

E-Zec Medical Transport Services Ltd

E-zec Medical Transport - Bristol

Inspection report

Avonside Industrial Park
12 Feeder Road
Bristol
BS2 0UQ
Tel: 01737822782
www.E-zec.co.uk

Date of inspection visit: 24 January 2023
Date of publication: 24/03/2023

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

Ratings

Overall rating for this location	Requires Improvement	
Are services safe?	Requires Improvement	
Are services effective?	Inadequate	
Are services caring?	Good	
Are services responsive to people's needs?	Requires Improvement	
Are services well-led?	Requires Improvement	

Summary of findings

Overall summary

We carried out a comprehensive inspection of E-Zec Medical Transport Services - Bristol, as part of our inspection programme. We inspected all our key questions: safe, effective, caring, responsive and well led.

They were last inspected in March 2018 but were not rated as the Care Quality Commission did not have the legal powers at that time to rate independent ambulance services. They were issued with 2 requirement notices, 1 for Regulation 17 (Good governance) and the other for Regulation 19 (Fit and proper persons employed). We found at this inspection the service had made improvements to meet those requirement notices.

Before the inspection, we reviewed information we had about the provider, including information we had received and intelligence available.

Following the inspection, the provider was served a warning notice under Section 29 of the Health and Social Care Act 2008, requiring them to make significant improvements to the responsiveness of the service and to reduce long waiting times for some patients to be collected and returned following outpatients/dialysis appointments.

We rated this location as requires improvement because:

- Not all maintenance issues had been identified and storage of some chemicals was not safe.
- Some patients were subject to long waits for transport which was not acceptable and placed them at potential risk of harm. Some patients had missed vital hospital appointments and one patient had their treatment time reduced.
- Not all patients could access their transport when they needed it which impacted on their access to care and treatment at other health care providers.
- Not all staff knew how to manage complaints in line with the providers policy.
- There had been improvements with the recruitment practices of new staff, but systems and processes to check staff had a full employment history with gaps explored was not effective.
- There were no staff meetings at this location for managers to impart information to the whole team.

However:

- The service had enough staff with the skills and experience to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. They were above the providers target for completion of the yearly mandatory training day. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Managers monitored the service provision and staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. They provided emotional support to patients, families and carers.
- The service took account of patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems. Staff understood the service's vision and values, and how to apply them in their work. Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and staff were committed to improving services. They had plans to reduce their carbon footprint to protect the environment.

Summary of findings

- The provider automatically renewed all Disclosure and Barring Service checks every 3 years for staff to reduce the risks to patients.

Summary of findings

Our judgements about each of the main services

Service

Patient transport services

Rating

Requires Improvement



Summary of each main service

We rated this service as requires improvement because:
See above for details.

Summary of findings

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Summary of this inspection

Background to E-zec Medical Transport - Bristol

E-Zec Medical Transport -Bristol is operated by E-Zec Medical Transport Services Ltd. The service provides non-urgent, planned transport for adults and children with a medical need who need to be transported to and from NHS services, who are registered with a GP. Patients need to meet the eligibility criteria agreed with the Integrated Care Board (ICB) to access the service. They are commissioned by the ICB to serve the communities of Bristol, North Somerset and South Gloucestershire.

E-Zec Medical Transport Bristol's fleet consists of 49 vehicles, including cars, vehicles for transporting people in stretchers, and vehicles with wheelchair access. The service has a main base in Bristol where they have 2 premises, unit 4 and unit 12. Unit 12 is where the call centre and some managers are based. Unit 4 is where vehicles were stored, and staff could access supplies. There are 2 satellite bases in Yate and Nailsea. We did not visit the satellite bases.

There is a registered manager in post at this location. They are also a registered for another E-Zec Medical Transport location. Registered Managers have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The service is registered to provide the following regulated activity:

Transport services, triage and medical advice provided remotely.

The service provides approximately 71,600 patient transport journeys per year.

How we carried out this inspection

We carried out a short notice announced, comprehensive inspection on 24 January 2023. This was announced so the registered manager was present and there would be staff and patients available for our inspection team to speak with.

During our inspection we visited the main Bristol location and unit 4 where vehicles and other staff were present. We spoke with 14 members of staff, including senior managers from this location and the registered manager. We spoke with 4 patients. We observed patient care by joining 2 ambulance crews during their journeys to collect patients for appointments and reviewed patient records. We reviewed their policies, procedures and other documents relating to the running of the service.

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

Outstanding practice

We found the following outstanding practice:

- The provider and location were looking at ways to reduce their carbon footprint and the effect on the environment. They were using eco-friendly cleaning products and encouraging staff to drive more economically to reduce fuel consumption and their carbon footprint. Future plans included the use of electric vehicles.

Summary of this inspection

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations.

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

Action the service MUST take to improve:

- The service must ensure patients are not subject to long waiting times either to be picked up or returned home from appointments to reduce the risks of harm. Regulation 12(2)(a)
- The service must ensure the location is properly maintained and the identified issues with the toilet must be addressed. All chemicals covered by the COSHH regulations must always be stored securely to prevent the risks to staff and visitors. Regulation 15 (1)(a)(d)
- The service must ensure they address any issues with the environment and recruitment of staff to prevent staff, visitors and patients being placed at risk of harm. Regulation 17(2)(a)

Action the service SHOULD take to improve:

- The service should ensure the clinical waste bin is always locked. (Regulation 15(1)(a))
- The service should ensure all heaters in the vehicles are working. (Regulation 15 (1)(e))
- The service should consider reminding staff about the importance of re-stocking vehicles to make sure they have all the equipment they require.
- The service should consider implementing staff meetings for all staff to attend.
- The service should consider informing staff how to handle complaints in line with the providers policy.






Our findings

Overview of ratings

Our ratings for this location are:

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

Patient transport services

Safe	Requires Improvement 
Effective	Inadequate 
Caring	Good 
Responsive	Requires Improvement 
Well-led	Requires Improvement 

Is the service safe?

Requires Improvement 

We rated safe as requires improvement.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Staff took part in an annual skills development (ASD) day whereby they completed their yearly mandatory training. The target set by the provider was 85% and the staff at this location were at 91%. For e-learning the lowest score for one training module was 82% just under the target and several were 100%.

Staff completed the training required for all health and social care staff about learning disability and autism, which included how to interact appropriately with autistic patients and patients who had a learning disability.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff who had contact with patients were trained in level 2 safeguarding adults and children. The safeguarding leads for the provider were trained to level 4 in safeguarding adults and children. Training compliance was at 90% which was above the providers target of 85%.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. The provider had a safeguarding team who were contactable 24 hours a day. They were able to share their concerns with this team and they would make the safeguarding referrals to the relevant local authority.

Patient transport services

Staff followed safe procedures for children. They had several different seats available for children depending on their age and build. Children were always escorted by a parent or responsible person. In the event of sub-contracted services, the independent service was clear on their responsibilities for notification of safeguarding incidents. Senior managers told us as part of their contract, sub-contractors had to notify them of any safeguarding incidents.

Senior Managers told us that the Safeguarding Team did not always receive feedback from Local Authorities about safeguarding referrals made. If they did receive feedback, it would be shared with the staff who raised the concern.

We saw evidence the provider conducted Disclosure and Barring Service (DBS) checks for all operational staff and these were renewed every 3 years. For subcontractors, as part of their due diligence process, they saw a list each year of new staff DBS.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises mostly clean.

Areas were clean and had suitable furnishings which were clean and mostly maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly for unit 12. The cleaning was undertaken by a third-party provider and areas checked by a member of staff from the provider.

The vehicle garage at unit 4 had a 'make ready' area where vehicles were cleaned by staff. All cleaning equipment was colour-coded to ensure staff used the correct equipment on the correct part of the vehicle. Cleaning products were risk assessed in line with 'Control of Substances Hazardous to Health (COSHH) requirements. However, the cupboard where these cleaning products were stored was unlocked and the sign had fallen off the cupboard. This was reported to the senior managers during our inspection. We have not had confirmation this has been addressed.

We checked 5 vehicles. Most were clean but one was dusty on the inside and all were dirty on the outside due to the weather conditions. We were told staff would clean the outside after each shift. We did find sweet wrappers in 2 vehicles in the driver's side doors and 1 of these also had a used face mask and used cleaning wipe, on another vehicle there was a mud flap in the driver's side door. All vehicles had a supply of personal protective equipment (PPE), clean linen and hand cleansing gel. On one vehicle, the hand gel dispenser was leaking, and another vehicle did not have a supply of bags to dispose of linen.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff told us they cleaned equipment after patient contact and explained the products they used.

Each vehicle was scheduled for a deep clean every 12 weeks. We saw records of when some vehicles had been cleaned and when they were next due. Staff also cleaned the vehicle at the end of their shift. Staff completed records to document this had been done. Team leaders would randomly check vehicles after they had been cleaned. Any issues would be reported back to the staff.

Patient transport services

Ambulance care assistants (ACA) were made aware of specific infection and hygiene risks associated with individual patients. This information was taken at the booking of the transport and shared with ambulance care assistants. Staff were able to get advice and support regarding infection control matters from the provider's policies and procedures. They could also ask the team leaders for advice.

Seniors managers told us staff were given information on how to launder their uniforms and were advised to keep a spare at their location in case they needed to change.

Training for staff in infection prevent and control was at 81% which was just under the providers target.

Environment and equipment

The design and use of premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all areas of the premises were always well maintained.

The environment was properly designed for its use and mostly maintained. However, we found the staff toilet in Unit 12 had a loose toilet seat, a broken toilet roll holder, no lights and no sign to warn staff about the hot water from the tap. This was reported to the senior managers during our inspection. Following the inspection, the registered manager told us they had addressed these issues.

The service had 49 vehicles for the Bristol locations. We checked 5 vehicles. We found that vehicles were road worthy, well stocked, and most of the equipment was working and well-maintained. This was reported to one of the managers during our inspection.

Staff were able to restock their vehicles at the bases.

There were records of equipment maintenance and schedules. These included MOT's, servicing and when some of the vehicles required additional mechanical repairs for example, cam belt. Managers were able to see on their computer system all records relating to each vehicle and this included any defects.

Staff had a system to report faulty equipment. Staff reported any defects, and these were reviewed by the fleet manager who made the decision whether the vehicle was taken off the road. This was recorded on their computer system and on a white board, so the managers were able to see which vehicles have the faults and those which have been removed from service. Some staff told us some of the heaters in the vehicles were not working but they still had to use the vehicles.

Staff were trained to assess patients and their wheelchairs for safe transfer. Wheelchairs had to be 'crash tested' to be used on vehicles. If a patient's wheelchair had not been 'crash tested' patients would need to be transferred into a suitable wheelchair provided.

Staff told us they were trained during their induction how to use the equipment in the vehicles, and this included stretchers and, wheelchairs.

Equipment was available that was suitable for specific patient groups such as children. The service had several different types of equipment to use for when they carried children depending on their age. Patients of all ages were appropriately secured in the back of all vehicles.

Patient transport services

Ambulance care assistants had access to up to date satellite navigation systems and each vehicle was fitted with a tracker so their journeys could be monitored.

Staff disposed of clinical waste safely. However, we observed the clinical waste bin was open in unit 4. This was stored in the garage area and only staff had access.

Assessing and responding to patient risk

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

Staff were able to recognise and respond to patients who become ill during their journey. Staff worked in pairs with one member of crew in the rear of the ambulance. Staff closely observed patients and would request an emergency ambulance if required.

Staff responded promptly to any sudden deterioration in a patient's health. We were informed of an incident following the inspection where staff had to call for medical support. They followed the correct procedure when calling for medical support. Staff told us during the inspection the action they would take, and this included calling for an emergency ambulance. This was in line with the providers policy.

Staff at the call centre would complete a risk assessment for each patient when transport was requested. This included a standard list of questions for example, about mobility. Ambulance care assistants were able to undertake risk assessments of patients for example, in relation to wheelchairs and if they had been 'crash tested'.

Staff shared key information to keep patients safe when handing over their care to others. Staff used mobile handheld devices to update records. They provided full handovers to clinical staff, family members and support staff when patients got home.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The service had enough staff to keep patients safe. Senior managers told us they required 98 fulltime equivalent staff to meet their contractual requirements. Due to service demands they had increased this to 110 fulltime equivalents with the use of bank, overtime and sub contractors. Six new staff were due to start shortly on their induction programme. More new staff were due to start in the coming weeks which would mean they would reach their target of 110 full time equivalent by March this year. Recruitment roadshows had been taking place at different locations to encourage new starters.

The managers could adjust staffing levels daily to the needs of patients and demands of the service. Some days were busier than others with transports.

The service had a reducing turnover rate. The latest figure for December 2022 was 5.3% which equated to 4 ambulance care assistants leaving and 7 new members of staff starting.

Patient transport services

The service had high sickness rate in December at 8.5% This included staff on long term sickness. The target was 3%.

The service used bank staff or sub-contractors to fill any gaps in their rotas.

New staff had a 2-week induction programme which was classroom based and after this they had 12 weeks of mentoring with other members of experienced staff. They were not allowed to work alone until they had been assessed and signed off as competent.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff had access to patient notes on their hand-held mobile devices and included information such as vision problems, mobility or travel sickness.

We examined 5 patient records on their system. An assessment of the patients' needs was undertaken by the control staff at the point of request for transport. The tick box assessment of their needs included for example, if they needed aids to mobilise.

Ambulance care assistants were notified by the control room staff if patients had any infection control concerns such as COVID-19 or if they had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.

Records were stored securely.

Medicines

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

Vehicles carried and correctly stored oxygen cylinders, but no other medicines were held on vehicles. This was only used during an emergency.

If patients were discharged from hospital with medicines, these would be carried in their belongings and patients took charge of them.

Incidents

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

Staff knew what incidents to report and how to report them. Staff described how to report incidents and were updated with feedback and any lessons learnt. Staff were able to report incident via their hand-held devices. Incidents were then reviewed by a senior manager and investigation started. Managers investigated incidents thoroughly. Patients and their

Patient transport services

families were involved in these investigations. Managers were able to track all incidents on their computer systems and update them as required. In December 2022, 7 incidents were reported by staff and these included patient falls and verbally aggressive patient towards staff. These were under investigation and due to be completed at the time of our inspection.

Trends were identified from incidents, for example, missed journeys and staff attitude. Learning from incidents was shared with staff, for example, information was shared about staff attitude and the number of incidents has since decreased. A senior member of staff from the providers quality team collated the top 3 themes monthly in the region and these were shared with senior managers at each location during governance meetings.

Learning from incidents were shared locally and across the provider either by e-mail or by bulletins which were displayed at the bases.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The provider had a system for senior staff to follow if an incident met the threshold for duty of candour. This included a letter to be sent to the patient and/or their representative.

Senior managers at this location told us they were working towards using the Patient Safety Incident Response Framework as they provide NHS funded care. The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Is the service effective?

Inadequate 

We rated effective as inadequate.

Evidence-based care and treatment

The service provided care and treatment based on providers and national guidance. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The staff room had a noticeboard with updates, and these were loaded to mobile devices for staff convenience. Managers were able to check if staff had read new policies and procedures.

Each month the provider had a policy which they highlighted to staff. During our inspection, it was the interpretation policy, and this was displayed on noticeboards at the locations we visited.

The patient's eligibility for the service was assessed at the time of booking transport. Staff were aware of the NHS England eligibility criteria for patient transport service to ensure they transported appropriate patients.

Ambulance care assistants (ACA) were made aware by the staff booking the transport, of patients with specific needs, for example, mental health needs. Ambulance care assistants also received a handover when collecting patients from hospitals or care homes.

Patient transport services

Nutrition and hydration

Patients had access to water during the journeys.

Journeys planned took account of patient's hydration, feeding and toileting needs especially in rural areas where journey times might be long. Ambulance care assistants ensured that patients had been to the toilet before leaving. Patients had access to water on the vehicles if needed.

Response times

The service monitored but did not always meet the agreed response times and this did not facilitate good outcomes for patients. Some patients were waiting for unacceptable amounts of times to be collected and returned from appointments. This potentially placed them at risk of harm. They were using the findings to help make improvements.

Performance was monitored by Key Performance Indicators (KPI) from the provider and Integrated Care Board (ICB) who managed the contract for patient transport.

Senior managers told us there was on average about 5930 journeys per month, and about 71,160 journeys a year.

The KPI for arrival at outpatient appointment/dialysis session was 75 minutes before the appointment started. In December 2022, out of a total of 1808 journeys, 1339 (74%) met this. However, 469 (24%) did not meet this KPI. The target for the service to meet was 90% and this was set by the ICB.

The KPI for return journeys or post appointment/dialysis session was collection within 60 minutes. In December 2022, out of 1586 journeys, 1250 (78%) met this. However, 336 (22%) did not. The target was 90% again set by the ICB.

During our inspection we were shown records for one-week in November 2022 which showed 15 patients were waiting over 3 hours with some having up to 8-9 hours wait. On another week in November 2022, the records showed there were 30 patient who waited over 3 hours, and one patient aged 89 years waited 8 hours and 9 minutes to be collected. These waiting times posed risks to patients, especially those over 3 hours as often these were elderly patients. There was a risk of harm to patients for example, dehydration due to lack of fluid.

Senior staff sent us information following our inspection about delays for patients. From the 18 January 2023 to 31 January 2023, there were 11 incidents where patients waited between 2 to 4 hours to be collected from dialysis sessions. Patients post dialysis were often fatigued after spending several hours on dialysis. Those long waits impacted adversely on their health and well-being.

For the same timescale as above for outpatients' journeys to appointments, there were 78 incidents; 56 patients had long waits and 22 where the service was not able to provide transport. This meant some patients did not make their appointments.

During the same period for outpatient return journeys back to their home, there was 76 incidents, 75 were long waits and 1 where transport could not be provided. Patients were experiencing long waits or left stranded which placed them at risk.

Patient transport services

In December 2022, the number of patients waiting over 1 hour to be collected from an outpatient's appointment was 247. This figure had started to reduce as in October 2022 it was 285 and November 2022 it was 345.

The service also provided transport for patients who were being discharged from a local NHS hospital and their emergency department. We saw data on this which showed there were also issues with patients waiting for long time to be collected. For one patient waiting for discharge from the emergency department, they had to wait over 5 hours to be collected.

When the service identified patients, who has had a long wait, they were put on the 'service recovery board' system. This was where the next 5 journeys they took with this service were monitored and followed up to identify if there had been an improvement. However, while patients who experienced delays were monitored on their next journeys to improve their experience, other patients continued to experience delays.

A patient told us during our inspection they had their dialysis time reduced because they were late for the start of their session. They also told us on another occasion, they had to wait 4 hours after their outpatient appointment to be collected from the department. This patient had their dialysis treatment reduced due to their transport being late which put them at risk of treatment not being effective. Another patient told us they had to wait about 4 hours when their transport broke down and it took a long time to get a replacement vehicle. Senior managers told us this was a subcontractor who did not inform their contact centre until 1.5 hours post the vehicle breakdown. We were not assured systems and processes were effective to respond to patients and to ensure adequate oversight of activities when services were subcontracted.

Feedback we had received prior to the inspection was about patients missing appointments due to late transport and long wait times. This was fed back to the senior managers at the inspection.

The service discussed their performance monthly with the ICB and identified areas of improvement. The commissioner told us they were working with the senior managers to make improvements to the service provision and felt that staffing was an issue but with recruitment ongoing, and once up to full establishment, they were hoping to see an improvement and reduction in the long waiting times.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received training for their roles.

Managers gave all new staff a full induction tailored to their role before they started work. New staff undertook an induction programme. The first 2 weeks were classroom based. Following this, new staff were supported by a mentor. For call handling staff, they had a week of observing other staff in the call centre before taking up the role and they had access to a detailed induction programme that also included scenarios. During this period, all new staff had probation reviews at 4, 8 and 12 weeks. They had to be signed off as competent following this to be able to commence full duties. Probation reviews were at 96% for January 2023 with 3 waiting to be completed.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service was at 94% for appraisals. Eight of these were staff on long term sickness.

Patient transport services

There were no team meetings for staff to attend. Staff representatives met with senior staff at regular interval and minutes were taken of these and shared. Following the inspection the provider told us it was not feasible to have meetings for all staff due to the numbers. After consultation it was decided to have staff representatives meeting with senior managers to bring any concerns, issues or feedback.

Managers identified poor staff performance promptly and supported staff to improve. The provider had systems to support managers to assist staff in progressing.

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

The service used compliance with staff training and observed practice to make sure staff were competent in their role.

Multidisciplinary working

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

Staff worked with other health care disciplines and with other agencies when required to care for patients. Ambulance care assistants were informed of any specific care needs or if the patient had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) directive.

The provider had a patient transport liaison officer (PTLO) at each of the local NHS acute hospitals to support the hospital staff with booking transport appropriate for each patient. The PTLO liaised with the hospital staff to ensure patients being discharged were collected quickly as possible.

Health promotion

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

Staff were able to signpost patients to information promoting healthy lifestyles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their transport in line with legislation and guidance.

Patient transport services

When patients could not give consent, staff would ask family or their carers if they would use the transport. If a patient had dementia, they might not be able to have the capacity to consent and were often supported by family member or carers on the journey.

Control room staff recorded if a patient had a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) or a DNACPR. This was to make sure ambulance care assistants knew if a patient collapsed whether they needed to start resuscitation on them.

Staff received and kept up to date with training in the Mental Capacity Act. Ninety five percent of staff at the Bristol location which included the satellite locations, had completed this training.

The Deprivation of Liberty Safeguards were not relevant to this service.

Restraint was not used by staff and they would try to defuse the situation verbally. Staff had reported an incident of verbal aggression in December 2022.

Is the service caring?

Good 

Compassionate care

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

Ambulance care assistants (ACA) were discreet and responsive when caring for patients. Ambulance care assistants ensured patients were adequately dressed before starting journeys. Ambulances were equipped with blankets to maintain dignity for patients if required.

Ambulance care assistants took time to interact with patients and those close to them in a respectful and considerate way. We observed several interactions between staff and patients which were kind and compassionate. Patients spoke of staff being very kind and considerate.

Patients said staff treated them well and with kindness. Ambulance care assistants were provided with detailed handover information for each patient such as sight loss and travel sickness and made appropriate adjustments. Patients were very happy with the standard of care provided.

Staff followed policy to keep patient care and treatment confidential. Patient information was stored on mobile handheld devices that were password protected. No patient records were used during the transfer process.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff said conflict between patients was very rare. Staff demonstrated awareness of how to challenge any inappropriate behaviour and would raise an incident for managers to consider appropriate action to take.

Patient transport services

As part of the providers feedback survey, patients were asked if they felt they were treated with dignity and respect. For December 2022, 89% said they were 'very satisfied' and 11% said 'satisfied'.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients told us that staff were very kind, even when they expressed frustration towards them.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients said staff showed awareness they were often being collected later than planned and were often tired after treatment.

Understanding and involvement of patients and those close to them

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

Staff talked with patients, families and carers in a way they could understand, Staff spoke with patients in a very caring and patient way.

Patients and their families could give feedback on the service and staff supported them to do this. Patients gave positive feedback about ambulance staff, but not about how journeys were planned.

Is the service responsive?

We rated responsive as requires improvement.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The service was planned according to the requirements set out in the contract designed by the Integrated Care Board (ICB). For each of the satellite locations, they had differing levels of demand which was overseen at the main Bristol location as set out by their contract with the ICB.

Senior leadership of the service had plans to expand the service to meet the needs of patients and local population. They planned to provide secure mental health transport.

Patient transport services

Facilities and premises were appropriate for the services being delivered. We visited the 2 premises, unit 4 and unit 12 in Bristol. Unit 12 was where the call centre and senior managers were based. Unit 4 was where vehicles were stored, and staff could access supplies.

Staff told us patients who were not at their home when they arrived to collect them for transport were contacted. Staff followed the providers procedure to make sure the patient was safe.

Meeting people's individual needs

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

Not all staff were aware of the policy on meeting the information and communication needs of patients with a disability or sensory loss for NHS funded care. We did not see any communication aids on the vehicles. Staff told us the call centre staff include in the patients records if they had any disability or sensory loss. Some patients with specific needs were able to have a family member or carer travel with them.

The service did not have information leaflets available in languages spoken by the patients and local community. However, senior staff told us this was an area they were working on.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to an interpretation system. To make sure staff were aware of this, the provider had a policy of the month and their interpreter's policy was the most recent one.

The provider had recently included autism and learning disability awareness in new staff inductions. All staff completed this when they started. We were told this was updated annually.

Staff had undertaken conflict resolution training to help them deal with violent or aggressive patients. Senior managers told us restraint was not used.

Access and flow

People could not always access the service when they needed it, which meant at times they did not receive the right care in a timely way.

Managers monitored waiting times and but could not always make sure patients accessed services when needed and did not receive treatment within agreed timeframes and targets. The service had twice monthly meeting with the ICB to monitor service provision. The main concern was the number of patients having long wait to be dropped off for appointments and when collected over the contracted allowed time.

The service undertook transport journeys for patients discharged from hospitals and emergency departments to help with flow through the hospital. The service sent us information following the inspection where patients had endured long waits for collection and return to home. From 18 January to 31 January 2023, the service recorded 17 incidents where they had not met the Key Performance Indicator (KPI) for transport to take patients home from hospital. Of these, 3 were where E-Zec Medical Transport- Bristol could not provide transport and the other 14 were where patients were waiting over 3 hours with 7 patients waiting over 4 hours. For discharges from the emergency department during the period 25 January 2023 to 31 January 2023, there were 4 incidents where patients had long waits. One patient was

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waiting over 9 hours to be collected. The service was working hard to address these, but the long waits were unacceptable. The provider told us after the inspection the staff at the emergency department plan the workload for the staff from E Zec Medical Transport Bristol. Regarding the patient who had the 9 hour wait staff at the emergency department felt it was best to keep the patient overnight and transport them home in the morning rather than the middle of the night.

Staff worked hard to keep the number of cancelled journeys at the last minute to a minimum. These were monitored by the service. For December 2022, there were 16 journeys which could not be fulfilled at the last minute. This was an improvement as in March 2022, there were 80 journeys cancelled at the last minute.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients could inform staff at the time of their journey, call the contact centre or make a complaint in writing.

The service displayed information in their vehicles about how to give feedback.

Not all staff understood the policy on complaints and how to handle them. Some staff told us they were not sure what to do if they received a complaint. However, staff had access to the complaints policy on their hand-held devices which gave them information on how to manage complaints.

Managers investigated complaints and identified themes. Senior managers told us they had 11 complaints in December 2022, which was a reduction compared to 20 in November 2022. The themes in December 2022 were around journeys, missed journey and long waits. For 2022, this service received 192 complaints, of these 92 were upheld, 56 partially upheld and 44 not upheld. This information was shared with the ICB.

Senior managers investigated complaints and responded to the complainant. The provider's policy had timescales to respond to the initial complaint and when the final response had to be issued. If patients remained unhappy with the result of the investigation, the complaints policy gave information on where to sign post the patient, for example, The Parliamentary and Health Service Ombudsman.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, there had been a complaint (which was also recorded as an incident) about a patient getting burnt from a heater in the back of one of the vehicles. Learning from this was shared across the provider and this included changes to the booking information taken and training in induction programme and yearly staff update about the position of heaters and patients.

Patients were put on the 'service recovery board' system following a long wait for transport or a complaint where the next 5 journeys were monitored by a central team to see if there had been an improvement to the service.

Is the service well-led?

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We rated well led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The leaders had the skills, knowledge, experience and integrity to manage the service provision. The senior management team at E- Zec Medical Transport-Bristol had been in post since the middle of last year. A new manager had recently been registered with us but was also a registered manager for another location. There were clear management structures for this area and the provider. Staff had access to team leaders at each location to include satellites to support staff daily.

The leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. The waiting time for patients was a concern to the senior leaders as was staff recruitment and retention. Recruitment was on track to be up to full establishment in March 2023.

Leaders were visible and approachable at local levels, but staff said they had not seen any of the senior staff at board level at any of their locations. Following the inspection the provider sent us details of when senior managers from the board visited this location.

Vision and Strategy

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

The provider has a clear vision and a set of values, which included, “We Listen, We Learn, We Adapt, Committed to Care, People First, Pride in Service and One Team”. Not all staff were aware of all the values, but these were displayed on notice boards at each location.

The senior leaders at this location had a realistic strategy which was to achieving good outcomes for patients using the service. This meant reducing the waiting times. A new computerised planning system was due to be introduced shortly and training was underway during our inspection. The plan was that this would improve the planning of journeys and help to reduce waiting times.

Staff told us they wanted to provide the best journeys for patients and to reduce any long waits.

The provider had plans to reduce their carbon footprint. A driver system was in use which assisted staff in driving the vehicles in the most economical way and they were looking in the future to change some vehicles to electric.

Culture

Patient transport services

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

Most staff felt respected and valued. All staff said they felt supported by the management team at E- Zec Medical Transport Bristol and this included the senior managers.

The culture was centred on the needs and experience of patients who used services. All staff told us they wanted to give the patients the best experience of transport and were disappointed when patients had long waits.

Most staff felt positive and proud to work in the organisation. But several staff said they did not like it when they were sent out to use vehicles that were not fully working. For example, when heaters were not functioning, and they had not had any access to blankets for about a month. Some staff told us they felt they were not taken seriously when reporting faults on vehicles or equipment. Staff told us managers were aware of this. Following the inspection, the provider told us they had not had any issues with the delivery of blankets, and they were readily available for staff to use.

The culture encouraged, openness and honesty at all levels within the organisation, including with patients who used services, in response to incidents and complaints. We saw evidence of changes to practice following incidents and complaints.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and there was learning and action taken as a result of concerns raised.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Each member of staff had appraisals and could discuss with their line manager any career development. Staff were able to apply for more senior roles as they became available.

There was an emphasis on the safety and well-being of staff. Senior staff told us after an incident, staff were able to de-brief with one of them or a team leader. Staff had access to a counselling service if required.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. However, these were not always identifying areas that required improvement. Staff at all levels were clear about their roles and accountabilities. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service as a team.

At the last inspection in 2018, there was no effective governance system to monitor service provision, lack of oversight by the board and no local management meetings. We saw at this inspection this had improved.

There were structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The provider had a computer system that recorded all information needed to review service provision both locally and at provider level. This service had a mock inspection in the weeks prior to this inspection and areas for improvement were found. The senior management team were working on the action plan at the time of our inspection. However, systems used had not identified all areas for improvement. We found the cupboard used to store

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chemicals covered by The Control of Substances Hazardous to Health (COSHH) was unlocked and sign had fallen off. The staff/visitor's toilet in unit 4 required the toilet seat and toilet roll holder to be repaired. There was no light for when it was dark and no sign to warn about the hot water. The registered manager told us following the inspection this had been addressed.

At the last inspection the service was issued with a requirement notice about recruitment practices as they were not obtaining all the required information for new staff prior to them starting work. At this inspection, we saw an improvement in the practices and information obtained. However, the service had not identified where staff interviewing the new staff had not explored employment gaps. In 3 of the 4 new staff records we examined, there were gaps in their employment history that had not been explored. This was despite the interview recording sheet prompting them to do this. On 1 of the interview records it was documented 'odd months' but this was not the case as they had several gaps of over 6 months. Auditing of staff recruitment records had not identified this issue.

All levels of governance and management mostly function effectively and interacted with each other. The senior managers at this location reviewed all the data throughout the month and completed a report for the ICB meetings. Staff at provider level also had oversight of this information and this was discussed at provider and local level management meetings.

Staff at all levels were clear about their roles and understood what they are accountable for, and to whom. All staff we spoke with knew their roles and who their line manager was.

There were arrangements with sub-contractors for oversight of the transport they provided for this service. Senior managers would contact the subcontractor for details about any incident, complaints. As part of the agreement the sub-contractor had to follow the policies and procedure of E-Zec Medical Transport. However, this did not always happen as previously mentioned the ambulance staff did not contact E Zec Medical Transport call centre to inform them of a vehicle breakdown. This was an improvement from the inspection in 2018.

Commissioners for the ICB had oversight of the contract on a monthly basis. Senior managers had to complete a presentation based on the Key Performance Indicators (KPI), complaints and incident as part of the meeting. Staff from the ICB monitored any actions needed to address areas that required improvement.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, not all risks were included on their risk register. They had plans to cope with unexpected events.

There were comprehensive assurance systems, which included performance issues and were escalated through clear structures and processes. These were regularly reviewed. All KPI information was shared with the ICB monthly which included performance against KPI for all journey and long waits for patients.

The provider had a systematic programme of internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. However, these had not identified issues with recruitment of new staff and the maintenance issues with staff/visitor's toilet and COSHH cupboard. Following the inspection, the service sent us a list of the number of audits that needed to be undertaken weekly and monthly. Results from these were shared with local managers and with the provider. These included health and safety checks such as water temperature checks, fire equipment and infection control.

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Arrangements for identifying, recording and managing risks, issues had been devised. The senior managers told us their risks, and these mostly aligned to their recorded risks. However, the risk of patients waiting for long periods of time for transport was not included on the risk register.

Potential risks were taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. A business continuity plan had been devised in case of disruption to services.

To support the business, the service used a sub-contractor. One of the senior managers told us and showed us the format tool used for due diligence checks. These were completed on sub-contractors prior to them starting work for E-Zec Medical Transport Bristol.

Information Management

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

Leaders had a holistic understanding of performance, which sufficiently covered and integrated patients views with information on quality, operations and finances. Information was used to measure for improvement.

The service had clear service performance measures, which were reported and monitored. This enabled them to monitor the provision of service and incidents where patients had to wait for transport.

There were effective arrangements to ensure data and/or notifications were submitted to external bodies as required. The registered manager was aware of what notifications needed to be shared with external bodies. Data was shared with the ICB monthly as part of contractual arrangements.

The service monitored journey activity via hand-held devices used by staff. Staff used these to record their arrival time to collect patients and departure time of journeys. Control room staff were able to monitor when there were any delays. Some staff said they had poor signal within some areas which meant that they could not update their hand-held devices. Staff told us when this happened, they were meant to ring the control room. For sub-contractors, they were also meant to add this information to their hand-held devices, but this did not always happen. They should contact the staff at the control room if they could not access a signal. A patient had reported a delay due to a broken-down vehicle where the sub-contractor had not contacted the control room to tell them immediately which result in a long delay.

The service monitored the number of long waits and cancelled appointments at the last minute daily. A 'critical failure' report was completed daily to review the number of incidents and to monitor against the KPI for contract from the ICB. Prior to the inspection, we received information of concerns relating to the management of information. We explored this further with senior managers who showed us their systems used to record data, for example, when patients were collected for appointments and when they were returned home. Ambulance care assistants (ACA) had handheld devices which they updated with this information. If they were not able to do this, staff in the control room could use the tracker on the vehicle to input the time or the ambulance care assistants would contact them. When this happened, the system recorded it as part of the audit trail. Senior staff said not all their sub-contractors followed this procedure and they had some data about journeys that was incomplete. If a member of the call centre altered the time during transport it would lock the details on the handheld devices used by ambulance care assistants for that journey so they would not be able to access any details about the patient. The service was not meeting the KPI set by the ICB.

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Information which included patient details was kept securely on electronic systems. All operational staff could access the information they needed to do undertake their roles. All laptops were password protected.

Engagement

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

Patients views and experiences were gathered and acted on to shape and improve the services and culture. Sixty-two patients were chosen at random per month and were asked to complete a patient survey with 6 questions (see caring for response to respect and dignity). These were as follows:

How likely are you to recommend our service to friends and family if they need our service? 81% said 'very likely' and 3% 'unlikely'.

When you booked your transport how satisfied were you with the handling of your booking? 65% were 'very satisfied'

Were you satisfied with your patient experience whilst in the ambulance? 89% were 'very satisfied'.

Was the standard of driving up to your expectations? 89% said they were 'very satisfied'.

Information leaflets were on the vehicles explaining how patients could give feedback about their experience.

Senior managers told us they tried to make themselves visible to staff. There was no active local engagement such as team meetings with ambulance and call centre staff all together. Staff representatives met with senior managers, they told us they wanted to increase the representation from minority groups for example, non-binary staff at these meetings.

The Chief Executive Officer (CEO) held 'town hall' meetings on teams so all staff across the organisation could attend and other members of the senior leadership team at board level were present.

Other ways the provider and senior managers at local locations engaged with staff included 'tool box' meetings with small groups of staff to share information, notice boards, e-mails, bulletins which included update on incidents where learning was needed to be shared across the all providers locations.

The E-Zec newsletters also provided staff with information about supporting their wellbeing. For example, as part of the rewards system, staff had round the clock access to a GP and counselling. Feedback from patients who had named a member of staff was also included and staff had their photograph taken.

Staff had access to complete a survey yearly. The latest results were for 2022. The questions included about their role, manager and well-being. The results were provider wide and areas for improvement were identified. For example, staff feeling valued and getting recognition for their job was under 30%. Senior managers felt they would see an improvement at the survey this year. However, 78% felt they were trusted by their manager to undertake their role and confident in their ability to do their job.

The service engaged with the ICB monthly to discuss service provision and KPI data.

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Learning, continuous improvement and innovation

Leaders were committed to improving services and encouraged innovation.

Senior staff at this location told us they had plans to develop patient transport to include mental health secure transport, to support the needs of the local community.

Local leaders and the provider were looking to improve their service provision. For example, to increase staff recruitment, they had started apprenticeship roles.

Leaders were also looking to reduce their carbon footprint and impact on the environment. For deep cleaning the vehicles, they used eco-friendly mist. They planned to change some vehicles to electric.

The provider had systems to reward staff. For example, driving system which supported better driving and reduced carbon emissions. The system talked to staff during the journey and each staff member had a score and the best score won a prize. The staff newsletter spoke about 'HAPI@E-zec' which was a reward and saving scheme. New staff who signed up got a £5 credit. Staff were able to be nominated for a 'shining star award'. This award was for staff who had gone 'above and beyond' in helping others.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Transport services, triage and medical advice provided remotely

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service must ensure they address any issues with the environment and recruitment of staff to prevent staff, visitors and patients being placed at risk of harm. Regulation 17(2)(a)

Regulated activity

Transport services, triage and medical advice provided remotely

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The service must ensure the location is properly maintained and the identified issues with the toilet must be addressed. All chemicals covered by the COSHH regulations must always be stored securely to prevent the risks to staff and visitors. Regulation 15 (1)(a)(d)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity

Transport services, triage and medical advice provided remotely

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The service must ensure patients are not subject to long waiting times either to be picked up or returned home from appointments to reduce the risks of harm. (Regulation 12(2)(a))