E-Zec Medical Transport Services Ltd

E-zec Medical - Norfolk

Quality Report

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Date of inspection visit: 29 January 2020
Date of publication: 06/04/2020

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

Ratings

Overall rating for this ambulance location	Good
Patient transport services (PTS)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

E-zec Medical- Norfolk is operated by E-zec Medical Transport Service Ltd. The service provides patient transport services to patients living in Norfolk and Waveney. The service has 25 ambulances which includes one high dependency vehicle which was used for preplanned transfers of patients deemed medically fit for transfers between two hospital locations. The service is operational seven days per week and largely provides transport for patients travelling to and from hospitals from their home address.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 29 January 2020.

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.

This was the services first inspection. We rated it as **Good** overall.

We found the following areas of good practice:

- The service provided mandatory training in key skills, including safeguarding, to all substantive staff and made sure everyone completed it. Infection control risks were manged well, and there was a cleaning schedule for all vehicles. Equipment and premises were suitable for needs. Patients risks were identified and service adjustments made to meet any needs this included the transportation of patients with limited mobility and children and young people. Staff kept accurate records of treatments. There was adequate staffing to meet demands on the service. Incidents were investigated and any learning shared across the wider team.
- The service provided care and treatment based on national guidance and evidence-based practice. Patient outcomes and performance was monitored and reviewed against service targets. Patients were supported to make decisions and staff were aware of patients who may require additional support. Substantive staffs competence was assured by regular assessments and appraisals although managers had limited oversight of bank paramedics. Staff worked collaboratively and operated a seven-day service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff gave emotional support to patients and their families.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with the wider system and local organisations to plan care. Individuals needs were met. Patients were able to feedback complaints or comments about the service and action was taken in response to concerns raised. The service shared learning across the organisation.
- Strong local leadership was visible and approachable. The corporate team were responsive to concerns raised and supported staff locally. The wider E-zec vision was reflected in local plans and staff were aware of their roles and responsibilities in ensuring the vision was achievable. Staff were supported and felt valued and performance and quality was monitored. Risks were clear and actions taken to address risks were clearly recorded.

However:

- The service did not routinely record the reasons for or actions taken when cleaning was not completed.
- Staff did not routinely record when faulty equipment was replaced or mended.
- Hazardous substance storage was not always clearly labelled.

Summary of findings

- The service used systems and processes to prescribe, administer, record and store medicines. However, these were not robust or in line with local policy.
- The local manager did not have oversight of bank paramedics training and competence documents.
- Risk registers were not always dated when they were reviewed.
- Meeting minutes were not always detailed.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals, 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)	Good 	E-zec Medical- Norfolk is a patient transport service which operates from Gorleston, Norfolk. There are 25 ambulances operating within the service, providing transport services from 5.45am to midnight, seven days per week. We rated Safe, Effective, Caring, Responsive and Well led as good.

Good

E-zec Medical - Norfolk

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Detailed findings

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Background to E-zec Medical - Norfolk

E-zec Medical- Norfolk is operated by E-zec Medical Transport Services Ltd. The service opened in 2017. It is an independent ambulance service in Gorleston, Norfolk and is commissioned to provide patient transport services for the communities of Norfolk and Wavney.

E-zec Medical Transport Services Ltd, is a national ambulance service which provides private and NHS patient transportation across 20 operational locations.

E-zec Medical- Norfolk has 25 ambulances and provides pre-planned patient transfers, largely between hospitals and patients homes. The service completes some out of area work when requested.

The service has had a registered manager in post since September 2019.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in ambulance services. The inspection team was overseen by Mark Health, Head of Hospital Inspection.

Facts and data about E-zec Medical - Norfolk

E-zec Medical- Norfolk opened in 2017 and this was our first inspection of the service. The service provided transport services for patients (including children).

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the main offices based in Gorleston. We spoke with ten staff including; patient transport drivers and management.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has not been inspected since registration with CQC.

Activity (April 2019 to December 2019)

- There were 41,330 patient transport journeys undertaken.

46 members of staff worked at the service, which included patient transport drivers, paramedics, administrative staff, managers and temporary staff.

Track record on safety

- No Never events

Detailed findings

- 37 incidents with no harm
- No serious injuries
- Seven complaints

Our ratings for this service

Our ratings for this service are:

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

Patient transport services (PTS)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

E-zec Medical- Norfolk is operated by E-zec Medical Transport Services Ltd. The service opened in 2017. It is an independent ambulance service in Gorleston, Norfolk and is commissioned to provide patient transport services for the communities of Norfolk and Waveney.

E-zec Medical Transport Services Ltd, is a national ambulance service which provides private and NHS patient transportation across 20 operational locations. They provide the local team with corporate support to ensure standardisation across all E-zec locations.

E-zec Medical- Norfolk has 25 ambulances and provides pre-planned patient transfers, largely between hospitals and patients homes. The service completes some out of area work when requested. The service is also commissioned to complete patient transfers for high dependency patients awaiting cardiac investigations or procedures. These are stable inpatients who require attendance at an alternative acute hospital for the procedure.

The service employs 48 whole time equivalent staff and provides 1878 hours of transfers per month. The service is operational seven days per week from 5.45am to midnight.

Summary of findings

E-zec Medical- Norfolk is a patient transport service which operates from Gorleston, Norfolk. There are 25 ambulances operating within the service, providing transport services from 5.45am to midnight, seven days per week.

We rated Safe, Effective, Caring, Responsive and Well led as good.

Patient transport services (PTS)

Are patient transport services safe?

Good

We rated safe as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff received training in safety systems, processes and practices. Staff were aware of their responsibilities in ensuring that they had completed mandatory training. Data showed that 100% of staff were compliant in mandatory training topics. This included clinical and non-clinical skills such as basic life support, manual handling and health and safety. There was a target for 95% compliance set by E-zec.
- Mandatory training arrangements and policies were in place for all staff. All staff were required to complete a two-week induction which contained all mandatory training. There was standardised training across all E-zec services which was provided by the E-zec training team. Once a staff member had been inducted, mandatory training was repeated annually.
- Training could be completed either in person, or through an online account depending on the topic. The E-zec training team completed most of the annual update training, although there were also local trainers to support staff in practice and complete some refresher training. Training was usually completed locally, however, staff could also access training being provided at other E-zec sites if necessary. Staff told us that training was easily accessible and that time was given to complete it.
- Training compliance was tracked by the training team and reviewed regularly by the manager. The training team flagged staff who's training would expire within the next three months to the manager and they would ensure staff were allocated onto the next available training dates.
- Training varied according to the staff roles and responsibilities. For example, clinical staff or those working with patients were required to complete additional training in safeguarding, manual handling and resuscitation, whereas those who worked in administrative roles received training in these areas, but to a different level. For example, manual handling training for administrative staff included inanimate objects and not people.
- The manager targeted training when possible to meet the demands of the service, for example, if there were incidents related to manual handling refresher courses in manual handling were provided.
- Bank staff working within E-zec were required to provide their training information to the training team prior to commencing their roles. Training information was recorded on the same system as substantive staff. We saw that paramedic bank staff records contained details of all training completed, professional registrations and driving licence checks. Locally, the manager was unable to identify what level of training the staff member had completed, as the database detailed topic of training and confirmed whether the training was in date.

Safeguarding

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

- Staff were aware of their roles and responsibilities in the reporting of any safeguarding concerns, internally and externally to the organisation. There were safe and effective systems, processes and practices in place and these were communicated to staff through regular training and updates.
- Staff received training in safety systems, processes and safeguarding practices. All staff completed safeguarding children and adults training level 2. The E-zec safeguarding leads were trained to level 4 safeguarding adults and children which enabled staff to escalate concerns to appropriately trained staff. Paramedics were trained to level 3 safeguarding children by their host organisation. This was tracked through the training team. Data showed that 100% staff had completed safeguarding supervision and training.
- Safeguarding arrangements and policies were in place for both children and adults, including assessing needs and providing early help. These reflected legislation and local requirements. Staff understood their

responsibilities and adhered to safeguarding policies and procedures, including working in partnership with other agencies. Any safeguarding concerns were escalated internally and then discussed with the local authority.

- There was an effective system in place for staff to report safeguarding incidents. The safeguarding contact details were available to all staff and were printed on key fobs to every vehicle, enabling staff to access support at any time.Incidents were also recorded on paper forms which were taken to the base office and actioned by the manager.
- Staff knew when to make a referral to the local safeguarding team and were able to describe what they would consider to be a safeguarding concern. Staff used patient referrals to highlight concerns about patient safety and we were given examples of where patients had identified patients at risk of abuse or neglect which had been referred to the local authority. The manager ensured that all patients identified at risk were tracked and any risks identified to ensure awareness for staff attending patients in their homes.
- Ambulance crews knew how to manage a situation at the locations they attended, including patients' homes or care homes. We were given examples of vulnerable patients and actions taken by staff to ensure safety. For example, patients being discharged from hospital with no support at home. Staff completed checks for the patients and ensured that they were settled and safe before leaving them.
- Voluntary staff were largely responsible for the transportation of children, although all staff received appropriate training in managing children. Children were not transported alone, and the service always ensured that a responsible adult/ family member accompanied the child for the transfer.
- The E-zec policy provided guidance on recognising people at risk of all types of abuse, including modern slavery and forced marriage. There was additional information in place to safeguard those in vulnerable circumstances, such as those with learning difficulties or complex needs. The safeguarding policy provided staff with guidance on protecting people from discrimination. This included harassment and discrimination in relation to protected characteristics under the Equality Act 2010.
- There were effective procedures in place to update staff when changes occurred to procedures. Staff were informed of any changes through team meetings, with minutes from the meeting being shared via email and in hard copy in communal areas. Staff also received bulletin information or alerts through closed social media accounts.
- Information about safeguarding was shared with others in a timely way. Staff ensured that any concerns were raised at the time of the incident/ concern. These were escalated to the local authority.
- There were processes in place to ensure the safe recruitment of staff. All staff were expected to complete advanced Disclosure and Barring Service checks prior to commencement in post and these were repeated every three years. Completion was recorded within the training database.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean. However, the service did not routinely record the reasons for or actions taken when cleaning was not completed.

- There was a process for the cleaning and maintenance of vehicles and premises. Cleaning was completed at the start and end of each working shift and between patients to prevent and protect people from a healthcare-associated infection. There was a cleaning checklist which was used by staff, to confirm compliance with cleaning. The local manager and fleet manager checked this.
- Staff used appropriate detergent wipes to clean vehicles during a shift. Ambulance drivers told us that if vehicles became heavily soiled, they would be removed from service and a deep clean completed. The service had access to a spare vehicle in the event of heavy soiling. Deep cleaning was planned to be completed every 28 days in line with policy. However, we reviewed the records for six vehicles and these showed that over the

last six months, cleaning had not been completed every 28 days. We saw that gaps between cleaning was up to 10 weeks. On discussion with the service, we were told that the person responsible for the cleaning had been promoted and a replacement staff member had been in post for two weeks at the time of inspection. This had meant that there had been a gap in the provision. To address this the service had sought assistance from an external provider who assist with deep cleaning, and therefore the frequency of cleaning had returned to plan. Despite the gaps in deep cleaning, we saw that vehicles were visibly clean.

- There was a process for checking compliance with deep cleaning completed by the external provider. We saw a report which detailed the cleans planned and completed, although it did not record reasons for none compliance or actions taken to address any deficit.
- Staff asked for details of any infections when bookings were made, which enabled staff to be aware of any specific infection and hygiene risks associated with individual patients. There was clear guidance for staff on managing the risks of infection in vehicles and how effective cleaning would reduce risks. This included details of cleaning procedure and personal protective equipment and handwashing.
- When patients were collected from other health providers, staff were informed of any communicable infections, which enabled them to clean vehicles after usage, and ensure singles patient transfers. However, if staff were not made aware of any infections prior to completing the journey, they could not make any necessary changes.
- Staff had access to an infection control and prevention lead, who could advise on actions to take if they were concerned about any specific patient conditions.
- We saw that personal protective equipment, such as gloves and aprons were available on all vehicles. Staff also had access to sanitising hand gels. Handwashing facilities were available at the offices and most pick up and drop off locations. We saw staff using hand sanitiser regularly.
- Staff used clinical waste bags to discard any soiled waste, at arrival at their destination. Clinical waste was managed correctly, using appropriate colour coded bags.
- Staff were responsible for maintaining their own uniforms, guidance was provided to ensure that they were cleaned at the correct temperatures and on their own to ensure non-uniforms were contaminated during washing.
- There was a robust process in place for the cleaning of equipment. Staff ensured that all equipment was cleaned after use.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, staff did not routinely record when faulty equipment was replaced or mended.

- The service was located in an industrial estate and included a large garage area and offices. These were found to be safe and secure, suitable for needs and well maintained. There was also an ambulance transport office used by the service at the local acute hospital. This was found to be easily accessible and was always secure.
- The service had 25 ambulances across the area. These varied according to roles, for example, there was one high dependency vehicle used for preplanned journeys, and multiple patient transport ambulances. These were largely based at Gorleston; however, the service had a small substation at Beccles, which enabled staff to access vehicles across the county. In addition to ambulances, the service coordinated volunteer drivers who used their own cars to transport fit and mobile patients to appointments.
- All vehicles in use by the service were around two years old. We were told that the replacement of vehicles was managed by the corporate team and scheduled for every five years. All equipment was standardised across the service which ensured that staff were familiar with equipment on different vehicles.
- All vehicles had annual servicing and there was a robust process for maintaining vehicles. The fleet manager maintained a file for each vehicle which contained details of insurance, MOT and servicing. Due to each ambulance being allocated to a specific schedule, any works could be completed when the vehicle was not in use. For example, if a vehicle was usually used between

12pm to 10pm, any maintenance was scheduled to be completed before 12md.The fleet manager also ensured that if a fault was reported on a vehicle, when it was brought into the garage for repair, staff would also complete all other servicing to prevent repeated pulling from service. For example, we saw that a wing mirror was reported as damage, and the repair was scheduled for the same time as a deep clean. The service stored some vehicle spare parts on site.

- There was a standardised vehicle defect form which was completed by a crew when they identified any issues with a vehicle. These were handed into the base and picked up by the fleet manager who addressed the issue reported. We saw that all reports were investigated, although not all were dated. Those that were dated, showed that the review of the faulty and repair was completed within 24 to 48 hours of reporting. The person responsible for the works signed the form to confirm action had been taken.
- As the ambulances had set operational times, staff could always access a different vehicle in the event that one ambulance was not available.
- The high dependency ambulance was not fitted with a fixed bin for clinical waste. This was escalated, and immediate action taken to correct this. Following inspection, we were provided with evidence that an external provider had been contacted and a suitable waste bin had been fitted to all vehicles.
- Vehicles could be tracked. In addition to an electronic tracking system the garage had a real time management board which tracked the location of each vehicle, their status and details of the crew.
- Vehicle keys were stored securely. Keys were kept in a key safe within the main office building, and substation building. Key safe codes were changed every three months to enhance security.
- We saw that all oils, antifreeze and vehicle fluids were stored in secure cupboards to prevent unauthorised access, although there was not a COSHH notice identifying that materials were stored in the cupboard. COSHH certificates were held in the main office.
- Crews had access to up to date satellite navigation systems, as per the 2015 Patient Safety Alert. The service updated the navigation system when vehicles were serviced or came to the garage for repairs.
- There were robust processes in place to facilitate the maintenance of equipment. An external provider annually serviced all equipment. We saw servicing details for all equipment. If a piece of equipment became faulty, it was removed from service and maintenance requested.
- Booking staff were made aware of any equipment needs for the patient transfer at the time of booking. We saw that there was a standardised checklist of questions asked that enabled staff to identify any equipment needs. Where possible, the services own equipment was used, however vehicles were also suitable for use by patients who had their own equipment. There were restraints available to secure chairs.
- Equipment available was generally suitable for the specific roles. We saw that the high dependency ambulance (HDA) had additional equipment for monitoring patients. The HDA was used predominantly for transferring a pre-determined group of patients between acute hospitals. For example, the service transported stable patients requiring cardiac (heart) investigations between two hospitals. Staff told us that the level of monitoring of these was determined by the individual paramedic responsible for the transfer. However, we saw that the heart monitor only facilitated that the heart was beating and did not facilitate the recognition of the type of heart beat. Although patients were deemed to be stable, there was a potential for patients' heart rhythms to alter undetected by the crew. We escalated this during inspection, and we were told that the service would identify a standardised level of monitoring for all high dependency vehicle transfers.
- All single use sterile items were found to be within date and staff told us they disposed of items as necessary.
- Emergency equipment was checked daily and calibrated annually as per local policy. We saw evidence that checks had been completed and due to expire in March 2020.
- We saw that there was limited access to suitable vehicle restraints for children. We were told that volunteer car drivers usually transferred children, and these used

either the patient's own equipment or a borrowed car seat. There were limited restraints for children who required an ambulance transfer. We escalated this during inspection and immediate action was taken to obtain suitable equipment.

- The service did not transport patients who were detained under the Mental Health Act 1983 were appropriate and safe. Staff told us that any patient referred who was identified as have being detained under the mental health act were referred to the local NHS ambulance service.
- Ambulances were fitted with fire extinguishers which were checked and found to be in date, with the expiry in March 2020. The main garage had appropriate fire exits, which were kept clear to enable access and egress. Fire exits were illuminated. There was a fire control station within the garage. This area held the fire extinguishers, fire blanket and displayed the evacuation plans.
- There was an appropriate spill kit for the management and cleaning of bodily fluids.

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. However, hazardous substance storage was not always clearly labelled.

- Patients using the service were generally well and being transported between their homes and hospital or vice versa. Comprehensive risk assessments were completed for all patient transfers. Staff used a patient transport risk assessment to capture information necessary for the planned journey. Guidance on completion included prompts for staff, for example, what the journey included, the equipment needed, and the abilities of the patient being transferred.
- Staff or patients arranging a transfer completed a standard questionnaire, relating to the type of transfer required, details of the patient's mobility, along with the details of location of pick up and drop off. We were told that booking staff were able to check information with the referrer, and always escalated to the manager if there were any queries or concerns. Any patient identified as being a high risk, were referred to the acute ambulance service. We were given examples of patients with dementia who required transfers, and staff ensured that it was safe to do so, checking that the patients was aware of the transfer and that there was someone to accept the patient on arrival to the destination.
- E-zec Norfolk were contracted to transfer medically stable patients between locations, usually two acute hospitals. The commissioning contract required a paramedic to complete these transfers and E-zec chose to use a high dependency vehicle staffed by one driver and one paramedic. Cardiac patients were transferred from the nearby acute hospital to another location. These patients were deemed to be medically fit for transfer between two locations. There was no formal E-zec assessment for this process. Hospital staff were required to identify those patients who would be stable and suitable to be transferred by the service. All high dependency vehicle transfers were required to be completed by a paramedic as part of contractual agreements. We were told that if the paramedic was not happy with the transfer following handover of the patient, they could refuse the transfer and request that the acute ambulance service picked up the transfer. We were told that this rarely happed, and patients were generally well.
- If staff identified a change in the patient's condition during transfer, the patient was escalated to the control room for advice and if necessary transported to the local acute hospital. For patients being transported using the high dependency vehicle, if a patient became unwell the transfer was completed as an emergency. All drivers of the high dependency vehicle were trained in blue light driving. Staff were able to seek support from senior staff in these situations through on vehicle radios. We were told that there had been five occasions within the last year when a patient deteriorated en route and required an urgent transfer.
- The service used templated patient transfer forms which enabled staff to record the patient's clinical condition. Recording their blood pressure, pulse rate, and medicines or treatments provided, along with details of the patient and the transfer planned.
- The service had policies and procedures in place to manage disturbed behaviour. Prior to completing a transfer, patients with any risks or behavioural concerns were reviewed to ensure that it was safe and appropriate for the service to transfer them.

- The service had an emergency preparedness policy which gave staff instructions on their roles and responsibilities for in the event of a major incident or adverse weather, signposting them to additional infromaiton and advice.
- The service completed monthly safety checks which included all aspects of the service from building to equipment. We saw that the checklist for December 2019 confirmed that all electrical equipment was in good working order, lighting worked, the area was free from trip hazards, there were adequate washing facilities, fire drills had been completed and areas were clean.
- Any alerts relating to medicines or products were sent directly to the E-zec head office and shared with the wider teams if they were relevant to the local service. E-zec Norfolk did not routinely mange alerts directly.
- The service had a major incident plan and we saw that this had been discussed with the board recently following a review. Information relating to any changes was being shared with the team to ensure adherence to policy. This included adverse weather.

Staffing

The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank, agency and locum staff a full induction.

- Staffing levels were calculated against the contract of work for journeys to be completed. The manager calculated the hours of work required against the service level agreed. For example, we were told that the contract currently required 1878 hours, and staff were employed up to these hours. There were 46 members of staff working within the team, and there were a further three staff members planned to commence in February 2020. Three of the 46 staff members were paramedic staff.
- Staffing levels were monitored on a regular basis and when changes occurred. For example, we were told that the service had been asked to provide additional ambulance cover at weekends, and they were working through the requirements to enable the service to do this.
- We saw that staffing levels generally matched the planned levels. We were told that staff were happy to cover any short notice absence and were flexible in meeting demands of the service. The service used staff with zero hours contracts to fill gaps in provision. Staff used the same bank staff where possible to ensure continuity of care.
- All staff were employed on a probationary period. On commencement in their role, they were allocated a mentor/ supervisor who would help complete probationary meetings and offer advice and support for the roles. We were told that meetings were planned. No new staff member was permitted to work alone and were always teamed up with more experienced staff. Once staff were happy in their roles, they were able to work as a solo ambulance driver, however, the manager always checked that staff were happy to do this prior to commencing the changes.
- Sickness and vacancies were largely covered by staff working additional hours or by regular bank staff. Any additional hours were tracked to ensure that staff had adequate breaks and rest between shifts.
- There were three paramedic staff who worked as bank staff. These staff members all worked for acute ambulance trusts and worked with E-zec on an adhoc basis. All bank staff completed the same induction training as substantive members of staff. Following inspection, we were told that a paramedic had been employed as a permanent member of staff to assist with the management of the high dependency ambulance team.
- The service used volunteer drivers, who were considered part of the team. These were usually individuals who offered one or two days per week, to transport the same patients. For example, one driver would transport the same patient to their dialysis session three times per week. All volunteer drivers were trained and monitored in the same way as substantive staff.

- Out of office hours the service had access to an on-call manager, at the head office. Staff told us that they could also contact the local manager if they had any concerns. E-zec provided a on call support for safeguarding concerns as well as operational concerns.
- Staff were encouraged to take their breaks away from the ambulances. We were told that most staff had breaks at the local hospital between journeys, although some staff returned to the office.

Records

Staff kept records of patients' planned journeys and any care and treatment provided by the high dependency vehicles. Records were clear, up-to-date and stored securely.

- The service records consisted of information necessary to confirm the type of patient transfer required. For example, information included any details of the planned journey, the patients' medical history if necessary and their mobility. All bookings were held electronically which was only accessed by authorised persons. A paper record of transfers was given to voluntary drivers and these were returned to the main office once the planned journeys had been completed. Records were stored securely in the main office.
- Patients records did not include clinical data other than those patients being transferred by the high dependency ambulance. For these transfers a patient transfer sheet was completed which detailed the patient's demographics along with details of any treatments or care provided. We saw that these records were clearly written and managed in a way that keeps people safe. The patient transfer records reviewed were clear and completed with dates and times of any interactions or treatments and with a signature of the crew members responsible for the patients transfer.
- Any patient being moved between teams, for example between acute hospitals, were transferred with all relevant records. These were prepared by the transferring hospital staff and presented to the ambulance crew, usually in sealed envelopes, for handing over at the destination. Staff did not provide information to the destination, other than details of the transfer. For example, the high dependency team would report on the patient's condition during transfer. Staff ensured that patient records were handed over to the correct destination to prevent unauthorised reading of patients notes.
- Staff had access to information that was relevant to enable timely care. For example, patients information was largely provided in advance of a transfer. The details were then shared with the ambulance crew or voluntary driver and kept electronically. Any paper copies of forms were stored in locked cupboards at the main office.
- There was one reported information governance incident, whereby a member of staff had accidentally left a patient record within a hospital. This was appropriately reported as an incident and investigated. In response staff were reminded about the need to ensure records were always held with the patient.
- Crews were notified of any special requirements for the patient by the booking staff. Key information was collected by the booking team and then highlighted to staff responsible for the journey, ensuring that the crew were aware of any special needs. For example, the need for oxygen or walking aids.
- Any patient who had an active do not attempt resuscitation (DNACPR) order in place were highlighted to the teams prior to booking transfers. Staff were familiar with these forms and regularly transferred patients who were on end of life pathways of care. DNACPR status was usually captured by booking staff and highlighted within the crews' hand-held device to ensure awareness.
- The service had a process for the disposing of confidential waste. There was a confidential waste bin within the office areas which was shredded by an external provider.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines. However, these were not robust or in line with local policy.

- There were minimal medicines used by the service. The high dependency crew were the only staff members who accessed medicines, which were provided for the transfer of stable cardiac patients. There did not appear to be a robust process for the management of

medicines. There were no patient group directives, which are standard operating procedures for the administration of specific medicines to a pre-determined type of patient.

- Medicines were stored securely, in a locked cupboard, within a locked store room. Locks were changed every three months. The store room was in the garage area, and not temperature controlled. The service had just commenced the recording of ambient temperatures and we saw that the temperature was around 10 degrees Celsius. Medicines storage was escalated as a concern during the inspection and action was taken to address this.
- The keys to the medicine's cupboard were secured in a key safe. This was in line with the policy; however, the policy stated that each key should be kept separate. This was escalated during the inspection and we were told that medicines management was under review.
- The main medicines cupboard contained a small number of intravenous fluids, such as normal saline, which were not temperature sensitive; however, we were concerned that the garage would increase significantly in temperature in the summer and expressed that this may not be in line with the safe storage temperatures of all products. The service informed us that this was currently under review and the upper limit was suspected to be 28 to 30 degrees Celsius.
- There was a secure cupboard, within the larger cupboard which held the emergency drugs when not on the high dependency vehicle. Emergency drugs are those used to treat patients in the event of a cardiac or respiratory arrest and were only permitted to be carried or administered by the paramedics. We saw that all drugs were in date. In addition to emergency drugs, there was some medicines such as oral paracetamol and metoclopramide (anti sickness medicine).
- Stock levels were audited weekly, and replacements ordered from the E-zec base in Staffordshire. There was no standardised stock level. They would arrange for replacement medicines to be provided by their pharmacist and then transported to E-zec Norfolk by a member of staff. We were told that this process resulted in a delay in receipt of medicines, however, we were told that medicines were not usually used, with the last recorded a usage being oral paracetamol in August 2019.
- Medicines used were recorded on patient transfer record sheets. We were told that staff recorded the medicine, dose, route, time and if necessary, the expiry and id number. Paramedic staff administered medicines based on their clinical judgment and in line with their training external to E-zec. This was raised as a concern during inspection, and in response the service implemented a process for standardising practice. We were told that a paramedic lead was employed to ensure that processes were standardised across the service in line with best practice and national guidance.
- We raised medicines management as a concern during our inspection and were told that staff had raised concerns regarding the management of medicines with the E-zec corporate team and a meeting had been completed in January 2020. The managing director, clinical lead and operations director had agreed to take immediate action in addressing the concerns flagged by the team and they were in the process of reviewing the policy and the provision of medicines. We saw a draft version of the amended medicines management policy and emails from E-zec to the local commissioning group discussing the need for support locally. There was a detailed action plan in place which detailed all the steps to be taken in resolving concerns before the end of February 2020. Following our inspection, we were told that the local CCG had agreed to support the team with medicines management and a local pharmacist had been arranged to support the team. The substantive paramedic was to be the person responsible locally for the management of medicines.
- Medical gases were stored securely (including Entonox, medical nitrous oxide and oxygen used for pain control). Gases were clearly labelled, and empty and full cylinders were stored separately. There was a sign in and sign out process for cylinder replacement, so each cylinder could be tracked to a vehicle. Gas collection and delivery was organised by the fleet manager. There was clear signage on the high dependency vehicle detailing the presence of medical gases.

Patient transport services (PTS)

- All ambulances had a medicine safe which could be used to store medicines whilst in transit; however, we were told that these were not used regularly.
- The service did not provide patients with advice on medicines, and only administered medicines to patients being transported by the high dependency vehicle if they became unwell. Any medicines administered in transit were recorded on the patient transfer record and highlighted to staff at the destination.
- The service did not have any controlled medicine, or those that require additional monitoring due to the risks of misuse.
- Patients were responsible for their own medicines when being discharged from hospital. Staff did not take handover of medicines from hospital staff when they collected patients.

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, the wider service and partner organisations. 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 understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. Staff we spoke with were able to describe situations that had been escalated as a concern or incident and describe the process of reporting internally.
- Incident reporting was completed using a standardised incident form available on the 'Hub', which was the staff internet. The forms could be completed online or printed, and hand written if preferred. The manager completed an investigation and if necessary a root cause analysis to identify any areas for learning. An incident log was completed weekly and details escalated to the board for review. We were told that staff did not receive training on completing incident forms.
- The number of incidents and details of actions taken to address them were reported to the regional managers and the board as part of performance reports. In 2019, staff reported 37 incidents. The themes for incidents included, injury to patient or staff (14), deterioration in patient's condition (including finding patients in difficulty on collection) (eight), verbal abuse to staff (five), poor discharge planning by acute hospitals (including, no access to home address, no person to meet on arrival and lack of information about patient's needs) (five), plus five others such as vehicle damage, and road traffic accident. All incidents were investigated by the manager and action taken to resolve issues flagged. For example, we saw that when staff had been repeatedly verbally abused by a patient, the manager spoke with the patient to confirm boundaries and explained that their behaviour was not acceptable.
- Staff told us that they did not always receive feedback about minor incidents reported, however did receive feedback about more serious incidents and those where learning had been identified. For example, staff reported that following an incident with the securing of a wheelchair, practice had changed. There were posters displayed detailing the learning within the communal area. Staff used the services social media sites to share learning as well as poster displays and verbal feedback.
- Patient safety was tracked by the review of incidents and complaints by the local manager and the corporate team. This process enabled staff to identify any themes or repeated issues that needed addressing to prevent reoccurrence. We were told that staff triangulated complaints, incidents and patient feedback to see if there were any common areas of concern.
- Incidents were reviewed by the local manager and the corporate team, and investigation outcomes were shared across the wider team at peer support meetings. We saw that staff were made aware of incidents at other E-zec sites and lessons learnt were displayed in communal areas.
- There was a robust process for the investigation of serious incidents and this included the sharing of information across the organisation. The service completed a root cause analysis of any serious incident and ensured that they completed an action plan addressing key concerns to prevent reoccurrence. Lessons learnt forms and posters were used across the organisation and we saw this in action on inspection.

Patient transport services (PTS)

- There were robust processes in place for the management of a major incident or working in adverse weather conditions. Policies clearly detailed actions to be taken and escalation processes. There was a serious incident policy, which outlined processes to be followed and grading of incidents.
- The service had key performance indicators which included the insurance of safe patient transfers. The service was clear of the need to report incidents to the local clinical commissioning group (CCG) as part of their monthly performance data. This was reviewed by the service, the corporate team and the CCG monthly to ensure compliance with the contract and patient safety. Data provide showed that the service was consistently meeting their targets.
- The service reported incidents to the CCG and met with them to discuss any concerns across the organisation particularly about any concerns with the system. For example, any issues with the local acute trust were escalated to the CCG for discussions with the trust.
- Any safety alerts were managed by the corporate team and the local teams informed of them if they were relevant to the service. We were told that the local team had not had to respond to any safety alerts in the last few months.
- We saw that where necessary patients or their relatives had been involved with the investigation of incidents, this included apologies where necessary and duty of candour. Staff were aware of duty of candour and how and when to apply it.

Are patient transport services effective?

Good

We rated it as **good.**

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.

- Policies and procedures were provided by E-zec Medical Services Ltd. These were standardised across all operational areas and reflected national guidance. The service ensured that transport was provided in line with national and local guidelines by reviewing activity and performance regularly. Any changes to guidance was flagged and the service adopted the new practice following the sharing of information across the team.
- Paramedic staff had access to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance, which provides clinical speciality advice to ambulance staff in the UK. The guidance is regularly updated, and staff could receive alerts for any changes.
- The service was not responsible for providing any direct care for most of the patients using the service. However, staff ensured that there were processes in place to prevent discrimination, including on the grounds of protected characteristics under the Equality Act 2010. Patients were treated equally, and any poor behaviour was addressed by the manager.
- The service did not transport patients who were subject to the Mental Health Act 1983. The booking team screened patient's eligibility for the service ensuring that they were suitable for the type of ambulance/ vehicle and staff available. Any patient with a known mental health illness was identified at the booking phase and were referred to the acute ambulance service for transportation.
- There was clear guidance for the transportation of children of all ages, and staff adhered to this. A responsible adult always accompanied children.
- Staff could access guidance and policies remotely and staff reported that the "hub" was easily accessible.

Nutrition and hydration

Staff provided drinking water for longer journeys and on the high dependency ambulance.

- For patients who were completing longer journeys, an assessment was completed to identify if it was safe and appropriate to stop for breaks. Staff reported that longer distance journeys were not frequent and that they were usually planned to enable the team to identify any needs for nutrition and hydration.
- Patients were able to provide their own refreshments if they wished.

Pain relief

Staff routinely assessed and monitored patients pain levels and regularly gave pain relief in a timely way.

- The service did not routinely assess patient pain unless the patient was being transferred using the high dependency vehicle. Paramedic staff would review patients' pain and could administer pain control, if necessary. We saw patient transfer sheets recorded pain levels and any medicines administered were clearly recorded.
- Paramedic staff were able to administer Entonox (medical nitrous oxide and oxygen) as pain control and its use was clearly recorded on the patient transfer records.
- Non-paramedic staff would inform any staff at the drop off point if a patient complained of pain during transfers. Staff told us they tried to ensure patients comfort throughout journeys. We were given examples of when wheelchairs were swapped for stretchers to ensure patients comfort.

Response times and Patient outcomes

The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements. **The service routinely collected information about patient outcomes**.

- The service routinely monitored their performance and response times. There was an agreement that patients referred on the day for discharge from hospital were collected and transferred within one hour of the referral. Staff confirmed that this was nearly always achieved.
- The service routinely monitored compliance and used this to inform contractual meetings with the clinical commissioning group.
- The service collected data around the number of transfers completed. We saw that the service completed between 4190 and 5010 patient journeys each month from April 2019 to December 2019.
- In addition to the numbers of transfers made, the service reported against ten key performance indicators. These included:
  - For inbound journeys: The percentage of users arriving between five and 45 minutes prior to their appointment time.
  - Journey times: The percentage of users on the vehicle between 0 and 90 minutes, Excluding journeys over 30 miles.
  - Outbound journeys (planned by 4pm the previous day): percentage of users waiting no more than 60 minutes after their booked as ready for collection.
  - Unplanned short notice/ same day bookings in hour's service (after 4pm, the previous day on the day requests): percentage of users collected within four hours of the journey/ ready time.
  - Unplanned short notice/ same day booking in hours service (after 4pm the previous day on the day requests): percentage of users (short notice) waiting no more than 60 minutes after their booking collection time.
  - End of life transfers from acute hospital to their choice of placement: percentage bookings met within two hours of the patient booking ready to travel.
- Service data showed that the service met all key performance indicators for November 2018 to November 2019. Apart from the end of life transfers, which did not meet the target twice within the same period. When the KPI was not met the service had to account for reasons why. For example, we were told that major road works had impacted on ambulances ability to complete journeys, and this was noted in the length of time taken for journeys within the road work area.
- The service benchmarked its performance against other E-zec locations. The E-zec board reviewed data across all areas and shared information on performance across the organisation. The local manager met with peers on a three-monthly basis and discussed performance as part of the governance processes.
- The service liaised directly with the local commissioning group to identify how they could meet additional demands. The level of service was agreed with the commissioners and then reported against and reviewed monthly.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance

and held supervision meetings with them to provide support and development. However, the local manager did not have oversight of bank paramedics training and competence documents.

- All new staff completed an induction programme which was standardised across E-zec. We saw that each staff member, had a checklist for their training, which included the completion of a care certificate, mandatory training and a driving assessment. Staff were expected to complete the checklist prior to commencing in their role. All staff were recruited on a probationary period and probation meetings were held regularly. Staff told us that probation meetings were supportive.
- Nearly all staff had an annual appraisal. We were told that the manager completed all appraisals within a set period, this ensured that all were completed annually and prevented compliance dropping. The local manager was the only member of staff who had not had an appraisal and did not have regular 121 sessions with their line manager.
- Following the probationary period, staff continued to have regular meetings with their line managers, although these were not always as a one to one or mentorship format. There was no clinical supervision provided. However, staff felt supported and stated that the local manager always made time to listen.
- There were three paramedic staff employed as bank staff within E-zec Norfolk. These paramedic staff were not provided with any training specific to their role by E-zec and all paramedic training was completed by their host organisations. The local manager had access to the central training records, however, these did not contain details of any training completed by paramedics. For example, they were unable to identify the level of safeguarding training completed, advanced life support and manual handling compliance. The local manager could only see if staff had completed training or not which meant that there was no oversight of individuals training. The training record recorded the paramedics Health and Care Professions Council (HCPC) registration details.
- The central training team tracked all training. Managers were sent a monthly report on staff who required training in the next three months. This process enabled staff to be booked on training sessions in advance of their expiry. Time was given to staff when possible to complete their training.
- In addition to the central training team, there were local trainers who assisted to train and mentor staff. Training was completed using standardised E-zec training programmes and presentations. We saw that in addition, staff used their specialist knowledge and skills to prepare additional training for staff. We were given examples of a training programme which had been introduced by staff locally which was planned to be rolled out across the organisation.
- Staff files were held by the head office and included details of references, and qualifications. We were told, that once a member of staff had been successful at interview, they were referred to the HR department who completed the recruitment process, obtaining details of employment, qualifications and references. These were not shared with staff locally, but local managers were informed of when the individual was clear and ready to commence in their role.
- We were told that, where possible, E-zec liked to develop their own staff, and gave individuals the opportunity to take on new skills and roles. We saw that several members of the team had progressed through all levels of the service and had been supported to take on new roles. Staff felt that E-zec invested in them providing time and funding for additional training.
- There was a large number of volunteer staff who assisted with the transportation of patients via cars. These team members were recruited in similar manner to substantive staff. They attended an interview and had to complete additional checks for driving skills, and disclosure and barring service (DBS). Training was provided in conjunction with the substantive staffs training. All training was completed annually.
- Ambulance drivers were required to complete additional driver training. Drivers were assessed when commencing in their roles, and any staff member required to drive an ambulance who may need to complete emergency transfers, were expected to complete “blue light” training. This was provided by a designated member of the E-zec team.

- Driving licences were checked every six months to ensure that staff were able to drive ambulances. There was a robust policy regarding accidents, and any staff member who had two accidents were dismissed.

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.

- The service worked collaboratively with the local acute trust to mobilise patients between their homes and the hospital. We saw that there was effective communication between the service and the local hospital for referrals and ensuring that patients were discharged in a timely manner. For example, the service liaised directly with wards to ensure patients were ready to leave at specified times.
- Staff from different teams, services and organisations were involved in assessing, planning and delivering care and treatment. The service regularly met with the local commissioning group who acted as a mediator between the acute hospitals and the service to ensure both parties were meeting the specifications of the planned roles. We were told that these meetings were productive and enabled open discussions about workloads.
- We were given examples of when the service had increased their capacity to meet the demands and pressures within the acute hospital and acute ambulance service. For example, the service would negotiate with additional patients could be transported when there was a high number of discharges planned or when activity was high. The service also gave an example of when they had been flagged down by a member of public to assist with a patient who had collapsed in the street. The service liaised directly with the ambulance service and after determining that there was no immediate life-threatening injuries transported the patient to prevent an acute ambulance being called out.

Seven-day service

The service operated seven days per week.

- The team had set working hours between 5.45am and midnight seven days per week. The high dependency vehicle was operational 10am to 8pm. Vehicles were rostered according to the capacity demands and crews allocated to match.
- The service was in negotiation with the local clinical commissioning group regarding increasing weekend services by one ambulance. However, staff acknowledged that this would require additional staffing and was in the planning phase.

Health promotion

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

- Managers told us that when ambulance crews attended patients' homes, they could identify any environmental factor which could impact on the patients' health. For example, trip hazards and clutter. The service provided patients with information on slips trips and falls. This gave advice on identifying risks in the home such as lighting and clutter, along with how to access support. The service also signposted patients at risk of falling to other services such as the red cross and local community health service.
- As the service did not clinically assess or treat patients, they were unable to offer clinical or medical advice but could signpost patients to their GP for support if they were concerned about a patient's condition.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent for transportation and they knew how to support patients who lacked capacity.

- Staff completed training in consent as part of their induction. This meant that they had knowledge of consent and decision making and were aware of legislation and guidance, however, as they did not complete any patient treatments, they did not need to have an in-depth knowledge. The exception to this was the paramedics who were trained in mental capacity act and deprivation of liberty safeguards by their host organisation.

Patient transport services (PTS)

- Patients were given a choice by the service as to the transfer, and the level of service provided. When booking transport in person, patients were given the choice of service provided, for example an ambulance or car depending on their abilities and needs. If a patient was unable to answer the booking questions or appeared to be confused during the calls, the patients were always referred to the acute ambulance service. We were given examples of patients with dementia who were transported by the service, usually with a double ambulance crew to enable the patient to be accompanied for the journey. Verbal consent was gained for all transfers.
- Patients who lacked capacity or were detained under a mental health section were not transported by the service. The service did not physically restrain patients.
- Staff transported several patients under 18 years old. A responsible adult always accompanied these.

Are patient transport services caring?

Good

We rated caring as **good.**

Compassionate care

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

- Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. Where possible these were taken into consideration when planning and completing patient transfers. For example, times of transfers were adjusted if possible to suit the patients' needs.
- We saw that staff took time to interact with people who used the service and communicated in a respectful and considerate way. We were given examples of where patients had requested a cup of tea before being transported and the ambulance crew postponed the journey to ensure the patient had a drink. We were also told of patients who preferred specific vehicles for transfer and these were provided if it was safe and appropriate to do so. For example, one patient preferred to travel by a car, and the team agreed to do this on the condition that the patient was well.
- Staff were sensitive and supportive to people who used the service. Some patients regularly used the service and where possible the same crews were used to complete these journeys. This enabled staff to form relationships with the patients and improved trust in the service.
- We saw that when patients were disruptive or disrespectful to other passenger's staff challenged their behaviour. We saw that the local manager completed conversations with abusive patients and outlined acceptable behaviour which needed to be adhered to.
- The service was respectful of the patient needs, for example, those patients who were receiving end of life care, were transferred on their own to maintain their dignity. We were given examples of where the service limited the numbers of patients being transferred due to their clinical condition. For example, ambulances did not usually transfer multiple patients requiring mobility aids or the use of a stretcher.
- Patients using the service did not usually require physical or intimate examinations or care. Patients with needs were managed appropriately and transferred on their own of possible.
- We were given examples of where staff had comforted patients in distress. For example, one patient had declined a transfer due to complaints of pain. The ambulance crew decided to attend their home at the pre-planned time anyway to ensure the patient was well and found the patient on the floor. The crew stayed with the patient until an acute ambulance arrived.
- Ambulance crews were able to provide patients with blankets to protect their dignity whilst mobilising between the ward/ home and the ambulance.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

- Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We were given examples of when

ambulance crews acknowledged that they may be the only person to have contact with the patient, or that they may be attending appointments that they were worried about. Staff told us that they endeavoured to be friendly, and jovial to ensure that patients were either distracted or felt that they could speak to staff about their concerns.

- The service did not provide treatment; however, they did offer timely support. Where possible, staff signposted patients to other services who could help.
- Staff did not routinely provide information to those close to people who used the service, however, would include them in conversations and offer support if able during transfers offering emotional support as necessary.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers.

- Due to the type of service, staff did not provide any clinical treatment and therefore could not provide advice or guidance or enable patients to make informed decisions. Staff did, however, offer support. Staff communicated effectively with patients, taking into consideration any protected characteristics.
- Staff would signpost patients and those close to them to other services if they felt it was appropriate. For example, patients were referred to their doctor if they complaint of any illnesses.
- We saw that patients' feedback was regularly collected. Feedback was largely positive, with comments including that 'staff were marvellous', 'perfect' services and 'couldn't be better'. Some feedback referred to delays being the only issue, although these were relatively small in numbers.
- The service aimed to collect a minimum of 28 feedback forms every month. Feedback was generally positive. In December 2019, 40 patients provided feedback, nine reported some concerns, such as late arrival and delays in pick up. However, 36 out of the 40 responses reported that they were satisfied with all feedback forms reported "amazing staff". November feedback was collected from 24 patients, six reported that there were delays or discomfort. October collected 40 responses, 32 were satisfied with the service and eight dissatisfied.
- Patients we spoke with felt that they were respected and said that staff were always polite and friendly.
- Any patient feedback was shared with the wider E-zec team. Patients details were not collected preventing any identification of individuals.

Are patient transport services responsive to people's needs?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

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

- The service offered patients within the local community a transport service between their homes and the hospitals. They also provided out of area transfers for outpatient appointments at other organisations or high dependency transfers for a predetermined group of cardiac patients. The service remit was agreed in advance with the local clinical commissioning group and all appropriate patients were given the service contact details for arranging their transport.
- The services provided reflected the needs of the population served and ensured flexibility, choice and where possible, continuity of care. Patients were able to pick transfer slots that suited their needs. Pick-ups were planned to enable the maximum usage of the vehicles and prevent repeated journeys to the same areas.
- The service worked to a planned schedule of activity with ambulance crews available at set times per week. These met the demands of the local area and reflected the busiest periods. For example, some vehicles did not start until later in the day ensuring that there was evening or night time cover.
- Facilities and premises were appropriate for the services that were delivered. Vehicles were well equipped and suitable to carry multiple passengers including children

and young people. Office and base rooms were easily accessible and suitable for storage and office duties. There was a training room available for training or larger meetings.

- The service reported that it was managed well, in line with commissioning agreements. Local commissioners were satisfied with the service being provided and were in negotiations about expanding services.
- The demands on the service could be flexed to meet the local demands. Additional vehicles were available, but hours were managed in line with contract agreements.

Meeting people's individual needs

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

- Patients with any specific requirements or needs were highlighted at the booking phase. For example, patients who had "do not resuscitate orders" in place or advance directives were highlighted to the ambulance crew on the booking forms. This enabled staff to respect decisions in place and hand over key information to staff on arrival to destinations.
- The service ensured that patients were discharged in a timely manner and if patients were transferred at night, ensured that there was ongoing care at the destination. Staff told us that they checked to ensure that frail and elderly patients had a suitable person at the home address or that a care package was in place. We were given examples of when ambulance crews assisted patients into their homes and ensured that they had access to a hot drink, food and heating was on before leaving them.
- Patients who were attending appointments outside the county were accompanied by a crew who waited to escort the patient back. These appointments were pre-planned, and staff were aware of the need to wait at the appointment location. Patients attending outpatient appointments locally were dropped off and then asked to contact the service to arrange transport back, this prevented the patients waiting for a specified time and enabled crews to continue to work instead of waiting until a predesignated time.
- Some patients completed repeated journeys, for example to the renal unit for dialysis. These patients were transferred where possible by the same staff to encourage a continuity in care. Journey times were monitored to ensure that patients arrived at appointment on time.
- There were reasonable adjustments in place so that people with a disability could access and use services on an equal basis to others. The ambulances were able to transfer patients with mobility issues using their own or the patient's equipment. There was also an ambulance available to transfer overweight patients.
- Patients identified as being at the end of their life were identified by the staff at the local hospital and confirmed when making a booking. All patients who were identified as being at the end of their life were transferred separately to other patients to maintain their dignity.
- Staff received guidance on managing patients who had active do not resuscitate forms in place. We saw that the policy reflected best practice and staff bulletins gave information regarding the use of ReSPECT forms. Prompting staff to be aware of patients' choice and promoting awareness of checking information provided for patients with these form in place for their transfer. ReSPECT forms are very specific forms that records information relating to the patients treatment in an emergency.
- Any communication needs were identified at the booking phase. Booking staff asked patients or the referring person to confirm any communication needs. For example, any disabilities or sensory loss. This was then accurately recorded on the patients transfer sheet which enabled staff to identify any needs prior to collecting the patient. We were told that staff were experienced in obtaining information from patients as to their needs, asking multiple questions to identify any needs.
- The service transported a number of children and young people between locations. Paramedic staff told us that they routinely transferred one patient who had additional needs due to their underlying health condition, however, most children were transported using volunteer vehicles. A responsible adult accompanied all children and young people.

Patient transport services (PTS)

- Staff had access to British sign language guidance which gave instructions for common phrases and the alphabet which could be used to assist communication. Staff reported that this was infrequently used but was available if the situation arose.
- There was an interpretation and translation service policy which gave staff guidance on accessing support for patients whose first language was not English. Staff could access translators if necessary, and this was arranged at the time of booking the transport.
- Staff were able to liaise directly with the acute ambulance services if they needed assistance or needed to refer patients for an alternative method of transport. The service reported that they worked alongside acute ambulance services within the hospital and therefore were able to discuss any concerns in person. Staff reported that there was effective partnership working between the acute ambulance crews and the service.
- Any patient who was identified as being aggressive or difficult to manage were managed safely by staff. We saw incident reports of verbal aggression from patients towards staff and these were always followed up by the manager who contacted the patient outlining acceptable and non-acceptable behaviour. Staff were able to refuse patients if they were physically violent and referred these patients to the acute ambulance service.

Access and flow

Patients could access the service when they needed it, in line with national standards, and received the right care in a timely way.

- The service did not transfer emergency patients. All transfers were pre-planned and booked in advance through the booking office. Service data showed that 95% of calls were manged by the booking team within the expected timescale of two minutes.
- The booking team used an electronic system to record all planned transfers. Patient details were held on the system and populated the planned activity or journey.
- A patient transport liaison officer (PTLO) was based at the local acute hospital trust. Their responsibility was to coordinate all transport and journeys. This included, all planned inward journeys, voluntary car inward journeys, return journeys on the day and planned discharges from hospital. The PTLO reviewed the list of bookings the day before to coordinate the best use of resources and used local knowledge to map out patient journey. For example, patients within a similar area would be coordinated to travel in the same vehicle, to optimise efficiency. The PTLO ensured that patients individual needs were met, for example, patients undergoing palliative care, those requiring oxygen therapy, and those who had additional mobility needs.
- Patients who were planned to be discharged on the same day were also coordinated by the PTLO. When identifying the names and addresses of patients being discharged the PTLO would speak directly to ward staff and explain that there were two or more patients being discharged to similar locations and they would coordinate the pickup time to suit all wards. This prevented a patient on one ward waiting excessively whilst another patient was getting ready for discharge.
- The PTLO liaised with the inpatient staff to ensure that specifications of bookings were accurate. Where patients' bookings were not appropriate, the PTLO worked with the wards to facilitate journeys, for example, where there was no one at the patient's home to let them in, the PTLO worked to contact the patient's family to ensure someone was available to meet the ambulance.
- The PTLO was also responsible for training of the booking system which enabled a consistent approach to information collected for planning journeys.
- High dependency patients were booked using the same process but recorded differently within the electronic system to enable easy identification. Patients were then assessed by the individual paramedic prior to completing the transfer. If the crew were concerned about the patient's condition, they were able to decline the transfer and refer to the acute ambulance service. However, staff told us that this had not happened before as patients were suitably referred.
- Ambulance crews would wait on site for those patients transported out of area, who required a return journey. This ensured that transport was available as soon as the patient was ready to return home.

Patient transport services (PTS)

- If the service was unable to pick up the referral, there was a clear escalation process. The PTLO had the autonomy to decline referrals in the event of high capacity or inappropriate referrals, for example, patients who were clinically unwell.
- The service transferred a small number of children. We saw that there were 145 children transported between April 2019 and January 2020.This was the equivalent of between 0.12% to 0.55% of the total transfers. The service completed between 4000 and 5000 transfers per month. Where possible children's transfers were completed by the voluntary drivers in a car using suitable car restraints to ensure patient safety. If a stretcher was required, ambulance staff ensured that there was enough room for the patients' carer to travel.
- Voluntary drivers were provided with a print out of pick-ups and drop offs. These were provided in advance of the planned journeys and amended by the volunteer if any changes made. The print outs were then returned to the transport office at the acute hospital, and the team updated the electronic system with the details of the journeys completed. All paper records were then transported to the main office and stored securely. This process enabled details of journeys to be tracked.
- Personal Data Appliances (PDAs) were used by staff to track activity and enable communication. The PDAs could time stamp and update the electronic system, task journeys, provide staff with the patient demographics and provide information relating to the patient needs. The PDAs also provided communication with the rest of the service and used instead of radios.
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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.

- Staff were aware of their roles and responsibilities for managing complaints and concerns raised. Patients were given clear advice of they wished to make a complaint, and staff informed them of who and how to contact the manager. Patients were regularly encouraged to give feedback. Staff could describe what information they provided to patients/carers that wish to complain.
- There was an E-zec process for the management of complaints. Complaints reported locally, were investigated by the local manager. There was clear guidance for staff on managing complaints which included guidance on managing concerns/ complaints, the escalation process and examples of best responses. E-zec had a two-stage process. Stage one promoted early resolution, where an apology was made, and actions taken to resolve the identified issue. This was used for simple complaints which did not require investigation. Stage two, referred to more complex complaints which required an investigation. The policy required action to be taken within 36 hours of receipt of the complaint. Stage one complaints were required to be managed/ resolved within ten working days, and stage two were expected to be responded to within 25 working days.
- We saw that the service had received 13 complaints between April 2019 and January 2020. These were tracked on a report which was shared with the board for oversight. We saw that complaints related to delays in pick up and miscommunication. All complaints were investigated and responded to within one week of receipt. Where complaints were upheld, we saw that apologies were given, and actions taken to prevent reoccurrence. For example, one patient who was transported regularly expressed concerns that they were unable to lie on a stretcher due to back pain. The response included highlighting to staff that the patient required a seat for all transfers in the future.
- We saw that lessons learnt were shared. For example, we saw a briefing template which shared information about an incident where one crew member transferred

a patient instead of two. The template shares the root causes of the incident and offers lessons learnt such as ensuring patients have the right number of crew in attendance ensuring mobility is recorded.

- Complaints from each operational area, were compared at corporate performance meetings. Managers shared complaints at peer support meetings and staff shared learning across the whole organisation. We saw that posters were displayed identifying outcomes of complaints and items of learning.
- Complaints information was also shared with the commissioning group and discussed as part of the commissioning meetings. This enabled an oversight of performance and any emerging themes.

Are patient transport services well-led?

Good

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.

- E-zec Norfolk was part of a larger E-zec organisation who managed 20 operational locations across the country. E-zec Norfolk had opened in 2017 having transferred from another provider to E-zec.
- E-zec has an established board, although we were told that the leadership had changed over the last year. The managing director had worked at E-zec for several years prior to taking on their current role. Additional changes to the organisation included a new director of human resources and a director of quality, compliance and safety. Operational managers and a finance manager supported these directors. The executive team were not based locally, however, staff told us that they were accessible. The managing director and clinical lead had attended the site a few weeks before inspection and spent time with staff.
- The operations director visited the site a minimum of monthly and was well known to the local staff.
- The manager met with the executive team every three months at the organisations peer support meetings.
- Local leadership was strong. The manager was respected and highly thought of by corporate and local staff. Staff reported that the manager was approachable.
- The local manager had an open-door policy and regularly engaged with staff, encouraging them to share any concerns. Although the staff did not complete team meetings, due to the team being small and working in close proximity, they felt that information was easily shared, and concerns could be addressed. We were told that conversations were often informal and not planned.
- There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The service had recruited a deputy manager who worked alongside the current manager to learn about the role. Staff also reported that there was corporate support for staff wanting to develop.
- Staff could identify the different leads, their roles and their responsibilities, although all staff reported that the local manager would be the usual person to contact if there were any problems.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

- There was a corporate "E-zec core values" document which promoted staff to be caring, honest, polite, respectful and reliable. There was also an E-zec corporate vision and strategy which reflected the core behaviours and promoted a caring service which was responsive to patients' needs.
- The service had clear values which were aligned to the corporate vision. These included ensuring that "patients were at the heart of everything" that they did, "providing a high level of customer service, using best practice and operating safely, responsibly and efficiently".
- Staff were aware of the corporate strategy and were aware of their roles in achieving it. The strategy was

aligned to the wider health and social care economy and focused on meeting the needs of the local populations and this was discussed with commissioning leads and acute providers regularly.

- The service worked collaboratively with the commissioning group to ensure that the service met the needs of the local population. We were told that staff were currently working through plans to increase weekend activity to meet additional demands from acute hospitals for discharging patients.

Culture

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

- Staff were largely positive about working for E-zec and felt supported, respected and valued. The service was in the process of introducing the employee of the month, which would recognise staff contributions to the service.
- There was an emphasis on the safety and well-being of staff. E-zec were committed to support mental health at work and had introduced additional training and support for staff. There was also an external counselling service available to staff and their families to support them through difficult times. We were told that the team could navigate callers to additional services if necessary and were available 24 hours per day.
- Staff relationships were positive. The team used a closed social media site to enhance communication. This was used to share any key messages, changes to practice and offer additional shifts to staff.
- The team were passionate about providing a patient centred service and we saw that staff spoke positively about patients and their needs.
- We saw that staff performance was monitored and challenged if it fell outside the expected standards.
- There was a positive open and honest culture, and we saw that staff felt they were able to raise concerns without fear of retribution. Staff told us that they had previously raised concerns regarding medicines management, and that the wider E-zec team had not appeared to act as quickly as they would have liked. Staff told us that in response, they continued to raise the concerns until they achieved a response from the corporate teams.
- There were mechanisms in place to provide staff with the developments they needed. Managers told us staff were encouraged to develop and take on new roles and responsibilities. Staff were deemed to be the company's biggest asset and managers felt that promoting development opportunities would encourage individuals to stay working for E-zec. Staff were supported to complete additional qualifications. There was a plan for all operational managers to complete a level 5 health and safety diploma, and E-zec were in the process of rolling out the programme. We were given examples, of where staff had been supported to complete additional training outside the organisation.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- There was a clear governance structure. Quality and compliance were reviewed monthly by the regional leads and the board. E-zec held national meetings for all locations every three months, which was attended by the local manager. This was their opportunity to share experiences and compare services. Board meetings were held monthly and any relevant information was shared with local teams. We were told that the corporate team were supportive and accessible. We saw that board meetings followed agendas which included updates on operations, such as new services, as well as finance, and compliance. There were also training sessions for example, emergency preparedness and we saw that actions from meetings were recorded and reviewed.
- In addition to the corporate review, the service had monthly meetings with the commissioning group to enable oversight of performance and to discuss any issues or concerns relating to the service provision or effective working with other local providers. The local manager completed the meetings with the

commissioners alongside the operational director, focusing on performance and the meeting of key performance indicators. This meeting acted as the opportunity to review the contract and discuss any amendments that may be required due to changes in local demands.

- There were clear lines of accountability within E-zec and there were expectations for engagement within the teams. Activity included monthly site briefings, quarterly site meetings, update posters, mini briefings daily, display of meeting minutes on notice boards and monthly representative meetings.

Management of risks, 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. However, risk registers were not always dated when they were reviewed.

- The service used a standardised risk matrix which gave a score depending on the likelihood of occurrence and the consequences.
- The service maintained a local risk register which fed into the corporate risk register. There were 10 open risks identified. The highest risk was the lack of a permanent paramedic to support the team with clinical aspects of the role, such as ordering and managing medicine and the high dependency vehicle. This risk was added in June 2018 and was the primary concern of the local manager. Concerns regarding the lack of permanent paramedic had been escalated to the board and in the interim, there were five bank paramedics, one of whom worked largely for E-zec. Following inspection, we were informed that E-zec had successfully recruited a permanent paramedic. Other risks included the management of medicines and the recruitment and retention of paramedic staff. There was one closed risk which referred to vehicles and servicing. The risk register was clear and showed mitigation taken, however, there were no details of review dates. We were told that all risks were reviewed locally and by the corporate team, and all staff were able to describe what the risk register contained. Risks were recognised by staff, who could clearly outline the main risks to the service and why.
- Performance was monitored by the commissioning group, and we were told that the frequency of this had been reduced due to satisfaction with the team's ability to meet their targets. The in-person meetings were planned to change to bi monthly, with a telephone call in between from January 2020.
- The service attended joint working groups with the local acute hospital trust and commissioning groups. These meetings were used to discuss any issues, for example, patients not being ready for discharge and tablets to take home not being available. The group had agreed that to prevent delays in transfers, ambulance crews were not to attend wards until patients were confirmed as being ready.
- There was a systematic programme of internal audit to monitor quality, operational and financial processes. We saw that audits were completed regularly and included aspects including cleanliness, hand washing and performance. There were associated actions for each audit to promote compliance.
- Potential risks were considered when planning services, for example, there were plans in place for seasonal fluctuations in demand, or disruption to staffing or facilities. The plans were displayed to enable staff to become familiar with them. There was an emergency plan and corporate contact details available to all staff for use in the event of a major incident.

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.

- There was an understanding of performance. Information was used to measure performance against key performance indicators (KPI)/ contract and to identify any areas of improvement. For example, any areas where the KPI was not met, were reviewed to identify where improvements could be made.
- Quality was considered to be equally as important as performance and staff were encouraged to ensure that they provided a quality and timely service for patients. Information was available to all staff relating to performance.

- The service used performance measures to identify trends and any areas for improvement. The manager had oversight of performance daily and could determine what actions had been taken to address an issue. For example, and delays in pick up were recorded and reasons noted. This enabled the manager to identify if there were any trends with specific locations or patients. For example, and ward that did not routinely ensure that their patients were ready for collection.
- An electronic system captured data which was reported on. Performance data was compared nationally to other E-zec areas performance.
- Information systems were secure and only accessible by designated persons.

Public and staff engagement

Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, meeting minutes were not always detailed.

- The service had a customer care charter which was given to patients as an information leaflet. The leaflet included guidance on the information needed when booking a transfer, details of waiting times, guidance on accessing patient records, providing feedback and how to contact the team with any concerns.
- Due to the nature of the service, we were told it was difficult to gather staff for team meetings. The service had therefore introduced staff representatives who attended pre planned meetings with managers to discuss any issues that had been escalated to them. Staff elected representatives who were key contacts for staff and attended monthly meetings. We saw minutes from representative meetings and found that these largely consisted of an update on previous items escalated and any new items. There were themes around cleaning vehicles, staff uniforms and vehicle management. Minutes were not detailed and largely consisted of titles and a sentence of explanation. This may not give someone not at the meeting details of discussions and actions being taken. The minutes for November 2019 were more detailed, the local manager completed these.
- Staff reported that E-zec had been slow to respond to concerns raised regarding medicines management and high dependency transfers. We were told that concerns had been escalated to the head office several months before the inspection. It was reported that following the change to the managing director, concerns had been taken seriously and there appeared to be actions in place.
- Managers and corporate leads told us that there was a positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population. Staff spoke openly about working with the acute ambulance providers, local acute hospitals and commissioners. They gave examples of where they supported each other.
- Patient feedback was collected regularly. Audits were completed by staff and patients were asked to give details of their journeys and their experiences. This information was used to identify areas for development. We saw that patients with specific concerns were responded to by the manager and agreements made to change the ways in which the service was provided if necessary to improve satisfaction with the service.
- Staff working in remote locations were able to gain support from the team representatives or the manager. The manager regularly visited other bases to interact with staff.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

- The service had changed their methods of working at the local acute hospital to be more responsive to demands. Rather than preplanning outward/ return journeys, the ambulance controller, based at the hospital, coordinated activity to meet demands. Patients or hospital staff would confirm that the patient was ready to leave hospital and the service guaranteed transport within one hour of the notification. Staff reported that this had improved patient satisfaction as they were less worried about making times for return journeys or have to wait for pre-planned appointments. Staff also reported that the process ensured that there

Patient transport services (PTS)

was additional capacity available to transfer patients at times of peak activity reducing the demands on services. This process had been so successful that the executive were promoting it in other locations.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve
Action the provider SHOULD take to improve

- The service should ensure that records contain the dates of replacement or mending of faulty equipment.
- The service should ensure that all hazardous substance storage is clearly labelled.
- The service should ensure that there are robust processes in place to ensure the safe prescribing, administration and storage of medicines in line with local policy and national guidance.
- The service should ensure that all managers have oversight of bank paramedics training and competence documents to ensure that they are capable of completing specific roles locally.
- The service should ensure that risk registers are dated when they were reviewed.
- The service should ensure that meeting minutes are detailed enough to enable staff to understand the context of conversations and information shared.