

E-Zec Medical Transport Services Ltd

E-zec Medical - Norfolk

Inspection report

Unit 5 Blackfriars Court
Beacon Park, Gorleston
Great Yarmouth
NR31 7RQ
Tel: 01737822782
www.E-zec.co.uk

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

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Good



Are services effective?

Requires Improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- Paramedics did not always complete service user records fully.
- The service did not complete routine patient record form audits for assurance of the clinical care provided.
- Outcomes for patients were not always positive.
- Managers did not always support staff to develop through timely yearly, constructive appraisals of their work.
- Service users experienced long delays for transport following their appointments.
- Local leadership was not fully embedded following significant changes in key management positions.
- Leaders did not always operate effective governance processes, throughout the service.
- Managers had not always identified risks to safety and performance, which meant mitigation of unidentified risks were not in place.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them. They managed medicines well.
- Staff provided good care and treatment, Staff worked well together for the benefit of patients and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- 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 with patients and the community to plan and manage services and all staff were committed to improving services continually.

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 overall because service user outcomes did not always meet the expected levels and service users experienced long waiting times for transport. Leadership of the service was not fully embedded with gaps in governance and risk identification. Responsive and Well led were rated as requires improvement with safe, caring and responsive were rated good.

Summary of findings

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Summary of this inspection

Background to E-zec Medical - Norfolk

E-Zec Medical – Norfolk is operated by E-Zec Medical Transport Services Ltd. E-Zec Medical – Norfolk is based in Gorleston, Great Yarmouth and provides patient transport services across Norfolk and Waveney and Suffolk through commissioning contracts with local clinical commissioning groups.

The service has 86 ambulance vehicles, which includes high dependency vehicle used for pre-planned transfers of patients deemed medically fit for transfers between two hospital locations.

Ambulance care assistants conducted most patient transport journeys and were trained in basic life support. The high dependency crews consist of a paramedic and ambulance care assistant, which meant that hospital staff escorts were not always required for service users that needed additional monitoring during their journeys. The service is operational seven days per week and largely provides transport for patients travelling to and from hospitals from their home address.

The service employed 164 whole time equivalent ambulance care assistants and one paramedic across the contracts in Suffolk and Norfolk. Additional paramedics were supplied by a third party at the time of our inspection. The service was contracted to provide 12,800 hours for patient transport service every month. The service completed on average 9,614 patient transport journeys every month from April 2021 to November 2021. The service was commissioned for the provision for child transfers, however, the service rarely transported children. A responsible adult always accompanied children, in accordance with the provider policy.

The service was last inspected in January 2020 where we rated the service good overall.

We carried out this unannounced inspection because we received information giving us concerns about the safety and quality of the service. The service had been without a registered manager since May 2021. We visited the registered location and the satellite base in Martlesham, Suffolk.

The only service provided by this organisation was patient transport services (PTS).

How we carried out this inspection

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

Areas for improvement

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

Patient transport service

Summary of this inspection

- The service must ensure that all operational, safety and performance risks are identified with mitigating actions in place. (Regulation 17)
- The service must ensure that patient waiting times for transport are improved. (Regulation 17)

Action the service SHOULD take to improve:

Patient transport service

- The service should ensure that a senior clinician reviews paramedic records to ensure care is provided in line with national guidance and provide feedback when clinical standards are not met. (Regulation 17)
- The service should ensure that staff participate in a timely annual appraisal process. (Regulation 18)
- The service should consider the implementation of more detailed records of discussion between the provider and locality managers.






Our findings

Overview of ratings

Our ratings for this location are:

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

Patient transport services

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

Are Patient transport services safe?

Good 

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training completion rate for staff was 94%. Mandatory training covered topics such as basic life support, moving and handling and infection prevention and control.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training completion formed part of the staff records held at the provider's head office. Local managers had access to the electronic staff records to review mandatory training completion, they also received notifications when staff were due their annual update.

There were electronic human resources records, which compiled information about each employee including mandatory training. This enabled effective management oversight of the training.

New staff received a full induction which included a driver assessment alongside core mandatory 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.

Patient transport services

Staff received training specific for their role on how to recognise and report abuse. Safeguarding adults and children formed part of the mandatory training programme. Provider data demonstrated that the staff compliance with safeguarding modules was 94%. Both safeguarding modules completed by staff were level two. The provider had safeguarding leads who had completed level four safeguarding training. Staff could access support from the safeguarding leads through a dedicated safeguarding telephone line.

Paramedics completed safeguarding adults and children to level three. The service rarely transported children, child transfers were undertaken by high dependency crews with a paramedic and were required to travel with a parent escort.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. This was supported by the provider safeguarding policy which clearly set out different forms of harm and abuse and referenced national guidance and safeguarding reviews. The policy was last reviewed in March 2021, the next review was due in March 2024.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff provided detailed examples of the type of concerns they had raised through the provider's safeguarding telephone service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had a telephone number for staff to contact in the event they had safeguarding concerns about service users. We observed that the safeguarding telephone number was attached to every vehicle key as a staff prompt. Staff knew the process to contact the safeguarding team to provide the details of their concern. The provider safeguarding team sent alerts to the relevant local authority safeguarding boards.

All staff had to complete Disclosure and Barring Service (DBS) checks every three years. New starters had a completed DBS before they started their role. Managers were alerted by the provider HR team when staff required a DBS renewal. Records we reviewed confirmed systems and processes for DBS check were in place. In addition, all volunteer drivers had complete DBS checks.

Cleanliness, infection control and hygiene

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

All areas were clean and well-maintained. The bases we visited and the vehicles we observed were visibly clean and well-maintained.

The service had a process for the cleaning and maintenance of vehicles and premises. Cleaning was completed at the start and end of each working shift and between patients to prevent and protect people from a healthcare-associated infection. There was a cleaning checklist which was used by staff, to confirm compliance with cleaning. The local manager and fleet manager checked this.

The provider had a comprehensive infection prevention and control policy in place which referenced national guidance and was within the review date. The service had additional standard operating procedures in place to reduce the spread of COVID-19 with social distancing of service users and the mandated use of personal protective equipment (PPE).

Patient transport services

The service generally performed well for cleanliness. The service had comprehensive vehicle deep cleaning records, which demonstrated that vehicle deep cleaning was completed at six-weekly intervals.

All staff areas in the bases had completed cleaning schedules which were signed and dated by the cleaning staff.

The service completed hand hygiene observational audits. However, the audits did not provide a compliance score. We reviewed observational audits undertaken in October 2021 and November 2021 staff had completed hygiene in line with the provider policy.

Cleaning records were up-to-date and demonstrated that all vehicles were cleaned regularly. Each vehicle had a folder which included maintenance information and deep cleaning. We randomly checked five folders which demonstrated staff had completed deep cleans in line with the provider policy. The fleet manager had oversight of electronic records of vehicle cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to PPE, with face masks, aprons and gloves available on the vehicles we checked. The service had plentiful supplies of PPE at the bases we visited. Staff wore face masks throughout their shifts to prevent the spread of infection. The provider's infection prevention and control policy followed the guidance set out by NHS England and the government in the use of PPE.

Staff asked for details of any infections when bookings were made, which enabled staff to be aware of any specific infection and hygiene risks associated with individual patients. There was clear guidance for staff on managing the risks of infection in vehicles and how effective cleaning would reduce risks. This included details of cleaning procedure and personal protective equipment and handwashing.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff had access to surface cleaning wipes and cleaning equipment within the vehicles to clean between service user journeys. Equipment used less frequently was covered with plastic with a label with date the item was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All vehicles used for the transportation of services were up to date with MOT and servicing requirements. The fleet manager had oversight of all vehicles and ensured that servicing and MOTs were tracked.

Staff carried out daily safety checks of specialist equipment. Staff completed vehicle checks at the beginning of the shift and recorded the checks electronically. However, not all supervisors had oversight of the vehicle checks as they did not have access to the electronic system in one of the Suffolk bases.

The service had enough suitable equipment to help them to safely care for patients. Vehicles were well stocked with single use items continence aids. The service had ensured that annual safety checks were completed for equipment such as stretchers, carry chairs and wheelchairs.

Vehicles were equipped with wheelchair harnesses; however, the provider had a policy to transfer service users to ambulance seats when they were able to transfer from a wheelchair to a seat.

Patient transport services

The service occasionally provided transport for children, we saw that child seats were available and child stretchers which could be used for babies.

Staff disposed of clinical waste safely. Staff had access to clinical and domestic waste receptacles at the bases and clinical waste bags on each of the vehicles. The service had a service level agreement in place for the safe disposal of clinical waste. Signed agreements were displayed in the bases.

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 knew about and dealt with any specific risk issues. Staff spoke about the procedures in place for a deteriorating patient and dynamic risk assessments if they needed to change the transfer method of a service user.

The provider had a standard operating procedure called Duty of Care (carriage of patients) in place for staff in the event of a deteriorating patient. Staff also had access to a flow chart which set out the process to summon help and support.

The provider had a standard operating procedure in place which set out staff responsibilities in relation to resuscitation decisions in end of life care, Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) documents. Staff spoke confidently about their responsibilities related to ReSPECT and DNACPR documents.

The service had high dependency crews for the transfer of medically stable complex patients between different NHS trusts. Paramedics monitored service users during these transfers and had access to a limited range of medicines which they could administer during the journey.

Staff shared key information to keep patients safe when handing over their care to others. The booking team completed eligibility questions for each transport booking and recorded patient information which crew had access to through the Personal Digital Assistance (PDA) devices. Crews updated the control room teams if service user information was out of date or incorrect.

Staffing

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

The service had enough paramedic and support staff to keep patients safe. The service had a low vacancy rate with an established bank of staff to support the service to cover vacant shifts. Staff had time to take meal breaks during their shifts. Staff told us they were able to take their meal breaks.

Managers accurately calculated and reviewed the number of staff and they could adjust staffing levels daily according to the needs of patients. Managers had access to regular bank staff and were able to adjust staffing at short notice to meet the service demand. The contact managers attended a daily online meeting with the local NHS trust to discuss the expected discharges for the day and the following days. These meetings enabled managers to review staffing for patient discharges.

Patient transport services

The number of staff matched the planned numbers. Staff worked to a rota with different shift patterns. The service had regular bookings, planned bookings and planned capacity for unplanned journeys for hospital discharges.

The service had low vacancy rates. The service employed 116 whole time equivalent across Norfolk and Suffolk. The service had vacancies for six whole time equivalent ambulance care assistants, a vacancy rate of 3.4%.

The service had low turnover rates. In November 2021 the staff turnover rate across Suffolk and Norfolk was 3.3%. The provider conducted exit interviews for all staff leaving the service, the main theme for staff leaving the service was due to rates of pay.

The service had low sickness rates. The staff sickness rate for ambulance care assistants across the Suffolk and Norfolk bases was 2%.

The service had regular bank and used bank staff to fill vacant shifts. Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff had completed a service induction identical to substantive staff and were required to complete mandatory training on an annual basis.

Managers limited their use of agency staff and requested staff familiar with the service. The service did not use agency ambulance care assistants. However, the service had a service level agreement in place for third party paramedic cover due to vacancies in the Suffolk HDU teams.

Records

Staff did not always keep detailed records of patients' care and treatment.

Paramedics did not always complete service user records fully. We reviewed ten patient record forms completed by HDU paramedics, of these nine did not have the name of the service user. Although the service user identifier reference was on the form, hospital staff would not be able to easily identify the correct service user if the copy of the patient record form became detached from the service user's hospital record.

Clinical record audits did not always provide assurance of senior clinician oversight of the care provided across all locality teams. This meant that we were not assured that paramedics received clinical feedback on their practice. However, the service did audit the quality of the completion of forms.

Staff could access service user records easily. The booking team recorded service user information needed by crews, which was available to crews once they were allocated the journey. However, crews told us some information was out of date or service user's mobility had changed since the initial booking was taken. Crews told us they contacted the control room to update the information or if they needed to make changes to the access of a service user's property.

Records were stored securely. Staff had access to service user information through Personal Digital Assistants (PDAs), crews could only access the service user record that they were allocated by the control room. Handwritten patient record forms were stored in a locked cabinet at each of the bases we visited.

Medicines

The service used systems and processes to safely administer, record and store medicines.

Patient transport services

Staff followed systems and processes when safely, administering, recording and storing medicines. Paramedics were able to administer a limited range of medicines to service users during transportation. The service had a service level agreement in place with a local NHS trust for the supply of medicines. The patient record forms we reviewed demonstrated when paramedics had administered medicines to service users noting the medicine, dose and the time.

Staff stored and managed medicines in line with the provider's policy. Paramedics kept medicines securely in locked cupboards in a locked room. The service kept records of the room temperature to ensure that medicines were not exposed to extremes of temperature. Medicines we reviewed were within the expiry date. In Norfolk the paramedics completed monthly audits of all medicines and medical devices.

Paramedics did not store or provide any controlled drugs (CDs) such as morphine, subject to additional home office security measures.

The service used medical gases, both bases we visited had locked storage for medical gas cylinders with separation of empty and full cylinders. All medical gases we checked were within the expiry date.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses and reported them appropriately. 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. The service had an electronic incident reporting system. Staff had access to the incident reporting system, and they provided examples of incidents they had reported.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff gave examples of the types of incidents they reported which included near miss incidents.

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. We reviewed three root cause analysis (RCA) investigation reports following serious incidents which demonstrated that staff had undertaken verbal and written apologies.

Staff did not consistently receive feedback from investigation of incidents, both internal and external to the service. We found inconsistencies in the learning shared with staff following serious incidents. In Norfolk staff spoke confidently about changes the provider had made following a serious incident. Staff in Suffolk could not always give examples of learning following incidents.

Staff met to discuss the feedback and look at improvements to patient care. The service reported incidents to the CCG and met with them to discuss any concerns across the organisation particularly about any concerns with the system. For example, any issues with the local acute trust were escalated to the CCG for discussions with the trust.

There was evidence that changes had been made as a result of feedback. Following a serious incident, the provider had changed their policy regarding service users travelling in their own wheelchairs.

Patient transport services

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The RCA investigation reports, and incident logs demonstrated that managers had contact with service users and the families during incident investigations.

Managers debriefed and supported staff after any serious incident. Staff told us they had support from their manager and the wellbeing service if they were involved in a serious incident. The RCA investigation report also detailed the support offered to crews after a serious incident.

Are Patient transport services effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983. Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. E-Zec Medical Services Ltd provided policy and procedure documents. These documents were standardised across all operational areas and reflected national guidance. The service monitored the effectiveness against national and local guideline in the provision of patient transport services.

The service was not responsible for providing direct care for most of the patients. The service operated a small high dependency service staffed by paramedics. Paramedics had access and worked to the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. This guidance provided clinical speciality advice to ambulance staff in the UK.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The service did not transport patients who were subject to the Mental Health Act 1983. The booking team screened all bookings to ensure they met eligibility criteria and identified any additional needs that patients had for staff to adjust their care.

The service had clear guidance for the transportation of children of all ages, staff adhered to this guidance. A responsible adult always accompanied children, in accordance with the provider policy.

Staff had access to all provider policies and procedures electronically. Staff told us they could access the policies easily when they were away from the base.

Nutrition and hydration

Staff assessed patients' food and drink requirements to meet their needs during a journey.

Due to the type of service staff did not provide food to service users. Staff could provide service users with water during transportation. Single use water bottles were stored in overhead storage in each of the vehicles we checked.

Patient transport services

Staff assessed longer journeys to identify safe stops for comfort breaks and for staff to assess the nutrition and hydration needs of patients. Patients were able to provide their own refreshments if they wished.

Response times and patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service had patient transport contracts with two Clinical Commissioning groups across two counties. The service collected journey information to monitor and report performance against key performance indicators.

Outcomes for patients were not always positive. The activity reports submitted to commissioners in Suffolk showed that the service had not met the 95% target of patients travelling to appointments arriving between five and 60 minutes prior to their booked appointment from April 2021 to October 2021. On average only 58% of journeys met the key performance indicator.

In Norfolk the service had consistently met the 95% target of patients travelling to appointments arriving between 5 and 60 minutes prior to their booked appointment from April 2021 to October 2021.

In Suffolk the service had not met the 95% target for return journeys within 60 minutes of the confirmed collection time from April 2021 to October 2021. Only 75% of patients had a return journey within the target time of 60 minutes.

Managers monitored results of patient outcomes. Contact managers told us that the service delivery model had changed to maintain social distancing of service users. This had impacted on the number of service users that could travel on one vehicle. The service had procured additional vehicles and staffing to deliver the service as well as recruiting volunteer drivers to meet the demand on the service. In Norfolk the control team did not book return journeys, the control centre was in the local NHS trust and allowed crews to complete journeys for other patients in between inward and outward journeys.

The service held regular engagement with commissioners to discuss performance against key performance indicators, demands on the service and challenges.

The service did not provide evidence they monitored internal key performance indicators (KPIs) for renal patient transport to ensure these service users had timely access to regular dialysis. This was not in line with guidance issued by Kidney Care UK, standards for dialysis transport, published in 2019. We saw no documentation or evidence that the service monitored the timeliness of transport for this specific service user group in the absence of commissioner KPIs.

Competent staff

Managers did not always appraise staff's work performance.

Managers did not always support staff to develop through timely yearly, constructive appraisals of their work. Appraisal data showed that 63% of staff working in Suffolk had completed the annual appraisal process compared with an appraisal rate of 100% in Norfolk. The service had recruited six new managers in Suffolk, with a recovery plan in place for outstanding appraisals to be completed by April 2022. The service had also prioritised service user journeys due to the increased pressure caused by social distancing requirements.

Patient transport services

Managers did not always ensure that staff received any specialist training for their role. The service required that all drivers completed an annual driving assessment. Data provided by the provider demonstrated a 55% compliance rate in Norfolk, however, of the 33 expired driver assessments 32 were less than a month out of date.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure that all existing and new staff had completed training required for their roles. Following the staff induction all staff had to complete a probationary period.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us they had a full induction for their roles, this included driver training and assessment.

The clinical educators supported the learning and development needs of staff. The service trainers for the dynamic risk assessment process, moving and handling and use of specialist equipment. Managers were able to refer staff for additional training if they identified additional training needs.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The central training team tracked all training. Managers were sent a monthly report on staff who required training in the next three months. This process enabled staff to be booked on training sessions in advance of their expiry. Time was given to staff when possible to complete their training.

In addition to the central training team, there were local trainers who assisted to train and mentor staff. Training was completed using standardised E-zec training programmes and presentations.

Staff files were held by the head office and included details of references, and qualifications. Managers told us, that once a member of staff had been successful at interview, they were referred to the HR department who completed the recruitment process, obtaining details of employment, qualifications and references. Managers had access to electronic staff records in the secure HR database.

Volunteer drivers were recruited in the same way as substantive crew members which included references and Disclosure and Barring Service (DBS) checks.

Managers identified poor staff performance promptly and supported staff to improve. Incident investigations confirmed that issues with staff performance, skills and knowledge were identified by managers and staff were supported to improve.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

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 from different teams, services and organisations were involved in assessing, planning and delivering care and treatment. Managers attended online meetings with local trusts daily to discuss expected discharges and the number of expected transport journeys for the day.

Patient transport services

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked collaboratively with local care providers and local NHS trusts. Staff provided information to hospital and care home staff following a transport journey.

The service maintained regular contact with commissioners, who acted as a mediator between the local acute hospitals and the service. The commissioners specified the requirements of the planned roles. Contract managers told us they found meeting with commissioners productive and supportive.

The service had increased vehicle fleet numbers to reduce the number of patients in vehicles in order to maintain social distancing. The service had also increased the number of volunteer drivers to provide single patient journeys.

Health Promotion

As the service did not clinically assess or treat patients, they were unable to offer clinical or medical advice but could signpost patients to their GP for support if they were concerned about a patient's condition.

Staff told us they spoke with service users if they identified hazards in the home for example clutter which may increase their risk of slips, trips and falls. Staff also sign posted service users to local community health organisations for additional support with mobility or falls prevention.

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 or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed training in consent during their induction, this knowledge was refreshed during annual mandatory updates. Consent training covered both adults and children, paramedics were the only staff group who provided treatment during transportation and had training in Gillick competency. Staff spoke confidently about their role and obtaining consent from service users such as, the use of seat belts.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood their responsibility to gain consent from service users, they also understood that service users were assumed to have capacity. They told us they explained to service users what they were doing and why they needed to use equipment. This was explained in a way which service users understood to gain verbal or implied consent.

Service users who lacked capacity or were detained in the Mental Health Act were not transported by the service.

Staff clearly recorded consent in the patients' records. We reviewed 10 high dependency patient record which demonstrated that staff had gained consent from service users.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Paramedics completed training about the Mental Capacity Act and Deprivation of Liberty Safeguards as they provided treatments in line with designation and national guidance where were required to gain consent.

Patient transport services

Are Patient transport services caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The service had a strong and visible person-centred culture. Staff treated patients with compassion, kindness and promoted their privacy and dignity, and took account of their individual needs.

During our inspection, we were unable to observe care provided by staff to patients. Staff spoke with compassion and demonstrated empathy when they gave examples of care and support they had provided to service users.

Patients said staff treated them well and with kindness. Service user feedback complimented staff for their kind and caring approach in making service users comfortable during their journey.

Staff followed policy to keep patient care and treatment confidential. Road staff used personal digital assistants (PDAs) for service user records. The crews could only access information about service users allocated to them. Staff we spoke with told us they ways of communicating with services users without breaching their confidential information. One example given was crews discussed and planned care before collecting service users.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We reviewed service user feedback which was a mixture of positive and negative feedback. Feedback about staff and their caring approach was extremely positive, however, theme of negative feedback related to the long waiting times for return journeys.

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. The service valued patients emotional and social needs. Staff we spoke with told us that the most enjoyable part of their work was talking to the patients and providing a listening ear and emotional support when patients were upset or distressed. Staff told us about examples of where they had supported service users and listened to their concerns.

One service user feedback to the service that “I got bad news at my appointment, [staff member] was so kind and made the time to talk to me how I was feeling, it was lovely as I had nobody at home to talk to.”

Patient transport services

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. One service user comment said that the crew had made them a cup of tea when they got home, "it was very kind and made my day a lot less stressful."

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care. Service user feedback complimented staff from the booking team and crews for their kindness and patients in explaining how the service worked. Comments from service user's family members, confirmed that staff took their time to explain what they were doing and why, with kindness, respect and patience.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff told us they chatted with service users during the journey to put them at their ease. Service user feedback comments confirmed this.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service actively sought feedback from service users to improve the service. Vehicles had posters which detailed the contact details for the feedback telephone number. The provider customer care team completed 28 random service user telephone calls for each commissioner contract every month, to gain feedback about the service.

We reviewed feedback provided by 97 service users; out of these 81 (83%) service users praised staff. The service had 16 (17%) comments which related to delays in collection times.

Are Patient transport services responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population.

Managers monitored and took action to minimise missed appointments.

Contract managers had regular meetings with commissioners to discuss service performance and plan for increased demand for transport services.

Patient transport services

The managers we spoke with told us that the model of the service had to change due to the COVID-19 pandemic. Prior to the pandemic up to five service users could travel in one vehicle, due to social distancing the service could only transport two service users in one vehicle. Some service users who were at high risk required single patient transport. This meant the service had to increase the number of vehicles and staff to provide the same service.

Managers had daily online meeting with the local trusts to discuss the planned discharges and the predicted number of patient transport journeys expected for the day.

Meeting people's individual needs

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

Patients with any specific requirements or needs were highlighted at the booking phase. For example, patients who had "do not resuscitate orders" in place or advance directives were highlighted to the ambulance crew on the booking forms. This enabled staff to respect decisions in place and hand over key information to staff on arrival to destinations.

Staff received guidance on managing patients who had active do not resuscitate forms in place. We saw that the policy reflected best practice and staff bulletins gave information regarding the use of ReSPECT forms. Prompting staff to be aware of patients' choice and promoting awareness of checking information provided for patients with these form in place for their transfer. ReSPECT forms are very specific forms that records information relating to the patients' treatment in an emergency.

There were reasonable adjustments in place so that people with a disability could access and use services on an equal basis to others. The ambulances were able to transfer patients with mobility issues using their own or the patient's equipment. There was also an ambulance available to transfer bariatric patients.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Feedback from service users and their families praised staff for the kindness toward them in ensuring service users with additional care needs were met. The feedback was about both booking staff and the crews involved in service user transfers. Staff spoke about how they supported service users in vulnerable circumstances to gain trust and ensure their comfort.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Any communication needs were identified at the booking phase. Booking staff asked patients or the referring person to confirm any communication needs. For example, any disabilities or sensory loss. This was then accurately recorded on the patients transfer sheet which enabled staff to identify any needs prior to collecting the patient.

The service had access to translation services. Each vehicle had telephone numbers for translation services for service user whose first language was not English. Staff had access to British sign language interpreters for to aid communication with hearing impaired service users.

Access and flow

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

Patient transport services

Due to low adherence to commissioner KPIs the quality of the service was impacted in Suffolk. Service users experienced long delays for transport following their appointments. Service user feedback referenced delays in outward journey delays with some service users waiting in excess of two hours for transport home.

The service did not transfer emergency patients. All transfers were pre-planned and booked in advance, through the booking team. This included bookings for the same day for patient discharges.

Booking for high dependency transport followed the same process as routine transport bookings and were pre-planned.

The service had patient transport liaison officers (PTLOs) based at each of the local hospital served by the contracts in Suffolk and Norfolk. In Norfolk the local control room was based within the NHS hospital to manage timely discharge transport and return journeys following appointments. This meant that crews did not have long waiting times between patient journeys.

In Suffolk inward and outward journeys were pre-booked with collection times. The service was co-ordinated and planned by control room staff based in Martlesham. The control room staff had direct contact with PTLOs based at the hospital sites.

Crews allocated to journeys to hospitals out of area waited to return their service users. This ensured that transport was available as soon as the service user was ready to return home.

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. The service had leaflets in each of vehicles we checked which provided contact details to raise concerns or make a complaint.

The service clearly displayed information about how to raise a concern in patient areas. The vehicles had a poster with the complaints telephone number. The service contacted 28 service users a month from each area to gain feedback about the service. This provided a further opportunity for service users to raise any concerns they had.

Staff understood the policy on complaints and knew how to handle them. Staff told us they listened to service user complaints and tried to resolve these. If they were unable to resolve the concerns staff provided service users with complaints information and reported the concerns to their manager.

The service logged all compliments and complaints. The service received 204 complaint from December 2020 to November 2021, of these 15 complaints were for Norfolk and 189 were about transport in Suffolk. Complaints increased from in May 2021 and remained at a high level until September 2021 with a reduction month on month from September to November 2021. The service received 62 compliments for Norfolk and Suffolk, from December 2020 to November 2021.

Managers investigated complaints and identified themes. Managers told us they investigated complaints and updated complaints records as actions were taken. Complaints form part of the provider governance and quality reporting.

Patient transport services

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers kept complaints logs which they updated following investigation and the resolution letters. We also saw that staff named in concerns were provided feedback on an individual basis.

Managers shared feedback from complaints with staff and learning was used to improve the service. Manager provided details of complaints which they shared with individual staff members and anonymised examples of learning from complaints shared with wider staff groups. The examples we saw demonstrated individual staff members had reflected on their performance following the complaint.

Are Patient transport services well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Local leadership was not fully embedded following significant changes in key management positions.

At the time of our inspection the service did not have a registered manager in post. The previous registered manager had left their post in May 2021. This meant the service had been without a CQC registered manager for longer than six months. However, one of the managers had started the registered manager application process.

The provider senior leadership team were visible in the bases. Contract managers and staff told us they saw the provider leadership team and they were support to staff.

Contract managers understood the challenges of the service. All managers we spoke with stated that meeting demands on the service was the greatest challenge. The service had to make significant changes to the operational model to accommodate social distancing, whilst maintaining the service capacity to meet the commissioner's performance indicators. This meant that the organisation had introduced new service delivery manager role in Suffolk, which was yet to be fully embedded.

All local managers we spoke with told us they were supported by the directors in absence of a CQC registered manager.

The service had contract managers for each of the Clinical Commissioning Group contracts the service held. They reported to the local quality and compliance manager.

Patient transport crew members reported to road-based supervisors who completed quality spot check audits and supported crews.

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.

Patient transport services

The provider vision was to build the business by embracing change and innovation, maintaining and developing good working practices as well as placing the utmost priority on gaining the highest levels of customer satisfaction. We observed the organisation vision and values on display in staff areas, however staff could not tell us what the organisation vision and values were.

Culture

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

The organisation valued staff, managers aspired to ensure that staff were supported as important members of the team. Staff confirmed that they felt encouraged and supported to raise concerns and action was taken when they raised concerns.

Staff we spoke with reported feeling happy in their roles and felt proud to provide care to service users. Staff told us they felt valued by their managers.

All staff we spoke with told us that they worked in a close-knit team, staff supported each other at difficult times for example through the height of the COVID-19 pandemic. Staff worked as a team to deliver care despite the challenges they faced.

All staff were encouraged to share their experiences, good or bad, to improve the services and staff wellbeing. Managers were confident to challenge behaviours that did not meet the organisations values, such as poor patient care. Staff representatives attended meetings with contract managers to raise issues or concerns. Meeting minutes demonstrated that staff were listened to and actions taken as a result.

Governance

Leaders did not always operate effective governance processes, throughout the service.

All levels of governance and management did not function effectively and interact with each other appropriately. There was no clear structure for effective escalation of local risks and issues. For example, the service held a monthly managers meeting attended by one of the provider directors. Managers discussed performance against commissioners' key performance indicators as well as safety and quality. However, we reviewed the minutes of these meetings held from August 2021 to November 2021 and found the records summarised the discussion points but provided limited details about identified issues. The minutes did not reference operational risks for escalation.

The provider held monthly safety, quality and performance review meetings attended by local quality and compliance managers across England. The minutes for the meetings held from July 2021 to September 2021, demonstrated the board discussed incidents, journey cancellation and complaints. The directors provided challenge to the area of poor performance and discussed strategies to improve.

Crews had mechanisms in place to communicate with contract managers through staff representatives. Managers communicated key messages, learning from complaints and incidents through bulletins available in staff areas in each base. Managers also sent update electronically via email. Staff we spoke with confirmed they had access to key messages and learning updates.

Patient transport services

Management of risk, issues and performance

Managers had not always identified risks to safety and performance, which meant mitigation of unidentified risks were not in place.

Each commissioner contract had a risk register. The Norfolk risk register had seven live risk entries, all of which related to the building and facilities. The Suffolk contract had four risk entries also related to the building and facilities. There were no risk entries on either risk register for the risk posed to staffing and performance due to COVID-19. There was no risk entry on the Suffolk risk register related to the performance against commissioner's key performance indicators, where these had not been met.

The provider safety, quality and performance meeting minutes did not demonstrate provider level or significant locality risks were formally discussed or logged.

The service had no formalised process to monitor performance for key patient groups, such as renal patients. This meant the service had no assurance processes in place to ensure the service was delivered in line with national guidance.

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. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected electronic and paper-based information to monitor safety, quality and performance. Paper records were stored securely in locked filing cabinets within the office. Staff accessed electronic records securely with individual usernames and passwords.

Staff had access to policies, clinical reports and updates which could be viewed through the electronic incident reporting system. At the time of our inspection the service was making changes to the electronic storage of policy document. Staff told us they had access to both systems.

The service submitted monthly reports to their commissioners to monitor progress against the agreed key performance indicators.

Engagement

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

The service had regular engagement with their commissioning providers to discuss activity and to work in collaboration in meeting the needs of the local population.

The service had a public website with information for the public and had a facility for service users to leave feedback. The service also had processes in place to gain feedback through randomised service user calls within each locality.

Patient transport services

Managers engaged with staff daily through the routine activities within the bases. Key messages and bulletins were shared with staff on base notice boards and via email. Staff representatives met with contract managers to raise staff issues and concerns.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had adopted electronic vehicle checklists to reduce paper storage and allow managers to review live vehicle checklists to escalate any required vehicle repairs in a timely way.