our inspection, the service had submitted three statutory notifications to CQC, and the registered manager understood their responsibility with regards to this. Managers discussed the notifications with the CCG monthly.

## Engagement

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

Whilst managers tried to show themselves as visible and having an open-door policy, there was no active local engagement such as team meetings with ambulance care assistants. Plans were in place to progress with staff engagement for example calls had been organised with different grades of staff to speak with managers about any concerns or queries they had.

At the time of our inspection most updates were related to provider level information such as the new vision and strategy. The senior leadership team discussed this at the time of inspection and stated this was due to the service being newly opened.

Leaders told us that they had implemented uniform changes following feedback from staff.

## Patient transport services

A provider wide staff survey had been conducted in April 2022; with headline results demonstrating how staff across the provider felt about working for the organisation. At the time of the inspection, the results were not at location level. We saw the provider level results were mixed for example 78% of staff felt confident in successfully undertaking their role. However, 29% of staff felt valued for the work they did.

Managers at the service were actively working with other stakeholders and local organisations to improve the service of patients. For example, managers had been working with the physiotherapy department at a local NHS trust, had a renal manager who worked with the local dialysis units, and were part of the silver command daily meetings which incorporated the CCG and the local trust.

The service made effort to engage with patients to get feedback. Staff called patients after they had used to service to ask the patients to give feedback. Managers used the information to produce reports to encourage learning and to report to the CCG.

### **Learning, continuous improvement and innovation**

#### **Managers were committed to continually learning and improving services.**

The service had future plans to develop patient transport into wider areas to support the needs of the local population.

The service had recently started using an environmentally friendly cleaning product which did not need to be risk assessed as it was not hazardous to health but was reported to have the same cleaning efficacy as other products used. This was part of a move to make the service more environmentally friendly.

The provider had devised a QR code which patients could scan with their mobile phone as an alternative way to give feedback.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Transport services, triage and medical advice provided remotely

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

We found three vehicles to be dirty in the patient area. For example, dirty flooring. We also found some of the fixtures and fittings in the vehicles to be damaged such as a tear in the material of a patient trolley.