E-Zec Medical Transport Services Ltd

# E-zec Medical Transport - Cornwall

## Quality Report

Cardrew Industrial Estate
Cardrew Way
Redruth
Cornwall
TR15 1SS
Tel: 01737822782
Website: www.e-zec.co.uk

Date of inspection visit: 18 and 19 May 2017
Date of publication: 22/09/2017

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 know to CQC and information given to us from patients, the public and other organisations.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

E-Zec Medical Transport Services - Cornwall is operated by E-Zec Medical Transport Services Ltd. The service is registered with the Care Quality Commission to provide the regulated activity: transport services, triage and medical advice provided remotely. Commissioning of the service was through the local acute NHS trust and NHS Kernow. NHS Kernow is the clinical commissioning group for Cornwall and the Isles of Scilly.

The CQC registered location is at the Redruth Depot. Throughout this report we will refer to the services provided in Cornwall as 'E-Zec'.

E-Zec had three depots in Cornwall at Redruth, Bodmin and Saltash. At Redruth station there were 13 ambulances capable of transporting patients on stretchers and wheelchairs, two ambulances for use with wheelchairs only, two bariatric ambulances and two cars. At Bodmin station there were a total of nine ambulances all capable of transporting patients on stretchers and wheelchairs and two cars. The Saltash station had four ambulances available all capable of transporting patients on stretchers or wheelchairs and a further two for use for independently mobile patients or those using a wheelchairs. A further ambulance was kept in Penzance to reduce the mileage when covering West Cornwall.

Between October 2016 and May 2017 E-Zec had completed 24,505 patient journeys in Cornwall. The total number of journeys each month in this time period ranged from 2757 to 3537.

The service employed 110 members of staff which included ambulance care assistants, management and administration staff. There were no paramedics employed in this registered location. Any community first responders working at E-Zec were not trained or utilised by the organisation.

A patient transport service was provided to adults and children, although children were required to be accompanied by an escort.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 18 and 19 May 2017.

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.

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

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

Staff did not always complete incident reporting tools to ensure the provider was aware of all incidents and near misses that occurred. Staff were concerned that when they did report incidents they did not always receive feedback about the issues they had raised.

Not all areas of the ambulance stations and vehicles were clean and hygienic. This did not promote the control of infection and increased the risks from cross infection. The provider needs to get better at monitoring and auditing the effectiveness of the cleaning procedures carried out by the staff.

The system of exchanging or disposal of soiled linen was not safe. Staff did not always know if there was an infection control risk when returning linen to the hospitals for laundering. There was not a formalised service line agreement in place for staff to return linen to the hospitals to exchange for clean supplies.

# Summary of findings

Storage of equipment and consumables was poor at Redruth station with clean consumables stored on the floor in the ambulance station and together with substances that are hazardous to health such as chemicals and engine oil. This could pose a risk of cross contamination.

Improvement is needed in the timeliness of repairing faults to vehicles. Staff reported that repairs such as to side door steps and seat handles were not mended promptly causing a danger to themselves and patients. We observed a number of issues with vehicles that needed addressing.

Staff reported a lack of training provision since they had transferred to E-Zec from the previous provider. We were unable to evidence that all staff were trained and competent in their roles. For example, we could not evidence that all staff were trained to use all of the equipment on the ambulances or that they had completed infection control training.

Staff were not trained to meet the needs of patients with specialised care needs such as mental health issues, patients living with dementia or a learning disability. We were concerned that at times patients were left unattended or with fellow passengers on ambulances, particularly when they had specialised needs that put themselves or others at risk.

Five members of staff we spoke with, were unable to demonstrate they were familiar with or had a good understanding of the organisation's policies and procedures, which were stored on the organisation's intranet, to support them in their role. The provider could not demonstrate that all staff had read and understand the policies and procedures. The policies and procedures provided information on organisational procedures and operational and clinical guidelines.

It was not clear from the documentation available and provided for us that all staff had received regular supervision and appraisal to highlight any issues or training needs.

Security was not always given high priority with ambulances left unlocked and keys unsecured in one of the stations.

Oxygen cylinders were not stored within a locked storage area, which meant they were accessible to anyone who entered the premises. They were also stored at Redruth in a way that posed a fire risk.

There was not a system in place for staff to record any care intervention provided to patients when being transported. This meant relevant information risked not being communicated to the receiving department or care home.

We received concerns prior to the inspection of delayed journeys which had had a negative outcome on the patients care, treatment and welfare. We evidenced during the inspection that there had been a number of journeys that had been delayed.

Staff were not familiar with, or could not discuss, the strategy and vision of the organisation. Staff did not feel supported by the management of the organisation and did not feel they worked as a cohesive team. There were not regular staff meetings for them to voice their opinions or feel listened to.

Senior staff were not familiar with the risk register, where to access it or how risks were processed to be identified on the risk register.

However, we also found the following areas of good practice:

The provider produced a monthly quality report that was presented to the board meeting to identify all incidents, complaints and reported safeguarding concerns.

Records showed that vehicles were serviced regularly and up to date with legal checks such as the MOT.

Staff followed the appropriate local procedures to report any safeguarding concerns they identified when collecting and transporting patients to appointments and home from hospital.

The provider had undertaken a planned recruitment drive to increase the numbers of staff following taking over the service in Cornwall.

# Summary of findings

The provider met regularly with colleagues from the local commissioning group and the acute NHS trust to enable face to face discussions to take place regarding developing or improving the service delivered.

The service employed a liaison officer to work at the local acute NHS hospital to improve communication between wards, departments and E-Zec.

Complaints received by the organisation were responded to in a timely way.

A new system of staff meetings was being implemented following our inspection and a staff representative had been elected from each station to attend a meeting with the managers of the service. The purpose of this was to enable the staff to give their views on the service and the working arrangements at E-Zec.

The views of patients were sought through telephone calls requesting a response to satisfaction survey questions. Most patients surveyed were satisfied with the service they had been provided with. Staff were kind, respectful and empathetic when talking about their patients.

**Professor Sir Mike Richards**
**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) | | We do not currently have a legal duty to rate independent ambulance services. |

# E-zec Medical Transport - Cornwall

## Detailed findings

**Services we looked at**
Patient transport services (PTS)

# Detailed findings

## Contents



## Background to E-zec Medical Transport - Cornwall

E-Zec Medical Transport Services - Cornwall is operated by E-Zec Medical Transport Services Ltd. The organisation is an independent ambulance service with the head office in Surrey. E-Zec Medical Transport Services Ltd has been in operation since 1998 in other parts of the country.

E-Zec Medical Transport – Cornwall is based in Redruth with branches in Bodmin and Saltash. The registered location at Redruth opened in March 2017 when it took over contracts for patient transport from another independent ambulance service. The service primarily provides a transport service to people living in Cornwall.

The service has had a registered manager in post since March 2017.

This was the first inspection of this service since its registration.

## Our inspection team

The team that inspected the service comprised a CQC manager – Julie Foster, CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise as a paramedic. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

## How we carried out this inspection

During the inspection, we visited the ambulance stations at Redruth, Bodmin and Saltash. We spoke with 25 staff including administration staff, patient transport drivers and management. We did not speak with any patients as we were unable to observe any patient journeys or meet with patients.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the first inspection of this service since registering with CQC in March 2017. We found that the service was not meeting all required standards of quality and safety. We had been made aware of a number of concerns regarding the service by patients and staff prior to the inspection.

# Detailed findings

## Facts and data about E-zec Medical Transport - Cornwall

The service is registered to provide the following regulated activities: transport services, triage and medical advice provided remotely.

Crews confirmed most trips were county based with some work in Devon. No higher dependency provision was provided and no provision of ambulance and services to events was undertaken.

The ambulance control centre was located in Newcastle, Stoke-on-Trent, and was open 24 hours each day and supported those staff working weekends and nights. We did not inspect this aspect of the service at this inspection. The control centre is assigned to another registered location and will be inspected as part of that service.

All frontline staff were Ambulance Care Assistants (ACAs). There is no formal recognised training for ACAs but the provider had implemented an induction and an ongoing programme of training. The responsibilities of ACAs include; driving, moving and handling of patients, patient care and comfort during journeys and safety and dignity of the patient.

The Saltash station was located within a secured storage unit on an industrial estate. The station had a lead member of staff, an administration staff member who worked part time and 13 ACAs with access to seven ambulances. No overnight service was provided and there was some limited weekend provision. The station comprised of one office and two store rooms. Parking was available outside of the office.

The Bodmin station was located on an industrial estate. The team leader at Bodmin had left and had not been replaced. There were nine ambulances, two cars and 16 members of staff. There were also two administrators. No overnight service was provided and there was some limited weekend provision. The station comprised of a parking depot and office space. External parking was limited and a compound area was available for secure parking overnight.

The Redruth station was located on an industrial estate. Internal and external parking was available with no secure external parking available. There were 17 ambulances and two cars available and a weekend and overnight service was provided. Saturday had four day crews and one night crew (7pm to 7am). On Sundays there were three day crews and one night crew.

Between October 2016 and May 2017 E-Zec had completed 24,505 patient journeys in Cornwall. The total number of journeys each month in this time period ranged from 2,757 to 3,537.

# Patient transport services (PTS)

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

## Information about the service

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection, we visited the ambulance stations at Redruth, Bodmin and Saltash. We spoke with 25 staff including administration staff, patient transport drivers and management. We did not speak with any patients as we were unable to observe any patient journeys or meet with patients.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the first inspection of this service since registering with CQC in March 2017. We found that the service was not meeting all required standards of quality and safety. We had been made aware of a number of concerns regarding the service by patients and staff prior to the inspection.

Crews confirmed most trips were county based with some work in Devon. No higher dependency provision was provided and no provision of ambulance and services to events was undertaken.

The ambulance control centre was located in Newcastle, Stoke-on-Trent, and was open 24 hours each day and supported those staff working weekends and nights. We did not inspect this aspect of the service at this inspection. The control centre is assigned to another registered location and will be inspected as part of that service.

All frontline staff were Ambulance Care Assistants (ACAs). There is no formal recognised training for ACAs but the provider had implemented an induction and an ongoing programme of training. The responsibilities of ACAs include; driving, moving and handling of patients, patient care and comfort during journeys and safety and dignity of the patient.

The Saltash station was located within a secured storage unit on an industrial estate. The station had a lead member of staff, an administration staff member who worked part time and 13 ACAs with access to seven ambulances. No overnight service was provided and there was some limited weekend provision. The station comprised of one office and two store rooms. Parking was available outside of the office.

The Bodmin station was located on an industrial estate. The team leader at Bodmin had left and had not been replaced. There were nine ambulances, two cars and 16 members of staff. There were also two administrators. No overnight service was provided and there was some limited weekend provision. The station comprised of a parking depot and office space. External parking was limited and a compound area was available for secure parking overnight.

The Redruth station was located on an industrial estate. Internal and external parking was available with no secure external parking available. There were 17 ambulances and two cars available and a weekend and overnight service was provided. Saturday had four day crews and one night crew (7pm to 7am). On Sundays there were three day crews and one night crew.

Between October 2016 and May 2017 E-Zec had completed 24,505 patient journeys in Cornwall. The total number of journeys each month in this time period ranged from 2,757 to 3,537.

# Patient transport services (PTS)

## Summary of findings

We do not currently have a legal duty to rate independent ambulance services.

**Are services safe?**

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

- The formal incident reporting process was not consistently adhered to and feedback following a reported incident was not always provided to staff. This did not ensure learning took place within the staff teams.
- The provider did not have a clear or formalised system to establish an overview of safety.
- Infection control and promotion procedures were not consistently followed to reduce the risk of cross infection.
- Not all staff were fully trained and competent to carry out their duties. This included the organisation's mandatory training and the use of specific equipment.
- Repairs to damaged vehicles were not always carried out in a timely way.
- Security regarding the storage of keys and ambulances had lapsed which provided a risk to the business.
- We observed that the oxygen cylinders at Redruth station were stored in an area which increased the risks of fire. This was addressed immediately by the provider when brought to their attention during the inspection.

However, we also found the following areas of good practice:

- The ambulance station at Bodmin appeared clean and hygienic.
- All vehicles had up to date records maintained regarding the MOT and servicing carried out to ensure the vehicles were legally roadworthy.
- Fire risk assessments had been carried out on the premises and action taken to reduce the risks should a fire occur.
- Staff reported any identified concerns regarding the safeguarding of adults and children to the appropriate agencies.
- Newly appointed staff were provided with a thorough induction training package prior to commencing duties.
- The organisation had a robust recruitment process with an active recruitment campaign in operation to improve the service offered to patients.

**Are services effective?**

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

- Patients were at risk of being provided with an ineffective service as there was no system in place to ensure that all staff had access to and had read and understood the policies and procedures. Five members of staff we spoke with were not aware of where to find the policies and procedures on the intranet and stated they had not accessed these.
- Patients did not receive a service from staff who were consistently supervised or provided with an annual appraisal.
- Staff were not fully aware or knowledgeable about the Mental Capacity Act or best interest decisions. The patient transport service was not always provided in a timely manner.

However, we also found the following areas of good practice:

- Policies and procedures to guide and inform staff adhered to national guidance and relevant legislation.
- The organisation worked well with external partners and attended external meetings to improve the service provided

**Are services caring?**

# Patient transport services (PTS)

We did not fully inspect the caring domain as we did not observe any direct care to patients and did not speak with patients and their relatives during the inspection.

**Are services responsive?**

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

- Patients did not consistently receive a planned or timely service. There were issues with booking of some journeys. This aspect of the business was managed by the control room which was not inspected as part of this inspection.
- Patients with specific care needs were not consistently supported by staff who were knowledgeable about their needs.
- There was no formal system to advise patients on how to make a complaint. There was no formal system to enable shared learning to take place following complaint investigations.

However, we also found the following areas of good practice:

- The organisation worked closely with the local commissioning group and acute trust to improve the service delivery in Cornwall.
- The service responded promptly to any complaints received.

**Are services well-led?**

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

- The organisation were not able to demonstrate that staff were aware of or worked within the vision and strategy of the service.
- Governance systems were not fully in place to enable monitoring of the service. No clear evidence was in place to provide assurances during, or following, the inspection that escalation of issues and concerns to the executive board were reviewed and actioned.
- Staff were not fully aware of the risk reporting system and action being taken in response to reported risks.
- Staff were not confident of the roles of local and national managers and did not always feel supported.
- There was a disconnect between staff and the organisation which was founded in the different staff contracts and terms of employment.

However, we also found the following areas of good practice:

- Local management meetings took place both within the organisation and with external organisations. This provided an opportunity to identify areas of development and improvement.
- A system had been introduced to enable a staff representative to share the collective views of the staff with local and senior managers.
- The organisation regularly sought the view of patients to identify areas of the service that could be improved.

# Patient transport services (PTS)

## Are patient transport services safe?

**Incidents**

- An electronic incident reporting system was in operation within the service. The electronic template provided staff with a guide to record all necessary information such as the person(s) involved, the date and time of the incident and relevant details.
- Staff told us that at times they completed paper incident records which were then uploaded onto the electronic system at some point. The paper copy was limited in that not all of the electronic drop down boxes were accessible.
- We were told all reported incidents were reviewed by the registered manager and then cascaded to the Head of Governance and Complaints within a monthly quality report. The monthly quality reports were collated and information provided to the nominated individual to inform the organisation's board.
- We were provided with the quality reports which included detail on incidents reported and any investigation or action taken as a result of the incident.
- Ten members of Sstaff told us they did not know the process that followed once they submitted an incident form and did not always receive feedback. Senior management staff told us that feedback to staff was provided verbally from the registered manager or through the use of notices on staff noticeboard and emailed information bulletins. We saw an example of a recent bulletin that was displayed in the staff room at the Redruth station.
- Incidents were not routinely reported by staff. Seven members of Sstaff we spoke with said they were unclear what would be defined as a reportable incident. There were no records kept of incidents that were low risk or no harm and near misses. Staff we spoke with could not describe what a near miss incident could be. This limited the service's ability to monitor incidents for any trends, to compare performance to other similar services and use the information for learning and service development.
- The service did not set its own safety goals and monitor their own safety performance to see if they were achieving those goals. Operational staff were unaware of any monitoring of the service provided.
- Concerns were raised to us regarding delays or inappropriate bookings by the staff who said they did not record this as an incident. The reason for not completing an incident report was that they would be spending too much time doing this as it was a frequent occurrence. Two members of staff told us that if such an incident occurred they would contact the control room and ask for advice. This did not ensure the formal incident reporting system was followed and limited the service's ability to ensure all key information was recorded, monitored and appropriate action taken.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The provider had a Duty of Candour policy and procedure that we were told was available to staff.
- We found that when we spoke with staff about the principles of Duty of Candour, this was not well understood by most of them. Duty of Candour was not included in staff training. Staff were unclear on where to access information relating to Duty of Candour. One member of staff thought a governance bulletin was available in the station which provided the information but then was unable to find it. This meant that appropriate action may not have been taken to comply with the appropriate regulations.
- We reviewed a complaint that had been made to the organisation and found that Duty of Candour principles had been followed in the written response to the complainant.

**Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)**

- There were no clinical dashboards available to establish an overview of safety.

  There were no clinical dashboards available to establish an overview of safety. The ambulance care assistants

(ACA) did not provide clinical intervention. The provider stated clearly that the ACAs were not considered to be clinicians and no paramedics were employed in this service.

**Cleanliness, infection control and hygiene**

- The service provided information to staff regarding infection control and promotion. This was available on the organisation's intranet. Not all staff we spoke with were aware of how to access this. We discussed this with senior managers who stated all staff had access to the intranet and had been advised where to find policies and procedures and training material. However, five members of staff we spoke with were not aware of where to find the policies and procedures on the intranet and stated they had not accessed these.
- A training module was made available to staff within the organisations on line training programme in relation to infection control. We were shown the content of this material and saw topics covered included the control of hospital acquired infections, handling body fluids, personal hygiene, uniform, hand care, use of protective personal equipment and hand gel, cleaning duties, replacement of linen, inoculation and splash injuries. However, staff we spoke with said they had not completed any infection control training since transferring to work for E-Zec some ten months prior to our inspection.
- We saw no evidence of hand hygiene or infection prevention and control audits. When staff were asked to show us on the central computer system they were unable to locate any information on audits.
- There were areas of the environment used by staff and visitors to the ambulance stations that were not effectively cleaned. This did not promote the control of infection.
- The cleaning of the ambulance stations at Redruth and Bodmin was undertaken by staff. A rota identifying a duty crew, of two people, each week were responsible for a listed number of cleaning tasks. However, it was not clear how much time was allocated to the cleaning tasks. Staff informed us they often did not have time to take their meal or comfort breaks so it was not clear how the cleaning tasks would be scheduled into their day. We observed that at Redruth station the cleaning rotas for each toilet had not been completed since 22 April 2017. Following the inspection the provider informed us that "A rota had been prepared previously but monitoring of the system was on an ad-hoc basis to correct this a more robust system has been developed and will be managed by the managers."
- Some areas were visibly difficult to maintain an adequate level of cleaning and infection control. For example, at the Redruth station the kitchen sink surround was damaged and so posed a risk of cross infection as the surface was permeable and therefore could not be cleaned effectively. The toilets were in need of upgrade to ensure they could be adequately cleaned. The radiators were rusting and the whole environment showed evidence of wear and tear. Staff would be unable to effectively clean these areas to minimise cross contamination onto uniforms and vehicles.
- We observed a number of areas where consumables were not stored appropriately. For example, we saw paper towel rolls and clean consumables stored on the floor in the station and clean consumables stored in the same cupboard as chemicals and substances that are hazardous to health and engine oil. There were two storage cupboards which had similar items in each so it was not clear what should be stored where to ensure clean consumables were separated to ensure they remained clean.
- At Bodmin station there was a member of staff who had been temporarily office based. They told us they had responsibility for ensuring the computer was updated and the office maintained. The facilities were of a good standard and appeared clean and hygienic.
- At Saltash station a commercial cleaning service was provided by the industrial unit provider for the office facilities.
- There did not appear to be a consistent system for the storage of damaged, dirty or clean and ready to use equipment. There was a 'red tag' system in operation to indicate broken equipment for repair. We saw some items with red tags, but these were stored with clean consumables and they had not been cleaned before being stored.
- Some equipment was sealed within a bag to show it had been cleaned and contained a sticker with the date of sealing. Other items had not been cleaned, for example

a bariatric trolley was visibly dirty. Staff we spoke with said that this was ready to use as needed. However, another member of staff later told us this was not working and could not be used. There was no red tag placed on it which caused a risk that it may have been used without being clean and in good repair.

- We also saw two stretchers stored at the rear of the station next to the parking for ambulances that were not covered or protected from dust or dirt which were ready to use. There were also two uncovered pillows in this area which did not indicate if they were clean and ready to use.
- All stations had contractual arrangements with an external provider for clinical waste bins and disposal. Deep cleaning took place monthly by this external provider and a report was provided. We reviewed the report for Bodmin which was produced in April 2017 and saw this had included vehicle swabbing results.
- Ambulances were routinely deep cleaned each month. The organisation maintained a spread sheet which showed each vehicle had been deep cleaned in May 2017 and the date the deep clean was due to be repeated.
- There was not a satisfactory system in place to dispose of used and soiled linen in order to prevent the risk of cross infection and promote infection control. We requested any service level agreements or delivery audits to identify the systems in place. The provider informed us that an agreement had been made with the deputy head of patient services at the local NHS acute trust but we were not provided with this confirmation in writing.
- All staff we spoke with said that when they were passing a hospital, either a community or acute trust, they would drop bagged up soiled linen to be cleaned. The staff consistently said that they would drop the linen on a ward or laundry and collect clean linen. They would not inform the staff at the hospital if there was any infection control risk. Often the linen had been removed from another ambulance and there was no system in place to inform the staff delivering the dirty laundry to the hospital if there was any specific infection control risk.
- We saw four bags of used and/or soiled linen waiting by the door for this disposal process at Bodmin station and two at Redruth station. There was a dustbin marked linen in the Redruth and Bodmin stations. This contained a number of sheets which had not been placed in a bag; it was not possible to determine if any of the linen was potentially infected or soiled with bodily fluids. This did not promote the control of infection.
- Notices were on display warning staff to remove the linen to a hospital on a Friday afternoon so that the soiled and used linen did not remain on the station floor all weekend. However, at the end of our inspection on Friday afternoon we observed there was linen waiting for disposal at the Redruth station.
- Staff were responsible for cleaning the ambulances at the beginning and end of their shifts. We observed one crew cleaning their ambulance prior to going off duty. Equipment in the ambulances appeared clean and hygienic.
- The hand held electronic devices used by the staff identified the checks and cleaning to be carried out on each ambulance and enabled the staff to indicate when these were completed. There was no auditing or checking to ensure the cleaning had been carried out to an adequate standard. Staff told us that if during a patient transport journey the ambulance became contaminated, it was taken off the road and returned to the station for a deep clean.
- At Redruth and Bodmin stations, the hose pipe used for cleaning the vehicles had a chemical feed into it for cleaning materials. There were colour coded mops with disposable heads (to reduce the risk of cross infection) and buckets for interior cleaning. The station at Saltash had the same chemicals available but these were dispensed from hand pumps which had to be carried outside to where the vehicles were washed. When not in use the dispensers were stored in a locked cupboard in the office.
- Personal protective equipment (PPE) such as gloves and aprons were available to enable crews to protect themselves and patients from transfer of infection. We saw that staff were provided with uniforms to wear while at work which reduced the risk of cross infection.

**Environment and equipment**

- Senior managers informed us that all equipment was up to date with servicing and maintenance. They said all equipment had been tested when the company took over the business in June 2016. We were provided with an electronic spread sheet which showed each vehicle and the equipment contained within it. Dates were recorded to show when the equipment had been serviced or maintained and when next due. There was no information regarding who had carried out the servicing. . However, the provider has informed us since the inspection this was carried out by an external company. At the time of our inspection, records were available for all ambulances to include MOT and servicing records.
- All vehicles had a check carried out by the staff at the start of their shift. Drivers conducted weekly checks on tyre pressure, tread wear, fluid levels and bulb checks. Equipment for checking tyre pressures was available at each station and stored in the office to prevent loss. The ambulances were stored either in or outside of the stations so the tyre pressures could be checked when cold.
- Defects were reported to the team leader and also recorded on the staff hand held electronic device to inform the control room staff. The control staff had responsibility for booking vehicles in for large repairs and service issues. The team leader for Redruth oversaw the routine servicing and repair programme for vehicles. Previously agreed services were used, for example a garage locally undertook repairs and a tyre specialist company dealt with all repairs and tyre changes. Repairs, MOTs and servicing checks were monitored and recorded in individual vehicles logs, on a whiteboard and electronic spread sheet by the team leader.
- Actions were planned in response to identified defects but some delays in repair were seen.
- We looked at eight vehicles that were used to transport patients; seven of these were ambulances and one car. We found that improvements were needed to ensure that these were ready and safe to use to transport patients.
- Records showed some delays in repair. For example on one ambulance, a side door was broken and letting rain in noted 31/03/2017. The vehicle had been sent for external repair 24/04/2017. A record for the same vehicle noted that the rear door had not been closing properly since 26/08/2016, the side door not closing properly since 10/11/2017 and the side rear door not closing properly since 04/01/2017. The vehicle was judged to be safe by the team leader 31/03/2017. We asked for, but were not provided with, evidence to demonstrate any formalised training or qualifications for team leaders to make these judgements. There was no evidence in the log to confirm that repairs had taken place.
- A further vehicle was seen to have a broken side step which had been taped into position so it could not be used. Patients were required to use the back door of the ambulance. A defect report had been completed and the ambulance deemed suitable for use in the interim.
- Two vehicles had seats with a broken armrest. Staff said they used the seatbelt to secure into position. The staff said a defect form had been submitted but no action taken. One member of staff said the vehicle had remained in a defective condition for 12 months.
- One of these vehicles also had a tail ramplift that was not secured in place. This could be a risk to staff and members of the public. The ambulance was used to transport bariatric patients and had equipment in place to assist with moving and handling. We noted that when the stretcher was in position in the ambulance there was insufficient room to have both side rails extended. This did not ensure safety for patients being transported.
- We saw vehicles that had sustained external damage which staff informed us were still in use. For example, a rear light was broken, plastic trim missing, side mirror broken and a fog light broken across three vehicles.
- During the inspection we were told Tthere were no dedicated spare vehicles in reserve should a vehicle develop a sudden fault. The team leader organised that one vehicle would not be working each day to coincide with the staff rota. This enabled a vehicle to be available if needed. Should a vehicle break down, this spare vehicle would be sent to transfer the patients. We observed and staff told us during the inspection that there were two vehicles which were not available for use due to the requirement of repairs. Following the

inspection the provider advised us that there were three spare vehicles to provide a back up service. Staff, including senior staff, were not aware of this when we spoke with them during the inspection..

- Records identified that fire extinguishers were checked annually by an external service contractor.
- A recent fire risk assessment had been completed and fire alarms fitted. Some checks were still waiting to be completed, for example the assessment of any asbestos in the building.
- Staff had access to safety equipment to transport patients to and from the ambulances and ensure they were safe during the journey. For example, lap belt restraint on stretchers and wheelchairs were in place. Staff had access to child seats and restraints to ensure children were safe during any journeys.
- Staff had no specific training on the use of equipment. Some of the staff were not confident in the use of the equipment within the ambulance. For example, the use of bariatric stretchers and winch. One bariatric ambulance was available at each depot. We were told that training had been provided to some staff regarding the use of these specialist stretchers and should their use be required only trained and competent staff would transport the patient. We were told that training had been provided to some staff regarding the use of these specialist stretchers and should their use be required only trained and competent staff would transport the patient. The provider informed us that the rotas were arranged to ensure that only appropriately trained staff provided a service to patients who required such specialist equipIt was not clear how the control room staff would be aware of individual staff member's competencies and allocate work accordingly.
- Procedures were in place for staff to follow regarding the security of the ambulance stations and vehicles. However, we saw evidence which showed staff did not consistently follow this guidance and the security arrangements at each station varied.
- At Redruth the station was secured when staff were not available and closed overnight. The ambulances were stored both inside and outside of the station. There was no security in place overnight and there was a notice in place advising staff of the close down procedure and noting that ambulances may have been tampered with. This served to remind staff of this possibility when carrying out the first checks of the day.
- At Saltash station the office was sometimes empty and so was locked and the alarm switched on. The location was within a storage facility which meant that at night the main gates were closed and staff had an access code if needed.
- At Bodmin station when staff were not in the station they locked the doors and closed the unit. We were made aware at inspection that there had been an occasion one morning when staff had left the station unmanned and open. This meant that there was a risk of unauthorised access to the office and ambulances and poses a significant risk. This had been reported internally as an incident and the senior management made aware. Staff had been reminded of the importance of security when leaving the buildings.
- Key cupboards were observed at Bodmin station to be left unlocked; this meant that there was potential access to all ambulances. On the first day of our inspection we noted four sets of keys in the unlocked cupboard.
- A key box system was in place for staff to insert those vehicles not fit for road use. The box was locked and so the keys could not be retrieved except by the team leader. This meant that there was no risk that vehicles awaiting repair or service could inadvertently be used.
- We observed that the vehicle access doors were the only means of entry being used at Redruth station. The pedestrian door was locked on 19 May 2017. This meant that both vehicles and pedestrians were using the same entry and exit and may place people at risk. At Bodmin station both pedestrian and vehicle doors were unlocked, with the vehicle door remaining open during our inspection. Staff came in through the vehicle entrance and did not always use the pedestrian entrance.

**Medicines**

- Medicines were not stored or provided by ambulance staff. This was with the exception of medical oxygen which was available if prescribed.
- Oxygen storage at Saltash was in a secure cage outside of the office. The cylinders were stored in a rack to

prevent them falling over. Crews confirmed the cylinders were stored upside down when empty and the oxygen supplier would monitor and replace cylinders when needed. Crew confirmed the system in place was effective.

- Oxygen storage at Redruth was not secure. There were two cages to separate empty and full cylinders. The cylinder storage cage had racking to prevent the cylinders from falling over. However, we noted that the 'empty' cylinders were not completely empty with several having approximately a third of their contents remaining. The cage holding the empty cylinders did not have any racking to prevent cylinders from falling over. This put staff and delivery staff at risk from injury when moving cylinders.
- In Redruth the oxygen cage was located directly under the main building electrical point and fuse board. We escalated our concern regarding inappropriate oxygen storage to the management at the time of inspection. In the event of oxygen leakage and an enriching of the oxygen in the air, a tripping fuse with a spark has the potential to ignite an oxygen rich atmosphere. When we raised this management were responsive to this and began moving the cage. It is of concern that this high risk positioning of the cage is a basic health and safety consideration and should have been assessed within the company's fire risk assessment.
- Both Bodmin and Redruth stations oxygen cages were unlocked and the combination locks left open. We were told that the keys were missing, although they were combination locks.
- Nitrous oxide combined with oxygen was carried in cylinders in some ambulances. This is a medical gas used for the relief of pain. These had been left in place from the ambulances' previous use and staff indicated that when the cylinders expire they will be removed. These cylinders had not been removed despite staff not having the suitable skills to administer the medical gas. This ran the risk of staff administering gas that they were not trained and competent to administer.
- First aid kits were carried in all ambulances and in some ambulances staff had access to an additional burns kit. It was not clear when these would be required as staff did not provide an emergency response service only a planned patient transport service.
- Instructions were available to staff on the transportation of patient's own medicines and about the transportation procedure and handover of controlled medicines. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Examples include: morphine and pethidine.

**Records**

- E-Zec used a nationally recognised system of information technology which provided software for patient transport services. The system provided support to the call centre during call taking, dispatch and incident tracking. Each crew member had a pin number to access the system which provided them with information and detail relating to each patient journey.
- Specific information relating to the patient was passed to the staff through on the hand held electronic device. If patients carried paper records with them, they were stored with the patient's property. The staff recorded detail of care and treatment provided to patients transported throughout the day on their electronic hand held device. If a patient required an intervention there was no way to record this to pass onto the receiving centre or care home as they were not able to print or send electronic records to the hospital or care home.
- The operations manager told us that all driving licenses were checked to ensure staff were licensed to drive the correct class of vehicle and did not have any driving convictions that would affect the organisation. Driving licenses were checked via the Driver and Vehicle Licensing Agency (DVLA). Drivers were requested to send an authorisation code which allowed managers to view their driving license in detail including any recent convictions. We asked to see evidence of the checks carried out for staff working for E-Zec and were provided with a spread sheet. There were 89 members of staff on the spread sheet who had been checked and were suitable to drive the organisations vehicles. This left 12 members of staff outstanding when considered against the number of staff we were told the organisation employed.

**Safeguarding**

- The E-Zec safeguarding policy (review date due 2017) identified adults at risk and provided definitions of types

of abuse and included reference to the Mental Capacity Act (2005). The policy provided a flow chart to advise staff of immediate actions to take to raise a safeguarding alert. We saw records of when staff had concerns and had raised alerts with the local authority safeguarding service. There was also a standard operating procedure for the transport of patients under the age of 18. A further policy identified that should a patient be under 16 years old an escort must be in place. Patients under the age of 18 would not be transported in an ambulance with other patients.

- Safeguarding training was generic and we could not ascertain the level of safeguarding staff were trained to. National guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that all ambulance staff including communication staff should be trained to level two. This applies to all clinical and non-clinical staff that have contact with children/young people and parents/carers. Due to the format of the training information we were unable to ascertain the number of staff who had completed safeguarding training to an appropriate level.
- We found that from January 2017 to May 2017 there had been 10 safeguarding referrals submitted by staff who were concerned about patients they had transported.
- We reviewed a safeguarding folder that contained all safeguarding concerns raised by staff and actions taken and reported to relevant safeguarding agencies. This evidenced that where staff had concerns for patients in their care appropriate action had been taken to safeguard them from abuse. Staff confirmed that they did not receive any feedback from alerts made.

**Mandatory training**

- All new staff were required to complete an induction training programme at the start of their employment. We requested information on the content of this training and were provided with the following list of subjects; understanding the staff member's role, personal development, duty of care, equality and diversity, work in a person centred way (including the Mental Capacity Act), communication, privacy and dignity, fluid and nutrition (for example, diabetic patients and their transport delays), awareness of mental health, dementia and learning disabilities, safeguarding adults, safeguarding children, basic life support (including types of medical patients and their management), health and safety, handling information – governance and infection prevention and control.
- The induction training took place over five full days. We were provided with a copy of a recent induction training programme which had been delivered to ambulance care staff and found a number of the topics covered between 9 am and 12.15pm on one morning constituted part of the mandatory training. The topics were safeguarding children and vulnerable adults, conflict resolution, capacity of consent and Caldicott principles, greener driving and carbon footprint and fire awareness. The time allowed to cover all of these subjects, some of which are complex, did not appear to enable sufficient staff learning, discussion and reflection.
- A programme of mandatory training was in place for all staff. This included face to face training and e-learning which was accessed via the staff portal. Staff were provided with access to the portal which could be used on computers in the ambulance stations or from home. The provider told us that "all mandatory training is determined essential by E-Zec for safe and efficient provision of a service to our commissioners and service users in order to reduce organisational risks and comply with policies, procedures and compliance guidelines."
- We asked for the topics which were considered mandatory and as such essential that staff completed. Mandatory training varied for the role carried out. We were provided with the following information that all E-Zec staff are required to complete; confidentiality/ consent, counter fraud, health and safety, medicines management, medical devices and equipment, infection control, fire, information governance, safeguarding adults and children, conflict resolution, equality and diversity, manual handling and safer people moving and control of hazardous substances.
- Additional role specific mandatory training for ambulance crew staff employed in Cornwall included intermediate life support and patient transport driving assessment.

- The e-learning training packages consisted mainly of PowerPoint slides or documents that were written in-house. There was no method for management or training lead staff to review the content or effectiveness of these training packages.
- The provider informed us that the training department were able to monitor staff compliance with completing the online training. We asked for evidence of the compliance rates for staff completion of the e-learning. We were provided with a sample of a small number of staff who had accessed the on line training portal. This did not provide us with evidence of the overall staff compliance. It is not clear how the organisation ensured that all staff remained up to date with their mandatory on line training.
- Face to face training within the organisation was the responsibility of three named trainers who worked nationally across the organisation. We were provided with information about, but no evidence, of their qualifications. All three trainers were paramedics who we were told had completed additional teaching qualifications.
- The organisation's trainers delivered first aid training to front line staff. The trainer's qualifications met the recommended national standards set down by Skills for Health. We were told about their qualifications but did not see evidence of these. We were told that in the Cornwall service one ambulance care assistant trained all other staff in Cardio Pulmonary Resuscitation (CPR) and that they had a St Johns first aid qualification. There was no record maintained of their certification to provide assurance they were suitably trained for this role. This training did not include CPR for children.
- No staff that we spoke with during the inspection had received an appraisal or discussed their training needs with their manager. The training policy and procedure for staff regarding their training stated that their annual appraisal process was designed to identify training and development needs and assist individuals to successfully complete the requirements of their job and improve their performance.
- We asked the provider for a training matrix to provide an overview of the training completed by staff employed by E-Zec. We were provided with a list of staff with some training listed next to their name and the date of when the training was next due to be undertaken. This did not give an overview of all of the mandatory training required to be completed by each individual, when it had been completed and when it was due to be updated. We noted that staff had not all completed the same amount of training; the least training completed by a member of staff was one episode of training and the most training undertaken was four episodes. There were the names of 82 members of staff on the matrix which left a lack of training information for the remaining19 members of staff employed in E-Zec Cornwall. We were therefore unable to assess compliance with the mandatory training for all of the staff.
- Not all staff were up to date with their mandatory training. A further spread sheet provided showed that 15 members of staff had 'missed training requirements' to complete bariatric training. A further seven members of staff were required to complete annual skills development training as theirs had expired, three staff required safer people moving training and five basic life support.
- Staff consistently told us they had not been provided with update training since transferring to E-Zec from their previous employer. Comments included "I have had no training with E-Zec at all – I have been reassessed by the training coordinator for CPR [cardio pulmonary resuscitation] – but that's all", "I have had no paediatric life support training" and "I feel like my training is not up to date – I know I need to do this, but I've not been assessed for CPR for two years. I don't know what training I should have and don't know who to ask about this".
- Staff training records held at the ambulance stations were incomplete and did not give assurance that mandatory training had been completed in full. Staff training records were seen for three crew members, and varied in their level of completion. The team leader confirmed they would expect to see a training record to include induction, first aid at work, CPR, infection control, moving and handling, safeguarding, oxygen management, consent and control of haemorrhage. In none of the three files we reviewed were full records

available to show the mandatory training completed. We did not see any evidence of training in dementia care, learning disability or mental capacity and Deprivation of Liberty.

- Staff told us that some training topics were provided in an electronic format. We reviewed an electronic matrix which was also not fully completed. We discussed this with senior management who did not recognise the matrix that had been developed and stated it was not accurate as it was not consistent with the organisation's training records.

**Assessing and responding to patient risk**

- Risk assessments were undertaken when staff identified that a patient may have specific needs. We saw evidence of risk assessments being completed prior to a journey being commenced. This ensured a successful service delivery and avoided delays and disappointment. Some risk assessments were carried out on site and others were undertaken on the telephone; staff we spoke to were unable to clarify when a telephone risk assessment would be appropriate or sufficient.
- Staff used the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach to assess patients. Should a patient be identified as deteriorating during the journey, staff we spoke with were clear of the action they would take. We were told the ambulance would pull over to a point of safety and a NHS emergency ambulance be called. All crews were trained to resuscitate adults, but not children. We noted and staff confirmed that there were no defibrillators carried to attempt further resuscitation. There is however, no specific requirement for ambulances providing patient transfer services to carry defibrillators.
- Staff did not have access to training to support patients with mental health needs. Should those patients being transferred have a deterioration in their mental wellbeing, crews would stop the journey and request support and advice from the control room. This would provide a risk to staff and patients if staff were not able to de-escalate or manage the situation.
- Staff expressed concern that they were asked to transport up to four patients together on one vehicle with differing care needs. We were provided with an example where three patients were transported together. One patient was living with dementia, one required stretcher transport and oxygen and the third patient required wheelchair transport and oxygen therapy. The staff were concerned that to enable the patient on the stretcher to leave the vehicle the other two patients had to be taken off the vehicle to make room and had to wait outside. When patients required assistance to access their home or treatment centre, other patients were left unattended on the vehicle. Staff were concerned that at times they had left patients living with dementia alone or with another patient. The member of staff told us they had raised this by telephone with their manager but not completed an incident report. In addition we saw complaints that referred to this practice.

**Staffing**

- The organisation told us there was a robust recruitment procedure which included face to face interviews and checks made to ensure the applicant was suitable to work with vulnerable adults and children. These checks included references from previous employers and a disclosure and barring service check. We were unable to ascertain the robustness of staff recruitment as personnel files were held at head office and therefore not available for inspection during the Cornwall unannounced inspection process. We requested information from the organisation regarding any auditing and monitoring they carried out to ensure the recruitment procedures were robust and all information in place. We did not receive this but instead received detail of the process followed. Therefore we were not assured how the recruitment process was monitored.
- The provider told us there had been difficulties when taking on the service in Cornwall due to a lack of information provided to the organisation regarding the numbers of patient journeys required. The provider considered key performance indicators showed signs of improvement following additional vehicles being made available and the employment of more staff. However, we did not see the data evidence to support this.
- All staff had category B licences which enabled them to drive the vehicles used by the organisation, and a driving assessment was part of the interview process. We saw two of these assessments being undertaken by applicants and a team leader who was a qualified assessor. The driving assessment comprised of 16

categories and basic driving standards. The provider had implemented a scoring system was used which an applicant would need to achieve the pass rate in order to proceed in the application process.

- Crew allocation and rotas were undertaken by the operations manager. A new rostering system had recently been implemented which was a rolling rota which allocated staff to be in a consistent team and regularly in the same ambulance. Staff told us that 'bank' staff were sometimes used at the weekends. However, we were later told that the 'bank' staff were employees of E-Zec who were doing additional hours. This meant the organisation were aware of the competencies of the staff member when allocating patient transport journeys. At times of sickness or annual leave staff worked alone as there were insufficient staff to replace a crew member. We spoke with one member of staff who told us that in a four week period they had worked alone with the exception of two shifts where an additional member of staff had been provided. This reduced the number of patients they were able to provide a service to as the patient was required to be mobile and not have any additional needs such as mental health issues. The staff told us they had not reported these as incidents as the management and control room were aware of the situation. It was not clear how such staffing issues were monitored or addressed.
- Staff consistently reported to us that they did not always have time for their comfort or meal breaks due to the planned transport allocated to them to complete. They all agreed there needed to be additional staff on each shift. The provider had recognised that additional staff and vehicles were required to meet the service demands and to this end a recruitment drive was on going.
- There was no shift brief each day. Staff attended the office, checked their vehicle and collected the work for that day. If no work was planned for a period of time, the staff would wait at the nearby trust for further instruction.

**Response to major incidents**

- The service had a major incident plan policy but staff we spoke with were not aware of this and were unsure of their role in the event of a major incident or business interruption due to adverse events.
- Staff told us they had not been provided with any training to enable them to be knowledgeable on how to deal with any major incidents.

## Are patient transport services effective?

**Evidence-based care and treatment**

- Local policies were available in paper format or electronically in the stations. Staff we spoke with said they knew there were policies and procedures and were able to locate the paper copies. Staff knew the policies were available via the provider's intranet knows as 'The Hub', but not all staff had regular access to them. Five members of staff we spoke with while knowing the policies were on the intranet, stated they did not know where to locate them.
- Senior management were confident that the policies and procedures followed national guidelines and that staff regularly accessed the electronic system to read them. They expressed surprise that staff had told us this did not happen. We did note that policies and procedures did reference national best practice guidelines. For example the National Institute of Clinical Excellence (NICE)
- Although many of the policies and procedures we reviewed did contain references to national guidance, this did not ensure that staff were following the up to date guidance and procedures. The provider could not give us any evidence that showed the staff had been provided with support and guidance to access the policies and procedures on line.

**Assessment and planning of care**

- The control centre provided initial information to the staff, via the hand held electronic device, regarding the planned transport journey and the specific needs and risks for individual patients.
- Staff went out in one or two person crews. Should a one person crew attend a journey which was not safe to undertake alone, the job would be reallocated. A lone working policy was available to all staff.

- The administrator at Bodmin station explained that they ring all of the planned journey patients for the following day to ensure the service was still needed. This reduced last minute cancellations. They also rang the hospital to check a patient's location.
- Staff told us the service did not provide food and drinks for patients. If a patient required food and drinks during long transfers then the service would stop at a service station for them.

**Response times and patient outcomes**

- The service used a recognised electronic software system to follow ambulance routes and track journeys. This enabled the control centre to see on scene and turnaround times, if the ambulance was switched on or off or was idling. This provided information to the organisation of patient time spent in the vehicle and any delays. Each hand held device was vehicle specific to prevent any confusion and identified which member of staff was driving.
- We had received information prior to the inspection that patient journeys were not carried out in a timely manner or at the time agreed with the patients. Staff confirmed that at times they were late to collect patients which had impacted on the attendance of the patient at their appointment. We asked to see audit outcomes of key performance indicators such as times of collection of patients and the monitoring of delays and aborted journeys. We were provided with a monthly review which included a number of key performance indicators.
- We saw that the organisation monitored the number of patients who arrived at their ultimate destination up to 30 minutes before their appointment time, up to 45 minutes before their appointment time and prior to their appointments.
- Between October 2016 and April 2017 the organisation consistently met the target set of 50% of patients arriving at their destination up to 30 minutes before the appointment time.
- A target of 90% of patients had been set to arrive at their destination up to 45 minutes before their appointment time. Between October 2016 and April 2017 the organisation failed this target each month, ranging from between 64% and 70% of patients arriving in this time frame.
- The organisation had identified a target of 90% of patients arriving at their ultimate destination prior to their appointment time. Between October 2016 and April 2017 the organisation failed this target each month, with between 70% and 76% of patients arriving prior to their appointment. 75% of patients arrived at their appointment prior to it.
- This meant that patients could not be confident they would arrive on time for their appointment. We did not see an action plan which would identify either the cause of the delays, or how the organisation planned to improve these key performance indicators.
- The organisation also monitored collection times for patients who attended hospital regularly for renal care and treatment. A target had been set at 90% of renal patients to arrive at their appointment up to 30 minutes prior to the agreed appointment time. However, between October 2016 and April 2017 the organisation failed this target each month, with between 55% and 67% of patients arriving in this time frame. This did not ensure compliance with the standards recommended by the National Institute of Clinical Guidelines (NICE). We did not see an action plan which would identify how the organisation planned to improve these key performance indicators.
- The organisation monitored performance against a target of 50% of patients who were collected at their agreed discharge/ready time up to 30 minutes after the identified ready time. Between October 2016 and April 2017 this target had been consistently met with between 50% to 59% of patients being collected within 30 minutes after the agreed time.
- The organisation monitored performance against a target of 95% of patients who were collected at their agreed discharge/ready time up to 60 minutes after the identified ready time. Between October 2016 and April 2017 this target had not been met during any month with between 58 to 67% of patients being collected in the time frame. This meant that patients could not be

confident they would be collected for their journey at an agreed time. We did not see an action plan which would identify how the organisation planned to improve these key performance indicators.

- There were further key performance indicators recorded regarding the length of time patients should spend on the vehicle during their journey, taking into consideration the distance that they lived. The monitoring figures for January 2017 showed that the service failed the targets for patients living over 10 miles from their treatment centre.
- The electronic system was used to support staff. For example, if 'drop off' had not been clicked a call would be made to the crew from the control centre to ensure there was not a problem. A panic alarm was also included on the electronic hand held device which staff could use to alert the control room of a problem.
- The work allocation from the control centre was problematic to staff. Staff told us that the geographical distances and complexities of the county meant that sometimes the journeys planned were not appropriate. They said under those circumstances they would ring the control centre to explain but were told to 'just do your best'.
- The organisation had attempted to improve the service provided by the control room. Staff told us that recently a member of the control centre staff had visited the region and the insight had meant some improvement of understanding of the delays.
- However, some bookings for journeys were unrealistic. We saw that one crew were booked to pick up a patient at 13:15 to go to the hospital. The staff did not start their shift until 13:30 when they would initially carry out vehicle checks. The journey to the hospital was 45 minutes. Senior staff told us the organisation had a contractual agreement in place that enabled them to deliver patients up to one hour early for their appointment. However, this did not negate the delay in picking up the patient at the agreed time. Staff told us they found the delays difficult to deal with and did not like letting patients wait. They were aware that their delays impacted on clinic appointments.
- Three members of staff told us if they were running late they would contact the control room so that they could inform the hospital or patient. However, they said that often when they arrived at the hospital or patient's house the information had not been passed on.
- Staff also explained that the three stations did not deal exclusively with the local area and sometimes were sent to the far side of the county when the local station could have provided that service.
- The provider attributed some of the delays in transport to external providers. For example, when collecting patients who due to appointment times were not ready for the journey at the time agreed.

**Competent staff**

- Senior staff explained the programme of training provided to all staff which was intended to ensure they were competent and skilled to carry out their duties. There was a member of staff responsible nationally for collating training information, compliance rates and ensuring the training was fit for purpose. We were told there was a comprehensive induction training programme and on going mandatory and role specific training. Please see previous comments regarding training.
- There was a staff handbook which included advice for staff about driving and specifically speeding restrictions. Any speeding issues would be forwarded to head office. Each 12 months staff had a licence check to ensure records were updated and included any convictions which would affect the company.
- Staff told us the induction had involved them shadowing an ambulance crew for the day. Staff we spoke with said they had received no training around the use of equipment within the ambulance. When we asked staff to show us how to test certain equipment, they were unable to show us how to do this properly. For example, the use of a stretcher specifically designed for use when supporting bariatric patients. A senior manager told us they had provided training to some staff regarding the use of specific equipment but were unable to provide evidence of which staff and when the training had been provided.

- Staff we spoke with had not received formal or informal supervision or appraisals with their managers to discuss any training or work related needs they may have identified themselves.
- Senior staff told us that all staff received an annual appraisal and met with their managers regularly to discuss any extra support they may need. The registered manager was on annual leave during the inspection. We were told by senior managers that the appraisal and supervision records were held by the registered manager and therefore this information was not accessible when they were not on duty. This did not ensure that the organisation had prompt access to staff employment information or oversight of any issues which may be required at any time.
- Following the inspection we asked for data regarding staff appraisals to evidence that this process was in place and that the organisation were able to monitor compliance. We were told “staff appraisals are conducted yearly unless areas of concern are raised by management or the staff themselves”. This did not provide assurance that the appraisals were up to date and that staff were supported within their roles.
- We asked for data relating to the provision of on going supervision for staff. We were told “all new staff worked with an experienced staff member as part of their probationary period. No new member will work solo until they are fully competent”. This indicates that the organisation does not have a programme of on going supervision to support staff or systems in place to performance manage staff who need support to improve.

  We were told “all new staff worked with an experienced staff member as part of their probationary period. No new member will work solo until they are fully competent”. This indicated that the organisation did not have a programme of on-going supervision to support staff or systems in place to performance manage staff who needed support to improve. Following the inspection the provider informed us that while they did not have any documented evidence and therefore a formal system in place, all new staff were monitored by other staff and team leaders. The provider added that should any competency issues arise these would be escalated to 'compliance'. It was not clear how the newly appointed staff member was included in this process.

**Coordination with other providers and multi-disciplinary working**

- A monthly meeting took place when senior staff from E-Zec met with colleagues from the acute NHS trust and the commissioning group. This enabled a face to face discussion to take place regarding the service and any developments or changes required.
- Staff we spoke with were not aware of coordination with other providers of patient transport services. They knew that work was sometimes passed to or received from other ambulance services but did not know how this process worked.
- A member of staff was employed to work as a liaison officer at the local district general hospital and we were told they were based within the hospital discharge lounge. This person’s role was to communicate between the wards and departments and the ambulance control centre regarding planning patient journeys. Staff were aware of the role and told us it was helpful to ensure accurate information about patient journeys was obtained and helped prevent delays. We spoke with a representative from the acute trust who made positive comments about this role and how this helped improve communications within the hospital. We were also told that following our inspection, another member of E-Zec staff had been recruited to work within the transport office at the acute trust to further improve communications. This was viewed favourably by the trust.
- Information about the running of the service and communication with other providers was provided to staff through email and bulletins placed on notice boards. Staff told us there had been no team meetings as it was difficult getting everyone together in the office. This did not promote working relationships within the organisation or understanding of wider working.

**Access to information**

- Some ambulances were fitted with up to date and effective satellite navigation systems. However, some staff informed us that they brought their own to work to

use during their shift as the systems in place did not always work effectively. We observed one member of staff carrying out checks on an ambulance which did not have a satellite navigation system. The ambulance had not had a working navigation system in place for at least two weeks although there was an action plan in place to address this. This did not ensure that staff would be able to make journeys in an effective and timely manner.

- Do not attempt resuscitation and treatment escalation plans were available in most instances to ambulance crews. When patient information was gathered by the control room any advanced patient directives were included to ensure crews were aware of any decision made about resuscitation. The hand held electronic device included notification to staff of a resuscitation decision. Staff had to identify they had read the plan before the electronic system would continue. The resuscitation decisions were not available for all patients.
- A standard Operating Procedure was in place for do not attempt resuscitation decisions (review date 2017) and a policy was available to staff for advanced decisions to refuse treatment. This ensured that staff were informed of the action they were required to take ensure patient's wishes were respected. However as previously mentioned, it was not clear that all staff had read and understood these procedures.
- General information for staff was accessed through the staff portal which all staff had log in details for. The staff portal stored a range of information including policies and training information booklets. Again it was not clear which staff had read and understood the procedures and policies. Senior management stated that the electronic software identified which staff members had accessed the portal and when but there was not an overview or monitoring to provide an audit trail of this.

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

- At the time of our inspection staff stated they had not yet received training on Mental Capacity Act and Deprivation of Liberty Safeguards. We were provided with an overview of the induction training content which identified the Mental Capacity Act and consent was included within this training. Not all staff had completed induction training when they transferred to E-Zec from its predecessor organisation. Two members of staff told us they had 'touched' on the Mental Capacity Act and consent during one training module but had had no specific training around this subject.
- Policies regarding the Mental Capacity Act were available to staff to support them. However, five members ofnot all staff we spoke with were aware of these policies or procedures and had not accessed them. Staff we spoke with did not have a clear awareness or understanding of the Mental Capacity Act, best interest decisions or consent. However, all staff agreed that they would seek the agreement of patients prior to assisting them with mobilisation or transporting them in their vehicle. Staff said they would not restrain patients during their journey. We did not see any evidence of restraint training or guidance for staff on this issue.
- The organisation provided a service when required to children. The Gillick competency is a test to identify children and young people under the age of 16 with the capacity to consent to their own treatment. The staff we spoke with did not know what Gillick competency was and had had no training regarding this. Therefore there was a risk that staff would not act in the best interest of a child or young person.

## Are patient transport services caring?

**Compassionate care**

- During the inspection we were not able to observe any patient journeys or direct care but noted that the staff spoke in a caring and insightful way of patients in their care.
- Feedback from a representative at the local acute trust was positive in that their observations of E-Zec staff found them to be kind and helpful.

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

- Eligibility to use E-Zec would be discussed by the control room staff and not ambulance staff at E-Zec. Information received by the control room would be

forwarded to staff via the PAD hand set. Any additional needs would be communicated in the same way. Any needs including interpreters for language and sign language would be organised by the control room.

- Staff were not aware of patients or relatives being involved in the plans to transfer. However, the administrative staff at Bodmin were seen to speak with patients and relatives to confirm journeys and so would discuss any issues raised at this time.

**Emotional support**

- The administrator at Bodmin station telephoned patients the day before their booked transport date. This was to ensure that the journey was still required and to answer any queries from the patient. When the administrator telephoned they were very sensitive to the risk of patients dying and family being upset. No training was provided for this role and we observed how well the administrator spoke with people and managed difficult and sensitive conversations well.

## Are patient transport services responsive to people's needs?
(for example, to feedback?)

**Service planning and delivery to meet the needs of local people**

- There had been some problems with delivery of the contract and the ability of the service to meet the contractual terms, due in part to issues that were inherited by E-Zec when they took over the service. Whilst these problems have continued, the Kernow Clinical Commissioning Group (KCCG) report very good engagement with senior managers at E-Zec who we were told were open and transparent with the KCCG. They had demonstrated a willingness to improve through proactive communication of issues, development of action plans and monthly contractual meetings, including monitoring of performance and on going issues with delivery. The KCCG reported some quality issues and concerns that were picked up on inspection, and have already been covered elsewhere in this report.
- A representative from the local NHS acute trust confirmed that they also attended these monthly meetings and that the meetings were useful to raise and discuss areas that were working well and those that required improvement.
- Patient journeys were booked and planned by the control centre which was located within another registered location elsewhere in the country. We did not inspect this aspect of the service during this inspection as this will be carried out during an inspection of the registered location.
- There were issues identified with the booking of journeys which had not been addressed by the provider. The service tracked the locations of its ambulances; the issues included for example, journeys booked for staff prior to the start time of their shift and delays in picking up patients from home and hospital appointments. Staff we spoke with said they were often sent county wide for over an hour to get to a waiting patient and they could see other ambulances on the tracking software with nothing to do who were much closer.
- The control room staff were advised of specific issues regarding transport services in Cornwall within their induction training. These issues included there being only two major roads in the County, access to properties and additional traffic during the holiday season. However, difficulties in journey planning remained evident.
- Delayed transport journeys had been reported as incidents / complaints by local NHS trusts. We found that the detail of these incidents was contained in a monthly quality report collated by the national governance and complaints lead. In the March 2017 report we saw a number of delayed transport journeys which had resulted in poor outcomes for patients. For example, one patient whose pressure ulcer was potentially exacerbated by waiting for transport for two and a half hours. Three journeys were not able to be completed. This was due to when staff arrived on the ward they had not been made aware that the patient required bariatric equipment. These facilities were not available on the ambulance and therefore the staff could not take the patient home. Another patient had transport booked for mid-afternoon but when the transport had not arrived some six hours later, the ward cancelled the transport in order for the patient to

remain on the ward overnight. Another patient journey had been booked for 4.30pm but the transport did not arrive until 10.26pm. The patient had been sat alone in a closed outpatients department waiting for their transport.

- All work agreed by the control office was standard patient transfers. No higher dependency work was undertaken.

**Meeting people's individual needs**

- At the time of the inspection the statement of purpose identified that the service could be provided to the whole population. This included adults, children and people living with learning disabilities or an autistic disorder, those with mental health issues or detained under the mental health act, dementia or a sensory impairment.
- We asked how staff were trained to deliver quality care to these groups of people and how the ambulances were equipped to support their needs during transfer. Staff were not able to tell us of any specific equipment that would promote the safety and comfort of patients with specialised needs during their journeys. For example access to support for people with hearing loss and / or speech impairment access.
- Staff had not received specific training to enable them to provide a service for people with mental health conditions, learning disabilities or for people living with dementia.
- An incident had been reported and was being investigated following the conduct of staff members during and after the transportation of a patient with mental health issues. The information provided to us from the organisation indicated that staff were not fully aware of their responsibilities when providing a service to patients experiencing mental health issues. We were not able to evidence from the training records provided that all staff had completed training regarding the care of patients with mental health needs. The provider was in the process of investigating the incident and gave assurances that appropriate action would be taken once the investigation completed.
- The organisation had access to translation and interpretation services through the control room. Senior management told us that all staff had a mobile telephone and could ring the control room to access this service. Staff we spoke with were not aware of any access to translation and interpretation services.

**Access and flow**

- We had received a concern prior to the inspection that a member of the public had been unable to contact the service by telephone. The control room was operational 24 hours a day seven days a week to receive calls, manage bookings and respond to queries.

**Learning from complaints and concerns**

- Complaints were managed by the operations manager and the compliance manager. Team leaders and crew members were not involved unless called upon for information. We were advised that any outcome from complaints was fed back to the staff involved for learning and included on the patient's notes. However, it was not clear how the outcome was shared across all staff to ensure learning across the organisation.
- Crews confirmed that there were no information leaflets available within the ambulance to advise patients how to complain.
- From January to May 2017 there had been 23 registered complaints from patients in regards to the service received; a key theme was in lateness or non-arrival of booked transport.
- There had been 48 complaints in the same time period from two local NHS acute hospital trusts in relation to booking errors.
- During our inspection we reviewed 20 individual complaints. Each complaint had a log number to trace where the information was stored on the electronic database. We saw one complaint related to an issue concerning patient safety and the timeliness of the patient's transport. No outcome letter was stored in the file but a note stated this was 'on log'. It was not clear what learning or actions had taken place as a result of this complaint.
- The organisation responded to all complaints in a timely manner. Apologies were offered to the complainant where there had been an unavoidable

delay in response. The response letters did not inform complainants of the action to take if they were not satisfied with the outcome. This did not enable complainants to progress their concerns.

## Are patient transport services well-led?

**Vision and strategy for this this core service**

- The strategy and vision for E-Zec Medical Services Cornwall was provided to us by the organisation following the inspection. The five year strategy aim as detailed in the documentation was "The five year strategy is to move from being good, to being great, ensuring that the culture of caring underpins all that E-Zec Medical does".
- The document identified the vision and strategic values as "At E-Zec Medical we will ensure that we empower and support staff to make decisions, this might mean empowering organisational culture changes to promote best practice and behaviour by removing historical barriers to improvement. By reviewing Issues that might arise we will encourage the principle for learning and best practice in both the education and training areas. We will continually review policies and procedures for best patient care and maximise the use of technology as a lever for change".
- Staff we spoke with were unaware of the service's vision or strategy and had not been involved in its development. We did not see any information in the stations for staff to view and understand their role in achieving it. There was no information for staff regarding the vision and strategy within the job descriptions or staff contracts which we were shown by the organisation. Staff were not aware how they could access this information.

**Governance, risk management and quality measurement (and service overall if this is the main service provided)**

- We were told that performance monitoring, governance and risk issues were discussed and actions agreed at the board meetings. Following the inspection, Wwe requested the minutes for the past three board meetings but the directors of the organisation refused to supply this information. We were told "The Minutes of the meeting with the board meeting contain commercial sensitive information."This meant we could not assure ourselves that appropriate governance systems were in place and that issues were escalated to and actioned by the board.
- Although incident reporting was centralised and reported monthly within quality reports, there was no formal log of incidents or near misses. This meant the service had no overview of incident trends locally and therefore limited the service's ability to learn from incidents and near misses.
- The organisation had employed an external company to carry out risk assessments on both the Redruth and Bodmin ambulance stations. We were provided with a copy of the risk assessments for Redruth and Bodmin stations but were not provided with any written evidence of any action the provider had taken to reduce or rectify the identified risks. However, we noted during the inspection that some areas had been actioned for example, heating in the crew room at Bodmin station. The report had identified damage to the Bodmin station which potentially exposed asbestos. Asbestos is dangerous when in a damaged state. The provider told us this had been followed up with the landlord to resolve the situation. We were shown emails which had been sent concerning this to the landlord. The roof appeared to be made of asbestos and seemed to be intact but there was no risk assessment in place regarding this.
- The service used a red, amber, green (RAG) rated risk assessment form for when staff identified on going risks during the course of their work. The provider stated that initially risks would be reported as incidents using the appropriate recording form submitted to the manager. Information from this form would be used by the manager to record the incident as a risk if necessary. Staff were required to report incidents and risks to their manager immediately to prevent further risk occurring. The risk management policy highlighted that to fail to do this would be classed as misconduct.
- During the inspection senior staff, including managers, team leaders and governance leads, were not able to direct us to the forms which were used to enter risks onto the risk register or articulate the process for raising a risk or how they were reviewed and or managed. We were told the nominated individual was responsible for oversight of the risk register.

- The management of risk by senior management did not provide assurance of provider oversight. Senior management staff told us there was a national and local risk register in place. We requested this register to be sent to us following the inspection but were provided with a blank document. This showed that the date the risk was identified was recorded, who raised the issue, a RAG rating, outcome if risk not managed, action required and any update. This, when completed in full, would identify the action which the organisation had taken to reduce the risk to patients and staff during the provision of a service. We were unable to ascertain that appropriate risks were being identified or recorded, or if any action was taken in response to the identification of risks. There was no formal process in place for reviewing, moderating or ensuring controls were in place to mitigate any identified risk.
- Staff we spoke with, including team leaders were not confident in their ability to access data such as incident reports or risk assessments. This did not enable feedback to be provided to staff regarding up to date information on the action to take to reduce identified risks. Whilst we appreciate some systems were in place to monitor and promote safety, staff were not aware of changed practices or reduced risk.
- We saw an example of how risk management was not appropriately escalated to inform learning of risk. Staff told us ambulances were sometimes left unattended and unlocked while staff collected and moved patients. We checked a number of ambulances at the stations and found these were kept locked when unattended. However, one of the stations had recently been left unlocked with no staff present for a morning. A memo was pinned to a notice board in the staff room reminding staff of security procedures. When we spoke with the national Head of Governance and Complaints he was unaware of this incident. However, the nominated individual had been made aware of it and had been assured action had been taken locally to ensure the incident did not reoccur. However, the action was to pin up a reminder notice, which is not sufficient to prevent recurrence of a potentially serious risk.
- There was no evident systematic programme of clinical and internal audit in place to ensure staff were following the correct policies and procedures or to monitor quality and identify what actions should be taken.
- The service had a lone working policy in place to ensure the safety and welfare of staff whilst at work.

**Leadership / culture of service related to this core service**

- The organisation provided us with an organisational structure following the inspection. We saw that managers had clearly identified roles and lines of responsibility and accountability was evidenced within the national roles. The organisational structure did not include the registered manager of the Cornwall services or other locations within the organisation. Therefore staff were not provided with a full management organisational structure.
- Two new regional managers had recently been appointed and were due to commence duties the week after our inspection. The purpose of this was to provide additional support to registered and operational managers who potentially could become isolated.
- The registered manager was away from the office during our inspection and we were provided with support and information from the newly appointed operations manager and team leader. We were told that roles and responsibilities were clear between the registered manager, operations manager and team leaders, however these were not documented and staff were not clear about who was responsible for what.
- Staff we spoke with were generally negative towards the management within the service. When we explored this further we were told that the visibility of and support from senior and local managers was minimal and staff felt unsupported in their roles.
- Ambulance crew staff we spoke with were not clear on the roles and positions of managers for their station. Some staff could not inform us who their manager was and who they seek advice or guidance from should there be any issues.
- A manager's meeting took place for the Cornwall services each week which was attended by the registered manager, operations manager, patient transport liaison officer and the team leaders. Issues and incidents which had occurred within the Cornwall

locations were raised and discussed at this meeting. We were provided with written minutes from these meetings which identified issues raised and decisions made.

- During our inspection we observed that one team leader was unsure of the names of two oncoming staff and had to request their ID when we questioned who they were. This posed a security risk and highlighted the lack of cohesion of staff and management.
- The implementation of team meetings was a recent process and not yet fully established. We reviewed minutes from team meetings for April and May 2017. These minutes described staff concerns but did not provide a plan of action to address those concerns, and it was not clear if or how these concerns had been escalated to senior management.
- Staff told us there were very few opportunities to meet together as a team. Two members of staff said there had "never had a team meeting to discuss issues or raise concerns about patient safety – the last meeting we had was when E-Zec took over last year and that was the only time I've ever seen a manager above X and X [local managers]. "
- Following our inspection a full team meeting was called to which all staff were invited to discuss any concerns or issues they would like to raise. This was planned to be held in a central location and chaired by the nominated individual. This demonstrated good intention by the organisation to listen to staff and seek their views of the service.
- During our inspection, through discussion with staff and observation of notices, we found there was a disconnect between staff. This disconnect was founded in which predecessor organisation the staff had worked for. Staff had either been transitioned from one of two predecessor organisations or had commenced employment since E-Zec had been in position. Staff felt that dependent on their employment history, their terms and conditions were varied and that this hampered effective multi-disciplinary working. Some staff felt disadvantaged and this was apparent during discussions with them; they told us "those of us who came from x (previous employer) have better terms and conditions than those of us who were employed directly by E-Zec – we are discriminated against". A notice in the staff room about overtime was written in a way that could be seen as confirming that perception. However, staff had been transferred to E-zec following TUPE Regulations. The TUPE Regulations preserve employees' terms and conditions when a business or undertaking, or part of one, is transferred to a new employer.

**Public and staff engagement (local and service level if this is the main core service)**

- Patient surveys were undertaken monthly to review patient experience. The administrator at Bodmin telephoned five random patients each month and asked a serious of customer satisfaction questions. The answers were forwarded to the provider's head office. The outcomes of the surveys were collated into a monthly report. We saw that in February 2017, 25 patients were asked to respond to the survey and that most were satisfied or very satisfied with the service they had received. One person commented they were dissatisfied with the booking of the transport, the journey in the ambulance and that they would not recommend the service to their friends and family. Any positive or negative results were forwarded to the staff in question. We saw evidence of one patient's positive comments about the support provided by a staff member.
- We were not aware of any overview or monitoring of patient feedback to identify any themes of concerns or positive comments made. This did not promote learning or the instigation of change.
- There had previously been regular meetings with the registered managers and senior management team within the organisation. However, we were told that these meetings had ceased due to work pressures but were being reinstated. This would provide an opportunity for management staff to meet together and discuss common issues and themes across the company to drive improvement. Staff told us there were rarely any staff meetings and six members of staff said they had never been to a staff meeting. This did not enable staff to meet together to discuss changes, policies, procedures or share information.
- Staff representatives from each base met with local and senior managers. This was a new system to enable staff issues to be raised and discussed. Prior to our inspection there had been one meeting, at which the

topics brought by staff included pay and rotas. We were told that at the time of our inspections there had been no feedback to give to the staff. However, we were provided with an example where one member of staff had amended their working hours to support their need to work closer to home. This showed the organisation had listened and supported the member of staff in their working hours.

- The staff rota system had recently been changed and now meant staff worked with the same colleague on each shift. Staff told us there had been no consultation prior to implementing this rota. Staff were mixed in their opinion about the new way of working but all considered that engagement prior to the changes being made would have been beneficial.

**Innovation, improvement and sustainability**

- Staff and managers told us that team meetings were planned to be reintroduced to provide staff with a venue to share their views and raise any issues.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital MUST take to improve

**Action the provider MUST take to meet the regulations:**

- The provider must ensure that staff follow the formal incident reporting policy and procedure to enable all key information to be recorded and appropriate action taken.
- The provider must ensure that staff are aware of the principles of the Duty of Candour legislation.
- The provider must ensure that all areas used by or accessible to patients, members of the public or staff are clean and hygienic and promote the control of infection.
- The provider must ensure there is a satisfactory system in place to dispose of used and soiled linen in order to prevent the risk of cross infection and promote infection control.
- The provider must ensure all staff are trained and competent to carry out the roles they are employed for.
- The provider must ensure that staff are provided with formal supervision and appraisals to enable them to discuss training and work related needs with their managers in a structured manner.
- The provider must ensure that local managers have access to staff personnel records such as appraisals and supervision records.
- The provider must ensure that patients receiving a transport service are not placed at risk from being left alone on the vehicle or at risk from other patients.

### Action the hospital SHOULD take to improve

**Action the provider SHOULD take to improve**

- The service should ensure that a log is kept of incidents reported in order to identify themes and appropriate learning identified. Feedback should be provided to staff following the reporting of an incident to enable learning.
- The provider should ensure that staff were aware of the major incident plan policy and procedure and what their role would be within this.
- The service should ensure staff are appropriately trained to use and test equipment.
- The provider should ensure that a system is implemented for reviewing the effectiveness of the training packages.
- The provider should ensure that evidence of appropriate qualifications of staff employed to deliver the organisation's first aid training to front line staff is available.
- The provider should ensure staff are trained and briefed on how to respond to a major incident or adverse event promptly.
- The provider should ensure that a system to monitor and audit the effectiveness of the cleaning of ambulances and equipment be implemented.
- The provider should ensure that vehicles are fitted with appropriate and working equipment to ensure patient transport can be carried out effectively.
- The provider should ensure that ambulances are made secure when unattended, both at the stations and when out on journeys. The keys for ambulances parked at the station should also be held securely.
- The provider should ensure that medicinal gases not used by the staff be removed from ambulances to reduce the risk of administering gas that they are not trained and competent to administer.
- The provider should ensure that driving license checks are carried out for all staff to ensure the vehicles they drive comply with the categories on their licences and that previous motor convictions do not negate the company's insurance.
- The provider should ensure that patients can be confident they will be collected for their journey in a planned and timely way. The provider should ensure that sufficient staff are on duty to enable planned journeys to be carried out at the agreed time.

# Outstanding practice and areas for improvement

- The provider should promote working relationships between staff in the organisation and implement a system to ensure effective sharing of information takes place.
- The provider should implement a system to ensure that all staff had read and understood the standard operating procedures and policies. For example, regarding the Mental Capacity Act, Do Not Attempt Resuscitation decisions (review date 2017), advanced decisions to refuse treatment and Gillick competencies. The provider should ensure patients are advised of how to make a complaint.
- The registered provider should ensure that when risks are identified the risk register details any action taken or planned to reduce the risk. The provider should ensure staff are able to access the risk registers.
- The registered provider should ensure staff are provided with clarity on who their line manager is and the responsibilities and roles of the local management team.
- The provider should ensure that patient feedback was monitored to identify any themes or concerns.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>• Staff did not always follow the formal incident reporting procedure, therefore not all incidents or near misses were fully documented. |

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour<br>• Staff were not fully aware of the Duty of Candour legislation and principles. Therefore there was a risk that not all incidents or events which should be considered under Duty of Candour would be reported and dealt with appropriately. |

| Regulated activity | Regulation |
|---|---|
| Transport services, triage and medical advice provided remotely | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>• Not all areas of the environment or the equipment used in patient journeys were maintained in a clean and hygienic way which caused a risk of cross infection.<br>• Used linen was not disposed of in a manner which promoted the control of infection |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>• Records and documentation did not evidence that all staff were trained and competent to carry out their roles when providing a patient transport service. For example, to patients living with dementia, a learning disability or with mental health issues.<br>• Mandatory training records were not complete to evidence that all staff had completed the planned training programme.<br>• Not all staff had been trained in the use and the testing of the equipment they were required to use when transporting patients.<br>• There was no documentation to evidence that all staff had read and understood the policies and standard operating procedures of the organisation.<br>• Not all staff had not consistently received regular supervision, with their line manager, or an annual appraisal to discuss their role and any ongoing support or training needs.<br>• Records of appraisals which had been carried out were not available to the manager in charge at the time of the inspection. |

| Regulated activity | Regulation |
| --- | --- |
| Transport services, triage and medical advice provided remotely | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Patients were not always monitored by staff during their journey which potentially put them or others at risk. |