PREMIER MENTAL HEALTH PATIENT TRANSPORT LTD

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Inspection report

Unit 17
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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	Inspected but not rated
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out a focused inspection of Premier Mental Health Patient Transport Limited on 29 September 2021. The inspection was conducted to review what actions and improvements had been made since our last inspection on 23 June 2021. At our inspection on 29 April 2021, we suspended the service for two months until 5 July 2021. When we re-inspected on 23 June 2021, we found improvements had not been made to a satisfactory extent and we extended the suspension for a further four months to 6 October 2021. At our inspection on 29 September 2021 we found some requirements we made of the organisation had not been satisfactorily addressed:

- Staff training records continued to fail to provide assurance as to whether staff were trained as required.
- Policies remained incomplete or unfit for the purpose of assessing and monitoring the service delivered.
- The provider did not ensure all staff had the legal employment checks. The recruitment process still failed to ensure safety checks for new staff were completed. References did not always match the job histories of some staff.
- The provider continued to fail to monitor the effectiveness of the service or have the capability to carry out assurance effectively.
- There remained inadequate processes to determine the risk to patients who were transported.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Inspected but not rated	Leaders did not run services well and did not use reliable information systems. The leadership team did not demonstrate they had the skills needed to lead effectively. There were no examples of leaders making a demonstrable impact on the quality or sustainability of services. The delivery of high-quality care was not assured by the leadership or governance. Leaders did not operate effective governance processes in the service as many of the policies relied upon by the provider continued to be inadequate, inaccurate and incomplete in several areas. Managers did not understand or monitor how the organisation was performing and the areas where improvements were required.

Summary of findings

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Summary of this inspection

Background to PREMIER MENTAL HEALTH PATIENT TRANSPORT LTD

Premier Mental Health Patient Transport Limited (formally known as Premier Rescue Ambulance Service Limited) is operated by Premier Mental Health Patient Transport Limited. It provides a patient transport service to people living in Devon and Somerset and the surrounding areas. If required, the service reaches further out into the South West of England and further afield to provide patient transport services. The provider delivers non-emergency ambulance transport for adults with mental health conditions, most of whom are detained under the Mental Health Act 1983. It also provides transport for non-detained adult patients, for example patients who are voluntarily going into hospital for referral or treatment.

We inspected this service using our focused inspection methodology. We carried out the short notice announced inspection on 29 September 2021.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? At this inspection, we concentrated on the issues within well-led as a follow-up to our previous inspections.

The provider is registered to provide the following regulated activity:

- Transport services, triage and medical advice provided remotely.

The registered manager had been in post since 2020. 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 provider had six members of staff. These included two care assistants, a driver and the three members of the management team. The fleet consisted of two vehicles and between 1 March 2020 and 30 March 2021, the service provided 989 patient journeys.

The provider had two days' notice of our visit to ensure staff would be available to give us access to the site and records.

How we carried out this inspection

The inspection was undertaken by two CQC inspectors and overseen by an inspection manager. During the inspection we spoke with the three members of the management team. We reviewed documents and records kept by the provider.

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

At this inspection, we told the provider it MUST take action necessary to comply with its legal obligations.

We told the provider it must take action to bring services into line with four legal requirements.

Action the provider MUST take to improve:

Summary of this inspection

- Persons employed by the service provider in the provision of a regulated activity must receive such appropriate training supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a) Staffing.
- Assess the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b) Safe care and treatment.
- Have systems and processes established and operated effectively to assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of services users and others who may be at risk; maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care provided. Regulation 17 (2) (a) (b) (c) Good Governance.
- Providers must have effective recruitment procedures established and operated effectively to ensure that persons employed meet the conditions. Information about candidates set out in Schedule 3 of the regulations must be confirmed before they are employed. Regulation 19 (3) (a) Fit and Proper Persons Employed.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Patient transport services

Well-led

Inspected but not rated

Are Patient transport services well-led?

Inspected but not rated

Leadership

The leadership team did not demonstrate they had the skills needed to lead effectively. There were no examples of leaders making a demonstrable impact on the quality or sustainability of services. The delivery of high-quality care was not assured by the leadership or governance. They did not understand or manage the priorities and issues the service faced.

The systems used by the provider to enable effective oversight of its business had not improved since the inspection in June 2021. We found the provider still did not have accurate information or was missing information to support good governance and provide assurance of a safe and quality service.

Managers could not demonstrate a full understanding of the priorities and issues the provider faced or how to manage them. While they had some understanding of the priorities of the service, they could not show how they could be assured they were providing a safe service or understand the process of good governance.

Governance

Leaders did not operate effective governance processes in the service. Many of the policies relied upon by the provider continued to be inadequate, inaccurate and incomplete in several areas.

We requested 20 of the most up-to-date versions of these policies at this inspection, the policy review schedule and any further updated policies. The managers provided 11 policies. We had previously reviewed 14 of the providers' policies and compared them to the 11 provided at this inspection.

Policies remained inadequate. In general, we found policies remained inadequate and did not fully reflect the services provided. There were inaccurate references in the policies, where it was evident they had been taken from other organisations and had not been adapted to reflect the organisation or the regulated activity. Some policies contained references and job titles which did not exist in the organisation or had different names.

Policies were not evidence-based. Very few contained appropriate references and or legislation/national guidance. There were no arrangements in the organisation for monitoring and governance of the policies and little evidence of monitoring the policies for effectiveness and compliance.

There was poor oversight of the policies including not being in the new name of the company which had been changed by the organisation in July 2021. There was no evidence of management review, sign off for policies, and they did not show who was responsible for, or who created the policy or any version control. Some policy titles did not match the content. There was no checking or audit system for accuracy and applicability of policies to the services provided.

The policies did not describe what training was mandatory or required to carry out certain skills. The provider did not have accurate information about staff training. There were no references to staff training requirements or frequency of training for staff in any of the policies where this would be required. As a result, there was a risk that staff may not be properly trained to carry on the regulated activity. A manager told us all six members of staff were fully trained. When we reviewed the six staff personnel files, these did not demonstrate that staff were fully compliant with mandatory training. The records for two members of staff showed 100% compliance, two showed 96% compliance, one showed 61% compliant and the final record showed 28% compliance.

The training policy did not contain the list of training provided to us as mandatory. The provider told us there were 28 subjects of mandatory training. The training policy did not list the subjects or state what training was required or the frequency it had to be completed or updated. None of the key mandatory training subjects, such as basic life support, were listed within the training policy as a requirement. This placed patients at risk from being supported by staff who were not adequately trained in the subjects considered to be mandatory by the organisation and national guidance.

The conveyance policy did not provide staff with guidance or instructions to enable them to reliably assess the risk score for conveyance of a patient. This meant patients could be exposed to the risk of harm if staff did not assess risk scores accurately as patients may have different transportation requirements depending on their needs. For example, a patient with a higher risk score may need more staff to assist with their transportation than a patient with a lower risk score assessment. However, there was no process or instruction to assist staff when assessing risk competently in order to safely convey patients. This could present a risk to the safety of patients and the staff. Patients who present with unknown risk to themselves and staff may not receive suitable numbers of escorts for their risk.

The recruitment policy was inadequate to ensure staff employed were suitable for the post, checked, risk assessed and vetted properly. The policy did not refer to the requirements imposed by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed the files of the six staff employed by the provider at the time of the September 2021 inspection. All recruitment files for staff remained incomplete for different reasons and were not kept in accordance with the providers policy or Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- One staff member, who was employed as a driver, had no record of his driving licence or driving assessment in his personnel file.
- In all staff files there was no satisfactory evidence of conduct in previous employment concerned with the provision of services relating to vulnerable adults.
- Staff had not been requested to provide a full employment history and this was not available in staff files.
- One staff file did not have a valid enhanced Disclosure and Barring Service check recorded. The provider also retained these certificates without any reason to retain this confidential personal information.

This lack of detail and incomplete records presents a risk to patients as the provider could employ staff who were not suitably qualified, competent, skilled, experienced and who have not had the right checks.

In relation to references for staff:

- Three staff files did not have adequate references. References had been requested, but one of these on file was not for an organisation the member of staff listed as a previous employer. This had not been risk assessed.
- Two of the references provided for two staff were character references and not professional references provided by a previous employer. There was no risk assessment of the lack of employment references for these staff.
- One member of staff had a character reference provided, but this was not from either of the referees listed on their application form.

Inspected but not rated

Patient transport services

The safeguarding policy did not provide accurate contact details for staff to report safeguarding concerns. The policy stated contact should be made with "the local authority" but did not describe which local authority or how to contact them. This put patients at risk of harm as a referral may be delayed or incorrectly reported. The policy did not originate with the organisation and was not adapted for the service provided. For example, it mentioned the employment of volunteers, which the provider did not use. The policy said staff would address abuse and any neglect, but this was not a responsibility of this organisation. The policy contradicted the recruitment policy in relation to the Disclosure and Barring Service (DBS) check on staff. The recruitment policy required all staff to have an enhanced disclosure, but the safeguarding policy said staff "may" have a DBS check. This demonstrated a lack of governance and oversight. The policy did not reference national guidance, particularly from the intercollegiate document on Safeguarding Guidance 2019 (revised). This created a risk that agreed national safeguarding guidance would not be applied in the organisation and may put patients and others at risk from use of outdated or ineffective guidance.

Managers did not understand or monitor how the organisation was performing and the areas where improvements were required.

The organisation had few systems to support the delivery of good quality and sustainable services. It did not have a formal system or process to regularly manage governance of the organisation.

Insufficient progress had been made despite the provider being aware of the issues.

There remained an unacceptable lack of oversight and assurance of the safety and quality of the service provided. The provider could not assure themselves or us they were able to assess, monitor and improve the quality and safety of the services provided through good governance processes.