

## PREMIER MENTAL HEALTH PATIENT TRANSPORT LTD

PREMIER MENTAL HEALTH  
PATIENT TRANSPORT LTD

## Inspection report

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Date of inspection visit: 23 June 2021  
Date of publication: 31/08/2021

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 safe?

Inspected but not rated



Are services effective?

Inspected but not rated



Are services responsive to people's needs?

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 (formerly known as Premier Rescue Ambulance Services) on 23 June 2021. The inspection was conducted to review what actions and improvements had been made since our last inspection in April 2021 where we suspended the service for a period of 2 months. We found some concerns had not been satisfactorily addressed therefore the service suspension was extended to 6th October 2021. We found:


- There were no reliable systems to ensure staff had the training required to keep service users safe. The training records did not provide assurance as to whether staff were trained as required. Systems did not support the registered provider to be assured that staff had undertaken mandatory training.
- Policies were either incomplete or unfit for the purpose of assessing and monitoring the service delivered. There was no policy for raising concerns, speaking up, nor was there a COVID-19 staff testing policy.
- The provider did not ensure all staff had the required employment checks. The recruitment process did not ensure safety checks about new staff were completed. There were no risk assessments for staff where references were missing and no explanations of any gaps in employment history.
- The provider did not monitor the effectiveness of the service nor have adequate processes to determine the risk to service users transported.
- The provider did not have a written formal plan or process to ensure staff were aware of changes to business practices and policies.
- There were no mechanisms for incidents to be identified correctly and no one within the organisation was trained to investigate them. Therefore, there was a risk that incidents would not be recorded and learning following incidents would not occur.

However:

- There was an improvement in the cleanliness of the vehicles and equipment from the previous inspection in April 2021. There were cleaning schedules, guidance and checklists for staff to refer to for cleaning the vehicles. All equipment was present, in date and stored correctly.
- The provider had implemented new daily and weekly checks of the vehicles to ensure they were in good condition and well maintained.

# 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  | See overall summary.         |

# Summary of findings

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### Summary of this inspection

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# Summary of this inspection

## Background to PREMIER MENTAL HEALTH PATIENT TRANSPORT LTD

Premier Mental Health Patient Transport Limited is operated by Premier Mental Health Patient Transport Limited. They provide 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 23 June 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? We were unable to inspect the caring domain at this inspection.

The provider is registered to provide the following regulated activity;

- Transport services, triage and medical advice provided remotely.

The registered manager has 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 has 15 members of staff. These include care assistants, drivers, the management team and administration staff. The fleet consists of two vehicles and between 1 March 2020 and 30 March 2021, the service provided 989 patient journeys.

The provider had 4 days notice of our visit to ensure staff would be available to give us access to the site and vehicles

## How we carried out this inspection

The team that inspected this location comprised of a CQC inspection manager and three CQC inspectors. During the inspection we spoke with two members of the management team. We reviewed documents and records kept by the provider and inspected the vehicles.

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 no outstanding practice.

# Summary of this inspection

## Areas for improvement

Action the provider **MUST** take is necessary to comply with its legal obligations. Action the provider **SHOULD** take is because it was not doing something required by a regulation but 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.

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

### **Action the provider MUST take to improve:**

- Use systems and processes to ensure all staff have attended and are up-to-date with mandatory training and key skills for their roles. The provider must have enough suitably trained, skilled and competent staff to carry out their duties. Regulation 18 (2) (a) Staffing.
- Ensure that systems and processes to support risk assessment enable the provider to transport patients safely. Regulation 12 (2) (a) Safe care and treatment.
- Ensure that it employs processes to support it to assess, detect, prevent and control the spread of infections, including healthcare associated infections. Regulation 12 (2) (h) Safe care and treatment.
- The provider must ensure it has processes that enable it to monitor and assess the quality of the service provided. Regulation 17 (2) (a) (b) (c) Good Governance.
- Ensure there are processes to support the identification, reporting and investigation of and learning from incidents. Regulation 17 (2) (b) Good Governance.
- Ensure it establishes systems and processes to enable all staff to work safely. Regulation 17 (1) Good Governance.
- The provider must conduct recruitment and keep records in accordance with Schedule 3, Regulation 19 (3) (a) Fit and Proper Persons Employed.

### **Action the service SHOULD take to improve:**

We told the provider that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The provider should take steps to improve the delivery of appraisals and supervisions of its staff.





# Our findings

## Overview of ratings

Our ratings for this location are:

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

# Patient transport services

|            |                                                                                                             |
|------------|-------------------------------------------------------------------------------------------------------------|
| Safe       | Inspected but not rated  |
| Effective  | Inspected but not rated  |
| Responsive | Inspected but not rated  |
| Well-led   | Inspected but not rated  |

## Are Patient transport services safe?

Inspected but not rated 

### Mandatory Training

**The service provided limited mandatory training in key skills to staff and did not make sure everyone completed it. Managers could not be assured staff were up to date with training.**

At the inspection in April 2021, we reviewed the staff training and development policy. This policy was not dated, did not identify the training needs of each staff group, specify what mandatory and statutory training was, how often it should be repeated, with no ratification process, not signed off by any senior managers and had no review date. The provider was unable to confirm whether it had been shared with staff. This meant the policy was ineffective. We reviewed this policy again and saw no further updates or amendments had been made, so the policy remained ineffective.

At the previous inspection the provider was unable to determine the correct number of staff employed as there were 29 staff on the training matrix and 22 on the supervision matrix. At this inspection the provider told us staff numbers had been reduced to a core of 15 staff including three managers, two drivers and ten escorts.

Training records did not provide assurance staff were trained as required. There was no system to assure the registered manager that mandatory training had been undertaken by staff. Managers showed us a training matrix which showed staff were 100% compliant against 26 mandatory training subjects. However, we found this was not the case. We were provided with a list of 26 training subjects the provider required staff to be trained in on an annual basis. We reviewed all 15 staff files and found that only two were fully compliant with mandatory training. We noted that 100% of staff had completed basic life support; however, only 53% of staff had completed clinical observations training. Compliance with mandatory training detailed in training records ranged between 33% and 100%.

There was no evidence of any training for staff on the Mental Health Act 1983.

The provider did not align itself to the Skills for Health Core Skills Framework or another equivalent framework. This framework includes statutory and mandatory training relevant for all healthcare staff. Therefore, the provider could not be assured staff had all the relevant mandatory and statutory training required to safely carry out their roles.

At the previous inspection, the provider told us they had to check individual personnel files for other training completed, but this was planned to move online. At this inspection they had engaged the services of an online training company which aimed to ensure they could have access to employees training records and be alerted when training was due to



# Patient transport services

expire. However this system relied on correct information being inputted. The evidence provided by the provider did not demonstrate assurance that the matrix being used to identify training completion was accurate as described above. Work to input information had not begun at the time of the inspection. As such there was no evidence that this system would address the need for the provider to have accurate oversight of training information. Furthermore, the provider did not have an action plan to increase uptake of mandatory training.

There was no established process to monitor training compliance on an ongoing basis. The provider held monthly business meetings; however, it was not clear if a training report was or could be produced to monitor lapsed training. Managers were not sure how to do this with the new electronic system and no accurate manual system existed. Managers told us they would only offer shifts to staff who had 100% training compliance; however, as they did not hold accurate information, there was no assurance that this could be achieved.

## Safeguarding

### **Most staff were trained in safeguarding however the policy did not explain how to apply it.**

At the inspection in April 2021 we found the provider had a safeguarding policy which was ineffective because: it was not dated, did not identify the training needs of each staff group or specify what level of training was required or how often it should be repeated. It also had no ratification process, was not signed off by senior managers, had no review date, no reference to best practice guidelines and was for adults only. At this inspection (June 2021) we found the policy included the process for reporting safeguarding concerns to the management team and local authority. However, it failed to specify the level of training required and did not align with intercollegiate safeguarding guidance. Therefore, the provider could not demonstrate how their staff were competent to manage safeguarding concerns. This policy had not been circulated to staff.

We found 93% of staff had completed safeguarding adults and children level 1 and 2 training. However; the provider's training matrix stated 100% of staff had completed this training, which upon reviewing the staff files was not correct.

We found Disclosure and Barring Service (DBS) enhanced checks were made for each of the 15 members of staff.

## Cleanliness, infection control and hygiene

### **The provider had improved infection and control for the vehicles. However, guidance for staff around infection prevention and control was not always clear. There were some systems to prevent and protect people from a healthcare-associated infection.**

At the inspection in April 2021 we found the provider's infection prevention and control policy was dated but had no evidence of a ratification process, was not signed off by senior managers, had no review date and did not include references to best practice guidelines. The policy referred to medical equipment not carried or required in patient transport services. The provider had told us their policy had been updated with precautions required for staff and patients regarding COVID-19. This had not been completed although the conveyance policy contained reference to COVID-19 precautions. At this inspection (June 2021) we found this policy had been improved, but it still did not fully detail risks and mitigations around infection prevention and control and did not contain any reference to COVID-19 precautions. Furthermore, it had not been circulated to staff. The policy therefore remained ineffective.

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We found 93% of staff had completed infection prevention and control level 1 and 2 and only 53% of staff had completed COVID-19 awareness training. However, the providers training matrix stated 100% of staff had completed training, which upon reviewing the staff files, was not correct.

We found there was no suitably trained infection control lead for the provider, which meant there was no responsible person to oversee the provider's management and monitoring of infection prevention. The provider told us a manager planned to undertake the necessary education for this role.

We found an improvement in the cleanliness of the vehicles and equipment from the previous inspection in April 2021. There were cleaning schedules, guidance and checklists for staff to refer to for cleaning the vehicles. We saw evidence both vehicles had been deep cleaned which included a microbial count before and after the clean. A microbial count indicates how many microorganisms are present in a sample. We were told the vehicles would have a deep clean every 4-6 weeks in line with current good practice. We were also informed the vehicles would also receive a weekly sanitisation valet which used products that conformed with the European standards: EN14476 and EN1276. These European standards apply to products used in the medical field. The provider had replaced the floor carpets with rubber which could be mopped and cleaned and had installed wipeable seat covers. However, the medical sanitiser used by the provider was household bleach which was not suitable for mopping the floors of the vehicles and the mops had no handles. The personal protective equipment was separated from the cleaning equipment and in its own protective storage box.

We saw evidence the provider was tracking the COVID-19 vaccination status of its staff.

## Environment and equipment

**The design, maintenance and use of facilities, premises, vehicles and equipment had improved to keep people safe.**

At the last inspection in April 2021 we found issues with the maintenance of the vehicles and equipment. At this inspection we found these issues had been addressed by implementation of a new system. The provider had introduced a weekly vehicle check list which included check boxes for fluid levels, vehicle condition, general cleanliness and extra functions check. There was also a check list of the items stored on the vehicles with a space for the number and expiry dates to be added. There was no evidence to demonstrate how this system worked because the provider was not providing any services at the time of the inspection.

The office environment allowed for social distancing of the management team. The premises had two toilets; however, one of these was being used as a storage facility. The vestibule served as a storage area for cleaning products and protective personal equipment but lockers and drawers had been provided for storage. This was a more suitable storage solution and items were no longer stacked on the floor.

We saw both vehicles used for patient transport services had current MOTs, were taxed and regularly serviced. We saw both vehicles were correctly insured.

## Assessing and responding to patient risk

# Patient transport services

**Systems and processes did not enable staff to conduct comprehensive or resilient risk assessments of patients and therefore risks were not removed or minimised. The information needed to plan and deliver effective care, treatment and support was not available at the right time. Information about people's care and treatment was not appropriately shared between staff.**

At the previous inspection in April 2021 we found issues with the booking risk assessment where information was not always transferred to the transport docket for the crew. After our inspection on 23 June 2021 we received a revised transport docket which assessed patient risk by calculating a risk score. The new form did not address the risk of patients being carried by the service that were not suitable to be carried by the service. There was no patient exclusion criteria and the risk scoring method meant some patients who were potentially not suited to be transported by the provider were not flagged as such by the risk score.

There was no evidence that the processes to underpin the introduction of this system to assess and responded to patient risk were present. The provider did not identify how staff would be trained in this new system nor whether it would be audited and monitored regularly.

The new transport docket did include a box where the COVID-19 status of patient could be recorded which was not present at our inspection in April 2021.

## Staffing

**The provider did not have 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 had no system to calculate staffing levels and skill mix.**

Following their suspension in April 2021, the provider had not fully taken action to implement improvements noted in our last inspections.

The provider recruitment processes were not in line with Schedule 3 Regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Schedule 3 sets out eight categories of information required to be kept by providers about all persons employed in the provision of services. We reviewed all 15 personnel files and found only two completely complied with the Schedule 3 requirements. Missing information included:

- Six staff files had no references and two staff files had only one reference.
- There were no risk assessments of staff where references were missing.
- Thirteen files did not have a full employment history as the application form only allowed for two previous employers information.
- Four did not have information about any physical or mental health conditions.
- One application had no information about qualifications despite the job description stating minimum qualification requirements.

This meant staff were not properly checked to ensure they were suitable to work in this environment.

## Incidents

**The provider did not manage patient safety incidents well. Managers sometimes investigated incidents but did not consistently share lessons learned with the whole team, the wider service and partner organisations.**

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At the inspection in April 2021 we found there was no embedded system or policy for staff to recognise what constituted an incident, a near miss, or how to report these. Therefore, the provider could not assure themselves all incidents and near misses were reported or acted upon. There was little evidence of learning from events or action taken to improve safety. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient and of poor quality. None of the management had training in investigating incidents or experience of investigating incidents from previous employment. However, the provider told us a manager was planning to undertake investigation training. There was no incident management policy at the time of the inspection in April 2021.

At this inspection (June 2021) the provider stated the policy had not been updated; however, there were plans for this to be addressed.

## Are Patient transport services effective?

Inspected but not rated 

### Evidence-based care and treatment

**The provider did not provide care and treatment based on national guidance and evidence-based practice. There was no evidence to show staff protected the rights of patients' subject to the Mental Health Act 1983.**

People's care and treatment did not reflect current evidence-based guidance, best practice standards or technology. Care or treatment was not based on a full assessment of a person's needs, physical or mental. There was very limited or no monitoring of the outcomes of patient's care and treatment.

At an inspection in February 2020 and again in April 2021, the provider was told to provide evidence based policies and procedures which were devised or reviewed using the latest and best practice guidance. There was very limited evidence to demonstrate this had improved at this inspection. Policies did not reflect best practice. We were told at the time of the latest inspection (June 2021) the policies had not been updated or changed since the April 2021 inspection. Therefore, policies were still not reflective of the scope and practice of the provider and contained irrelevant information, were lacking in detail, had no review dates, had no ratification process and did not refer to legal requirements. We also found key policies were missing details such as staff testing for COVID-19. Managers told us this was a work in progress.

The provider had introduced a new IT system that could monitor whether staff read the providers policies, however ,this was not functioning at the time of the inspection and there were no updated policies to put onto the system.

The registered manager talked about audits which would be carried out in future. However, there was no written audit programme as such listing the audits and the time periods in which they would be conducted.

### Competent staff

**The provider did not ensure staff were competent for their roles.**

People received care from staff who did not always have the skills or experience needed to deliver effective care. Managers did not appraise staff work performance but held one off/unplanned supervision meetings with them and did

## Patient transport services

not provide support and development. We reviewed all 15 staff records and saw no evidence of any appraisals, supervision or other developmental meeting. Therefore, staff were not supervised or managed effectively. As no appraisals of staff had been completed, it was unclear how staff were supported and helped to develop. There was no evidence of learning and minimal reflective practice.

At previous two inspections (February 2020 and April 2021) and as part of the suspension notice, we told the provider it must ensure there were processes to provide all staff at every level with an appraisal and regular supervision. We found at this inspection the provider had still not progressed this action. We were provided with very little evidence to show annual appraisals were undertaken for any staff, although we saw one staff member had an appraisal booked. No appraisals or supervision were carried out during the suspension period.

New staff participated in an induction period; the staff handbook stated this had a 90-day timescale. At the end of this period, managers told us they signed off the induction checklist. We saw evidence of some staff having had the induction in their personnel files. However, when we reviewed all staff files, we saw ten files did not have a completed induction checklist to demonstrate completion or the staff member was competent to do the role.

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

**Staff did not follow national guidance to gain patient's consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

The provider could not assure themselves staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national standards and guidance. From our review of 15 training records, 13 people had completed training for the Mental Capacity Act 2005, but only seven had completed consent training as set out in the mandatory training requirements.

## Are Patient transport services responsive?

### Meeting the needs of people in vulnerable circumstances.

**The provider did not always identify and meet the information and communication needs of people with a disability or sensory loss.**

At the previous inspections in February 2020 and April 2021, it was identified the provider should provide staff with access to pictorial cards to aid communication for patients who were not able to verbally communicate. At this inspection, we inspected the two vehicles used for transporting patients, pictorial communication cards were present and there were also contact numbers for translation services in the manual in each vehicle.

We found 100% of staff had training in conflict management and prevention and management of violence and aggression theory and 86.5% in prevention and management of violence and aggression practical. We were able to identify staff had training as we reviewed the files of all 15 employees. We were told all staff were 100% compliant against these training modules which was not accurate in the case of prevention and management of violence and aggression practical.

# Patient transport services

## 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. We did not see any 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.

Managers did not demonstrate a full understanding of the priorities and issues the provider faced or how to manage them. Managers had some understanding of the priorities of the service but could not demonstrate how they could be assured they were providing a safe service.

### Governance

**Leaders did not operate effective governance processes. There was a lack of systems to measure or monitor safety and performance.**

The systems used by the provider did not enable effective oversight of its business. We found the provider did not have accurate information or was missing information which would support good governance. The provider did not have accurate information about which staff were trained in what and did not have enough information for safely recruiting staff. This is explained in more detail under training and staffing under the safe section of this report.

### Management of risk, issues and performance

**Leaders did not demonstrate they had systems to manage performance effectively. We did not see evidence of risks being escalated and issues identified to reduce their impact.**

At the inspection in April 2021 we saw a risk register that was limited in its scope. There were risks which were identified that were not present on the register. At the June 2021 inspection we saw that there were some additional risks listed and that these had been allocated to individual managers. However, we were not provided with information on how the provider was managing or mitigating the identified risks.

The provider did not have a system to update staff at regular intervals of changes to its business or a means to share learning amongst staff. The provider was installing a new system to help with this communication however it wasn't installed at the time of the inspection.

### Engagement

We found there was no coherent plan to communicate the changes made since the last inspection with staff in preparation for the re-starting of services following its suspension. There were no detailed or written plans of what this re-start would look like. We were told staff would be re-inducted; however, there was no written plan or check list for this re-induction process.

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                                              | Regulation                                    |
|-----------------------------------------------------------------|-----------------------------------------------|
| Transport services, triage and medical advice provided remotely | S31 Urgent suspension of a regulated activity |