Coperforma Limited

Coperforma Demand Management Centre

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Coperforma Demand Management Centre is an independent organisation, which manages patient transport service (PTS) for patients who meet the eligibility criteria within the areas of Hampshire, London and Sussex. Coperforma manages patient transport service between patient's homes and hospital. The service does not have a fleet of vehicles, but operates by managing the required transport and subcontracts the transportation of patients to a number of transport service providers.

We undertook an unannounced comprehensive inspection of the Coperforma Demand Management Centre at Andover on 12 and 13 July 2016. We inspected against the following key questions: are services safe, effective, caring, responsive and well-led?

We do not currently rate independent ambulance providers; therefore, ratings were not applied.

Our key findings were as follows:

- The service had a system in place for reporting and recording incidents. However, learning and action points from incidents and complaints were not disseminated to staff. Systems and processes were not always reliable and appropriate to keep patients safe.
- Vehicles and equipment used by transport providers were not always safe and appropriate.
- Comprehensive quality assurance checks had been performed on all transport providers, to ensure they met the necessary requirements in a number of areas.
- Patient transport service was managed, in line with the current standards and legislation. Staff had the skills to carry out their roles effectively, and in line with best practice.
- Some services were planned and delivered in a way that met the needs of local population. However, due to the patient transport not being reliable and timely some patients could not access services, for assessment, diagnosis or treatment when they needed to. The service had developed and introduced a number of initiatives to improve access.
- The service did not have a robust system for handling, managing and monitoring complaints and concerns.
- We observed patients were treated with respect and kindness during all interactions with staff. Staff explained the care and treatment they needed to provide appropriately for each patient so they understood. Patients received information in a way that they could understand.
- Vision and strategy had not been developed. The service did not always proactively engage all staff, to ensure that the voices of all staff were heard and acted on. Performance issues were being reviewed, and joint work with other organisations had commenced to address these concerns.
- The provider did not demonstrate they fully understood their legal requirements with regard to the Health and Social Care Act 2008. They had not assessed the two centres in Sussex against the Commission's "What is a location" criteria to identify whether they needed to follow the Commission's legal requirements to add the locations to the provider's registration.
- The service was looking for ways to develop, improve and sustain the service and had introduced a number of IT interventions improve care for patients.

There were areas of poor practice where the location needs to make improvements.

Importantly, the location must:

Summary of findings

- Ensure a robust system is in place for handling, managing and monitoring complaints and concerns.
- Ensure robust systems are in place to assess, monitor and improve the quality and safety of the services provided.
- Ensure the vehicles and equipment used by contracted services is appropriate for safe transportationof patients, including wheelchair users
- Ensure patients receive timely transport services so they can access the health services they need from other providers.
- Ensure there is learning from incidents and the learning and changes to practice are shared across all staff.
- Ensure transport provider staff always have essential information about patient's needs so care is delivered safely and risks to patients are minimised.
- Ensure systems and processes are in place to implement the statutory obligations of Duty of Candour.
- Ensure a vision and strategy for the service developed and to ensure this is embedded across the organisation.
- Ensure a manager for the regulated activity is registered with the Commission.
- Ensure the provider and registered persons understand their legal requirements with regard to the Health and Social Care Act 2008. This must include a review of all centres against the Commission's "what is a location" criteria and where necessary follow the Commission's legal requirements to add the locations to the provider's registration.
- Ensure the Commission is notified of safeguarding incidents and incidents affecting the running of the service.

In addition the location should:

- To proactively engage and involve all staff to ensure voices are heard and acted on.
- To ensure a system is place to monitor and review staff training needs.
- Ensure all staff are trained in Duty of Candour.
- Continue to develop and embed the service delivery specialist role in the local hospitals.
- Ensure the 'Simultaneous Translation Service' or any similar system is implemented so translation services are always available.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)		We do not currently rate independent ambulance providers, and therefore ratings were not applied.

Coperforma Demand Management Centre

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Detailed findings

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Background to Coperforma Demand Management Centre

Prior to 1 April 2016, the booking element of the Sussex Patient Transport Service (PTS) was provided by the Patient Transport Bureau, and managed by a local Clinical Commissioning Group (CCG). The transport function was delivered by another local NHS ambulance trust.

In 2014, the previous NHS ambulance trust decided not to continue with the PTS contract beyond the scheduled end date of 31 March 2015. However, a one-year extension was agreed with the ambulance trust to continue delivering the service until 31 March 2016, to allow the CCG to undertake a review of the local NHS PTS and how it could be improved for patients. Subsequently, a new specification was developed, informed by widespread public, user, staff and clinical engagement. The contract was opened for interest and the bidding process commenced.

Following the procurement process, Coperforma Limited was awarded a four year contract (with an option to extend by a further year) to operate as the Managed Service Provider of PTS across Sussex from 1st April 2016. Coperforma Limited was also managing patient transport services for the NHS in London and Hampshire, prior to the Sussex contract.

The mobilisation and transition of the contract from the previous NHS ambulance trust to Coperforma Limited had identified a number of concerns, which had directly affected the delivery, and performance of this contract. These included issues with data quality, workforce and transport provision, and information technology.

Coperforma Limited and the CCG acknowledged that the overall standard of the service since its launch on 1 April 2016 had not been acceptable and had issued public apology to all affected.

In response to these concerns, the CCG and Coperforma Limited jointly developed an action plan to address the current issues and to monitor the performance of this contract. The CCG and Coperforma Limited held weekly meetings, where progress of the action plan was monitored. At the time of the inspection, the CCG were working closely with Coperforma Limited and providing necessary on-going support to ensure the requirements of the contract were being met.

Furthermore, the CCG had commissioned an enquiry into the transition and mobilisation of the PTS contract from the previous NHS ambulance trust to Coperforma. An independent organisation was commissioned to carry out this review.

Between April to July 2016 the Care Quality Commission (CQC) received 52 complaints, directly from patients, relatives, the service staff and hospital staff. These complaints raised a number of concerns, which included delays in pickups, cancellations without notification, inappropriate vehicles dispatched, vehicles not arriving leading to missed appointments and difficulties in getting through to the control centre. Furthermore, the CCG had shared their concerns with the Commission about the poor performance of this contract and the impact this had on patient safety.

In response to these concerns, we carried out an unannounced comprehensive inspection. This inspection

Detailed findings

was to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service.

Our inspection team

The inspection was led by a CQC inspector. The inspection team also included a second CQC inspector and a contracts manager specialist advisor.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Before visiting Coperforma Demand Management Centre, we reviewed a range of information we held about the location and asked other organisations to share what they knew. We carried out an unannounced comprehensive inspection on 12 and 13 July 2015.

We spoke with 16 staff, including the chief executive officer, chief finance officer, governance lead, clinical quality manager, HR manager, IT manager, demand centre manager, call handlers, complaints manager, service delivery manager, and service delivery specialists.

During the inspection, we observed the communication between the demand centre staff and the patients and clinical staff. We reviewed policies and procedures the service had in place. We checked to see if complaints were acted on and responded to. We looked at documentation including relevant monitoring tools for training, staffing, recruitment and resilience planning. We also analysed data provided by the service both before and after the inspection.

We did not speak with patients during this inspection. However, in the period of April 2016 to July 2016 we received communication and information from 52 patients, relatives and staff, from which we had spoken with 26 patients.

Coperforma Limited manages aspects of one regulated activity from Coperforma Demand Management Centre. This is in respect of transport services, triage and medical advice provided remotely. Therefore, the scope of this inspection was confined to this regulated activity.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Coperforma Demand Management Centre manages patient transport services (PTS) for people who are unable to use public or other transport due to their medical conditions. Bookings are made by the patient or by the clinician at the hospital. PTS is free at the point of use for eligible patients. Patients are transported via pre-booked journeys for arrival at their destination.

Coperforma Demand Management Centre does not have a fleet of vehicles, but operates by managing the required transport and subcontracts the transportation of patients to a number of transport service providers. At the time of the inspection, transportation of patients was delivered by 15 independent patient transport providers.

Coperforma Limited manages patient transport services from three control centres. The three control centres are; (1) Coperforma Demand Management Centre, Thruxton Down House, Thruxton Down, Hampshire, SP119AN, (2) Pacific House, Sovereign Harbour Innovation Park, Eastbourne, BN236FA and (3) 1 The Causeway, Goring-by-sea, West Sussex, BN126BT. The control centres at Pacific House, Eastbourne and The Causeway, Goring-by- Sea were opened to meet the increased demand of service following Coperforma Limited's award to manage PTS services in Sussex.

This inspection was carried out at Coperforma Demand Management Centre, Thruxton Down House, Hampshire. This was the only centre detailed on Coperforma Limited's registration, with the Commission, as a location.

Summary of findings

The service had a system in place for reporting and recording incidents. However, learning and action points from incidents were not disseminated to staff. Systems were not in place to ensure safe and effective monitoring of patterns and trends from all incidents. The service had recognised this risk, and to address this concern a new case management system was being introduced.

Systems and processes were not in place to implement the statutory obligations of Duty of Candour (DoC). Training for senior management team in DoC had not been implemented, although we were told this training had been planned.

Vehicles and equipment used by transport providers were not always safe and appropriate. During the initial phase of the contract the provider did not have appropriate levels of transport resources to meet demands of the contract. Patients raised concerns with the Commission, regarding vehicles, equipment on the vehicles and the suitability of the vehicles of the patient being transported. To address these concerns the service had sourced additional vehicles to manage the operational difficulties and to manage the variations in demand during peak times. During the inspection, we observed and found the functions of the booking system enabled demand centre staff to seek information from the patients on their mobility, the type of vehicle needed and any equipment required. We saw evidence this information was requested by staff at the booking stage.

The service had significantly underperformed on the contractual key performance indicators (KPI's), in

Patient transport services (PTS)

particular in the first two months of the contract. However, we saw evidence that the provider had made significant improvements on performance, across all KPI targets. The service and the local Clinical Commissioning Group (CCG) were working together and monitoring the KPI's on a weekly basis. The evidence from these meeting showed that the service was making continued improvement and were on target to meet action plan trajectories, within the agreed timescales.

Patient transport services were managed, in line with the current standards and legislation. Staff had the skills to carry out their roles effectively, and in line with best practice.

Feedback from some patients and relatives was negative. Many felt staff that the call centres did not always demonstrate a caring manner. Patients felt deceived with false information and promises.

During the inspection, we observed the communication between the control centre staff and the patients and clinical staff, was of a caring and compassionate nature. Staff explained the information they needed to provide appropriately for each patient so they understood. Patients received information in a way that they could understand.

The needs of the local populations were not always fully identified or taken into account when planning services. For example, ambulances that could not take a wheelchair were being sent to patients.

Due to the patient transport not being reliable and timely, some patients could not access services, for assessment, diagnosis or treatment when they needed to.

The service did not have a robust system for handling, managing and monitoring complaints and concerns.

However, to address these concerns the service had developed and introduced a number of initiatives to improve access. A designated renal team had been developed at the control centre to manage all renal patient bookings. A dedicated staff member was employed, who contacted patients a day before their appointment to confirm transport requirements and to ensure the appointment had not been cancelled or changed by either the healthcare provider or patient.

The service had employed service delivery specialists (SDS) at each hospital where they routinely provided transport. The SDS's were based at the hospital. SDS conveyed important information relating to delays, cancellations and waiting times, to both patients and staff.

The evidence from recent patient satisfaction scores, reduced number of complaints, and improvements in the KPI targets, indicated the measures put in place to address concerns around service planning and access were having some positive impact.

Vision and strategy had not been developed and embedded across the organisation. The service did not always proactively engage all staff, to ensure that the voices of all staff were heard and acted on.

The provider did not demonstrate they fully understood their legal requirements with regard to the Health and Social Care Act 2008. They had not assessed the two centres in Sussex against the Commission's "What is a location" criteria to identify whether they needed to follow the Commission's legal requirements to add the locations to the provider's registration.

The service had not taken all measures to identify, assess and manage risks when taking on a new contract. The service was not routinely managing safety and risk consistently was unable to demonstrate a safe track record.

There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes.

However, the management team were aware of quality issues and priorities, understood what the challenges were and took appropriate action to address these. There was evidence the management team had taken some action to address the on-going concerns.

Contractual performance issues were being reviewed, and joint work with other organisations had commenced to address these concerns.

The service was looking for ways to develop, improve and sustain the service and had introduced a number of IT interventions improve care for patients.

Patient transport services (PTS)

Comprehensive quality assurance checks had been performed on all transport providers, to ensure they met the necessary requirements in a number of areas.

Are patient transport services safe?

By safe, we mean people are protected from abuse and avoidable harm.

- The service had a system in place for reporting and recording incidents. However, learning and action points from incidents and complaints were not disseminated to staff.
- Systems and processes were not always reliable and appropriate to keep patients safe, for example current systems in place for managing incidents was not safe.
- System and processes were not in place to implement the statutory obligations of Duty of Candour.
- Vehicles and equipment used by transport providers were not always safe and appropriate.

However,

- Staff completed their statutory and mandatory training.

Incidents

- The service had a system in place for reporting and recording incidents. Staff reported incidents via an electronic system. All incidents were graded into risk categories, from 'minor' through to 'critical', to ensure investigation and actions were taken in timely manner. All the incidents were held at the management centre.
- All staff we spoke with knew about their responsibility to report incidents and knew how to do this. Staff felt confident reporting incidents, which senior staff investigated. The incidents we reviewed had been dealt with appropriately.
- However, the systems and processes were not always reliable and appropriate to keep patients safe. For example, incidents, feedback, safeguarding, complaints were all recorded as 'exceptions' on the electronic system. These items had not been differentiated on the system. This posed a risk because the way the data had been collated meant the service did not monitor patterns and trends and was unable to effectively use this data to drive improvement and learning.
- The management team had recognised this was an issue and had held discussions to introduce a new case

management system to address this concern. The IT manager confirmed they had received a specification and implementation work was in progress for this new system.

- We found no evidence of any learning from incidents to avoid reoccurrence. The staff we spoke with, told us learning from incidents was not shared. We reviewed eight sets of minutes from senior management meetings, and found there was no record of discussions about learning from recent incidents.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- All staff had access to policies, such as serious incidents, complaints, whistleblowing and incident management, which referenced elements of duty of candour. However, these policies did not provide information on the legal processes that staff were required to follow.
- At the time of the inspection, training for senior staff in duty of candour had not been implemented. We were not provided with a timescale of when this training would be provided. However, the senior staff we spoke with were able to describe the principles of DoC.
- The provider's quality assurance processes for their transport providers included, comprehensive checks on the systems in place to meet the DoC regulatory duty, as reported in the well-led section below. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.
- Business continuity plans were in place, in the event of an emergency.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction. This included training in: children and adult safeguarding, information governance, first aid, moving and handling and customer service skills training.
- Training was delivered by face-to-face teaching and practical sessions. Some staff were happy with the quality of the training, and in particular found the customer service skills training beneficial. However, other staff told us the training was inadequate and more training was needed. This included in training in areas such as call handling and scheduling.
- At the time of the inspection the provider did not have systems in place to monitor staff training. The human resources (HR) manager told us they had plans to devise a training record for all staff. This would ensure they were able to monitor the training staff had completed and keep oversight, of when renewal training was due.
- Information we received from patients and members of staff from some of the transport providers prior to the inspection, suggested that some transport provider staff did not have the required training to carry out their work. However, the provider's quality assurance processes for their transport providers included, comprehensive checks of mandatory training completed for all crew members, as reported in the well-led section below. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.

Safeguarding

- The service had safeguarding children and adult policies and procedures in place to protect vulnerable patients. The service had an appointed safeguarding lead for vulnerable adults and children. They had been trained and records showed they had the necessary training to enable them to fulfil this role.
- Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and told us they would speak with a team leader or manager if they had a safeguarding concern. Contact details were easily accessible.
- Staff received safeguarding awareness training during the induction period, which was specific to their role. The training records we reviewed supported this.
- Information from the CCG evidenced the provider recognised incidents of suspected abuse and made appropriate and timely referrals to the local safeguarding authority. From the period of April- July 2016, 3 referrals had been made to the local authority. However, the provider had not notified the Commission of these allegations of abuse.

Patient transport services (PTS)

Cleanliness, infection control and hygiene

- During the inspection, we observed the environment at Coperforma Demand Management Centre centre was clean and well maintained.
- Coperforma Limited manages aspects of one regulated activity from Coperforma Demand Management Centre. This is in respect of transport services, triage and medical advice provided remotely. Coperforma Limited carried out comprehensive quality assurance checks on the transport providers who provided the other aspects of the regulated activity, to ensure this regulation requirement had been met. The providers' quality assurance processes for their transport providers included, comprehensive checks of cleanliness and hygiene of vehicles. This included visual inspection of vehicles, checks to confirm vehicles had been deep cleaned, evidence that vehicles were cleaned between patients and daily was reviewed, and spot checks were sampled. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.
- From the patient survey information we reviewed we noted patient satisfaction scores had increased on the cleanliness of vehicles. Patients were asked questions on how satisfied they were with cleanliness of the vehicles. The responses were graded between 1-5, with 1 being very poor and 5 very good. In April 2016, 4 surveys had been completed and the average scores for cleanliness of vehicles was 3. In June 2016, 475 patients had completed a survey, from which an average score for cleanliness of vehicles was 4.5. In July 2016 a total of 409 patient surveys were completed, the average score was 4.6.

Environment and equipment

- In the period 1 April to May 2016, Coperforma Limited did not have appropriate levels of transport resources to meet the contractual obligations.
- To address these concerns, Coperforma Limited had sourced additional vehicles to provide additional capacity to address the operational difficulties, manage the variation in demand during peak times, enable staff training and to ensure the PTS was operating within contractual requirements.
- In the period 1 April to 30 May 2016 seven people, including patients, their representatives and members of staff, contacted the Commission with concerns regarding vehicles, equipment on the vehicles and the suitability of the vehicles of the patient being transported. Concerns included vehicles not having the equipment to secure patient wheelchairs safely and no lift in the vehicle to enable patients in wheelchairs or with mobility difficulties to access the vehicle.
- We also received information from members of staff in April 2016 that indicated they did not receive information about patients' mobility, or additional needs. This meant they were not aware of the individual needs of patients until they meet the patient when they were picking them up.
- During our inspection, we observed and found that the functions of the booking system enabled demand centre staff to seek information from patients on their mobility, the type of vehicle required and the equipment needed. We saw evidence that this information was asked for at the booking stage.
- Coperforma Limited manages aspects of one regulated activity from Coperforma Demand Management Centre. This is in respect of transport services, triage and medical advice provided remotely. Coperforma Limited carried out comprehensive quality assurance checks on the transport providers who provided the other aspects of the regulated activity, to ensure regulation requirements had been met. The provider's quality assurance processes for their transport providers included, comprehensive checks of environment and equipment carried on vehicles, as reported in the well-led section below. This included checks, on the suitability of vehicles, if the equipment kept on the vehicles was appropriate and well maintained and review of service records. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.

Medicines

- Coperforma Limited manages aspects of one regulated activity from Coperforma Demand Management Centre. This is in respect of transport services, triage and medical advice provided remotely. Coperforma Limited

carried out comprehensive quality assurance checks on the transport providers who provided the other aspects of the regulated activity, to ensure regulation requirements had been met.

- The provider's own quality assurance processes for their transport providers included, comprehensive checks of medicines carried on vehicles, as reported in the well-led section below. This included checks to ensure all vehicles had appropriate medication, appropriate checks were maintained for the medicine and staff were appropriately trained. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.

Assessing and responding to patient risk

- Call handlers followed a script so relevant questions were asked at the time of booking about a patients' mobility or additional needs. If concerns were identified a risk assessment was carried out. The information uploaded on the patient dispatch system. This meant it was accessible to relevant staff within the contracted patient transport services.
- However, some staff who worked for the transport providers contacted the Commission before the inspection. They told us they were not given information about patient's needs, such as mobility needs until they arrived to pick the patient up.This meant there was a risk the vehicle or equipment on the vehicle was not appropriate to mitigate risks associated with patients' mobility and wellbeing.
- Staff had access to policies and procedures to follow should a patient become unwell during the journey.

Staffing

- Records we reviewed contained evidence that appropriate recruitment checks were undertaken prior to employment. These included proof of identification, references and with the appropriate criminal records checks through the Disclosure and Barring Service (DBS). The service had a recruitment policy that set out the standards it followed when recruiting staff.
- Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the demand centre staff to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including administrative staff, to cover each other's annual leave.
- The provider's quality assurance processes for their transport providers included, comprehensive checks on staffing levels and staff recruitment processes and training, as reported in the well-led section below. This included through checks on staffing levels by reviewing staffing plan, the flexibility of staffing plan and how sickness and leave was managed. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.

Anticipated resource and capacity risks

- The service had robust IT resilience planning. For example, if there was an electricity outage or if the site became hazardous, measures were in place to deal with this risk. This included, a backup generator, two other control centres to work from.
- All staff had remote access to the IT systems, which meant the service could still run if staff could not access the control centres.

Response to major incidents

- A business continuity plan was in place to deal with a range of emergencies and major incidents that may affect the daily operation of the service. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, full loss of computer system (both short term and long term), and adverse weather preventing vehicles from operating. This ensured that the service would be able to maintain services to patients in the event of an incident affecting the availability of the building or the services required to run the building.

Are patient transport services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Patient transport service was managed, in line with the current standards and legislation.

- Staff had the skills to carry out their roles effectively, and in line with best practice.
- Patients' needs were assessed and were regularly reviewed and updated.
- Staff were positive about the induction process and the initial training they had received.

However

- The service had significantly underperformed on the contractual key performance indicators (KPI's), in particular during the first two months of the contract. However, there was evidence that the service had made improvement

Evidence-based care and treatment

- Coperforma Demand Management Centre managed patient transport service (PTS) in line with the guidelines in the Department of Health 'Eligibility criteria for patient transport services' document.
- Call handlers assessed patients' eligibility for the service at the time of booking by asking set questions. If patients did not meet the criteria, staff gave advice on other services they could use.
- Staff at Coperforma Demand Management Centre had access to guidelines and protocols electronically. Staff could also access these remotely if there was an incident, which prevented staff accessing the demand centre.
- The provider's quality assurance processes for their transport providers included, checks on the systems in place to ensure they were adhering to all relevant national guidance, as reported in the well-led section below. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.

Assessment and planning of care

- When a booking was made by the patient or the clinician, the control centre staff checked the patient's requirements. For example, they asked: did the patient require an escort, can the patient weight bear, the type of vehicle needed, mobility levels, is a in place and whether the patient has any challenging behaviour. Staff also asked clinicians if the patient had dementia to ensure appropriate arrangements could be made. The patient's requirements were recorded in the booking record and the notes were available to the crew members via the PDA system.
- This detailed recording enabled the planners to allocate the appropriate crew and vehicle to the journey. In some situations, a double crew was used to better support patients' individual needs. Crew members accessed this information about the patient on the personal digital assistant (PDA).
- However, some staff who worked for the transport providers contacted the Commission before the inspection They told us they were not given information about patient's needs, such as sight or hearing impairment or dementia until they arrived to pick the patient up.
- The control centre shift working and vehicle availability was regularly reviewed. The control centre had a capacity of 25% to cope with peak periods. The service had ad hoc transport providers on standby to pick up on shortfalls and to help with service demands. At the time of the inspection, there was no data to confirm how often there was an shortfall, or when and how often standby providers were used.
- The service had an agreement in place with all transport providers, which allowed flexibility in adjusting staff breaks when there was surge in demand.

Patient outcomes

- There were key performance indicators (KPIs) set by commissioners for the PTS based on national guidance. KPIs are a set of quantifiable measures used to gauge or compare performance in terms of meeting agreed levels of service provision.
- The control centre staff had a good knowledge of the different KPIs and allocated journeys to help meet the KPIs.
- The IT manager told us they presented a report on how Coperforma Limited were performing to the key KPI's in the contract, at the weekly senior management team meetings. The KPI performance was reviewed and monitored on a weekly basis. This was supported by the meeting minutes we reviewed.

Patient transport services (PTS)

- The KPI data presented to us showed that Coperforma Limited had been significantly underperforming on KPI's of the contract during the period of April-May 2016. For example, the call handling target threshold between April-May 2016 was between 74%-88%, however this was missed as Coperforma Limited was achieving between 36% to 73%. Similarly, the renal inbound timeliness target was between 60% to 84%, however this was missed as Coperforma Limited was achieving between 44% to 86%. In the same period the renal outbound timeliness target was between 26% to 84% however Coperforma Limited was achieving between 21% to 66%. The renal patients not transported target was between 21 to 7, and Coperforma Limited was achieving between 32 to 4. Other outbound timeliness arriving on time target was between 45% to 84%, however Coperforma Limited was achieving between 32% to 84%.
- In the period of June-July 2016 the call handling target was between 90% to 95%, and Coperforma Limited was achieving between 51% to 94%. In particular, in the period of 15 June to 30 June Coperforma Limited consistently achieved up to 94%. Renal inbound target was between 86% to 95%, and Coperforma had achieved 87% to 94%. Similarly, the renal outbound target was between 86% to 95%, and Coperforma Limited had achieved 68% to 92%. The other inbound timeliness target was between 86% to 95% and Coperforma Limited had achieved between 66% to 94%.
- In same period, Coperforma Limited had consistently exceeded the renal patients not transported target. For example, from the period of 6 May to 21 July 2016 the renal patient target was 7, and Coperforma Limited had exceeded this target consistently by achieving between 5-1.
- Similarly, the other patients not transported target had also been exceeded and was ahead of plan.
- Coperforma Limited and the CCG monitored the KPI's on a weekly basis. The weekly review dated 7 July 2016 concluded that performance had improved across all remedial action plan measures. In this meeting it was agreed that data presented showed a continued improvement in inbound timeliness for both renal and non-renal patient journeys. Both these indicators were in line with the agreed remedial action plan trajectories. The data provided also demonstrated significant improvements on performance against outbound timeliness indicators for both renal and non-renal patient journeys, but these still remained below the agreed trajectories in the remedial action plan and required immediate focus to improve performance to the trajectories. Coperforma Limited had put in place action plans to mitigate the risk and to ensure targets were met.
- Other improvements discussed and agreed within this meeting included: patient satisfaction scores had increased to 92%, a 4% increase from the previous week, renal and other inbound journeys continued to be on plan to meet targets, renal patients not transported had decreased from an average of 20 to 2 and remained ahead of plan, other patients not transported had decreased from an average of 21 to 2 and remained ahead of plan, complaints had decreased from a high of 32 per day in April 2016 to an average of 2 for last week and outbound performance for all patient groups had improved marginally from the previous week.

Competent staff

- There was a comprehensive induction process in place for all staff, employed and volunteers. All staff had an induction checklist, and we saw evidence that competencies were checked.
- As staff had been in employment for less than a year, formal appraisals had not taken place. We saw evidence appraisals had been planned for all staff. This ensured learning and training needs would be identified and reviewed.
- The provider's quality assurance processes for their transport providers included, comprehensive checks on staff recruitment checks and training, as reported in the well-led section below. At the time of the inspection, the provider was assured that all the independent transport providers were meeting these requirements.

Coordination with other providers

- Service delivery specialists attended bed meetings or operational meetings at the hospitals, to help in the co-ordination of transport for patients who were due for discharge or to prioritise patients for transport if demand for beds on a ward increased.

Multidisciplinary working

Patient transport services (PTS)

- The patient dispatch system included information from other providers about whether a patient had an advanced care plan, advanced decision to refuse treatment or do not attempt cardiopulmonary resuscitation order in place.
- Coperforma Limited was working closely with the CCG, to address the contractual performance concerns. The CCG was also providing support with the governance processes, to ensure these underpinned the improvement aims and objectives.

Access to information

- Staff were aware, through the information provided on their person digital assistants (PDA), of patients' individual needs such as a sight or hearing impairment or dementia. This enabled them to give additional care to patients when needed.
- Volunteer car drivers and independent ambulance providers could access the same information as PTS staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were required to provide their consent to have their details shared and uploaded to the system.
- Coperforma Limited's quality assurance processes for their transport providers included comprehensive checks of staff's understanding and application of consent and ensuring the principles of Mental Capacity Act are adhered to by all staff when required, as reported in the well-led section below. At the time of the inspection, the provider had sought assurances to ensure all transport providers met these requirements.

Are patient transport services caring?

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We observed the communication between the control centre staff and the patients and clinical staff, was of a caring and compassionate nature.

Staff explained the care and treatment they needed to provide appropriately for each patient so they understood. Patients received information in a way that they could understand.

However,

Feedback from some patients and relatives was negative. Many felt staff that the call centres did not always demonstrate a caring manner. Patients felt deceived with false information and promises.

Some patients told us the delays in transport had caused emotional distress.

Compassionate care

- Patients and their representatives contacted the Commission with information about the service provided by Coperforma Limited in the three months before the inspection. Although all these contacts raised concerns about the service provided, most people told us most ambulance staff providing the transport were kind, caring and very apologetic about the service provided. However, many felt staff at the call centres did not always demonstrate a caring manner.
- Patients and their representatives felt they were not listened to. When enquiring about late transport, patients and their representatives felt they and were 'fobbed' off with comments such as the transport will be with you in 10 minutes, which in the majority of times was incorrect information.
- During the inspection, we observed the communication between the control centre staff and the patients and clinical staff, was of a caring and compassionate nature.
- Staff were professional in their approach and patiently dealt with patients and clinical staff during the booking process.
- Coperforma Limited had sought feedback from patients. Patients were asked questions on how satisfied they were with the politeness and helpfulness of crew members. The responses were graded between 1-5, with 1 being very poor and 5 very good.From the patient survey information we reviewed we noted patient satisfaction scores had increased in these areas. For example, in April 2016, 4 surveys had been completed and the average scores of politeness was 4.3 and for helpfulness 4.5. In June 2016, 475 patients had completed a survey, from which an average score for

politeness was 4.7 and for helpfulness 4.6. In July 2016 a total of 409 patient surveys were completed, and an average score for both politeness and helpfulness was 4.6.

Understanding and involvement of patients and those close to them

- Staff working at Coperforma Demand Management Centre were polite and clear in their explanations to patients and health care professionals when explaining the criteria to access the service. They phrased questions in a different way if a caller did not understand. This ensured staff captured the correct information about the patient and the contact centre arranged appropriate transport for them.
- Patients calling in to use the service had their eligibility assessed by the control centre. Staff explained the eligibility criteria and what was require for this to be met. If a patient did not meet the criteria to use the PTS, staff at Coperforma Limited supported them by signposting the patient to other services, for example a private taxi company, rather than simply terminating the call.

Emotional support

- From the contacts, we received from patients and their representatives before the inspection we found many patients felt stressed and upset due to transport delays and resulting missed medical appointments. They felt the provider did not take into account the emotional impact the poor delivery of service at that time was having on them. Comments received included the "stress of waiting and not knowing if you will be picked up for dialysis is worse than dialysis itself," "unnecessary stress caused to cancer patient who needs daily radiotherapy" and that staff on the call line "don't even apologise or care." Some patients told us they felt their known mental health illnesses had deteriorated due to the stress of delayed transport and lack of clear information about what was happening with the transport.

Supporting people to manage their own health

- Patients had to meet set eligibility criteria to use the service. Control centre staff could access a list of alternative patient transport services for patients whose health had improved and who no longer needed to use the PTS.

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

By responsive, we mean that services are organised so that they meet people's needs.

- The service did not have a robust system for handling, managing and monitoring complaints and concerns.
- Due to the patient transport not being reliable and timely, some patients could not access services, for assessment, diagnosis or treatment when they needed to.
- Services planned and delivered did not always meet the needs of the patient. For example, ambulances that could not take a wheelchair were being sent to patients. For patients who used a wheelchair to mobilise, ambulances did not have a lift to support them with mobility difficulties accessing the ambulance.

However

- The service had developed and introduced a number of initiatives to improve access.
- There was evidence some services were planned and delivered in a way that met the needs of local population. For example, a designated renal team had been developed at the control centre to manage all renal patient bookings.
- The service had developed some systems to enable them to meet the individual needs of patients. The needs of different people were taken into account when planning and delivering services.

Service planning and delivery to meet the needs of local people

- The service provided non-emergency transport for patients who were unable to use public or other

transport due to their medical condition. This included those attending hospital, outpatient clinics, being discharged from hospital wards or requiring treatment such as chemotherapy or renal dialysis.

- During the first two months of the Sussex contract the service were not planned and delivered to meet the local population's needs. This was because the service had not anticipated the demand when taking on the new Sussex contract.
- An independent enquiry had been commissioned by the local CCG which looked into the adequacy of the mobilisation arrangements for the new PTS Sussex contract
- This report found that Coperforma Limited were very positive and confident throughout the mobilisation process, and had assured the CCG that a seamless and successful transition on 1 April 2016 would take place. Coperforma Limited had given assurances that phased or staged transfer was not needed. Coperforma Limited did not raise any major concerns with the CCG on not being fully ready for 1 April 2016. This meant that the service did not adequately plan the service planning and delivery to meet patient's needs.
- However the service had taken actions to ensure the services planned and delivered met the needs of local population. For example, in response to the initial poor provision of transport of patients for renal dialysis, which resulted in patients having their dialysis treatment shortened or missing their dialysis treatment, a designated renal team had been developed at the control centre to manage all renal patient bookings. The renal team ensured regular crew members were used for these journeys and had regular contact with them, to ensure continuity of care and timely access. All pickups were arranged and allocated to crew members the night before the journey, and crew members were able to access confirmed booking information via their patient display assistants (PDA).The renal team had been in place for four weeks prior to the inspection. No data had yet been compiled to measure the effectiveness of this arrangement; however the service was meetings KPI targets for all renal patients and staff did tell us that patients had provided positive feedback.
- Coperforma Limited had employed service delivery specialists (SDS) at each hospital where they routinely provided transport. The SDS's were based at the hospital, and were the first point of contact for patients and clinical staff. SDS also conveyed important information relating to delays, cancellations and waiting times, to both patients and staff. They worked closely with staff to co-ordinate discharges, preventing delays. They also spent time seeking feedback from patients and staff on the transport service and how it could be improved. The SDS team had been deployed in each hospital from the start of the Sussex contract.
- The online booking system allowed hospital staff to see the estimated time of arrival. The SDS team had provided training to hospital staff in using the system, and continuously monitored any on-going issues.
- The provider told us they held monthly meetings with all the transport providers. In line with the service level agreement, performance targets were reviewed and discussed at these meetings. Trends and patterns were analysed and actions plans put in place to address issues.

Meeting people's individual needs

- Information the Commission received from patients and their representatives showed that in April 2016, that although information about patient needs was provided to Coperforma Limited when the transport was booked, this had not always resulted in appropriate transport being provided for the patient. Examples included ambulances that could not take a wheelchair being sent for patients.
- However we found at the inspection that at the time of booking a journey, call handlers asked relevant questions to obtain information on the patient's mobility, the type of vehicle required, what equipment was needed, additional needs such as hearing or sight impairment and if the patient needed an escort, for example if they were living with dementia or had learning disabilities. Staff also recorded whether a patient was bariatric.
- Dementia, learning disabilities and physical disabilities were three areas flagged, using the colour coding system on the computer system.

Patient transport services (PTS)

- Planners and management staff described how they responded to the differing demands of the service depending on the time of day and location. Crews were sometimes required to work in different areas, if there were more journeys in these areas needing completion.
- Control staff members described how they had provided transport service for a patient who did not have a NHS number (a unique patient identifier). Staff did not simply decline the patient from the service, and instead established the individual's need to access to treatment and care and made every effort to organise this for them.
- The service did not have a provision for patients who did not speak English. Staff told us they had not come across this as a concern, but would not know what to do should this arise. A 'Simultaneous Translation Service' had been designed; however this service had not been implemented, as reported in the well-led section below.

Access and flow

- Some patients could not access other services, for assessment, diagnosis or treatment when they needed to, because the transport service was not timely or reliable. Between the period of April to July 2016 we received 64 complaints about the service, which included 63 incidents where patients were not able to access treatment and care due to transport failures. These included missed appointments for: CT scans, chemotherapy and radiotherapy sessions, dialysis oncology and endoscopy. This was a risk to patients as they were unable to access treatment and care in a timely manner.
- In response, the service had developed a number of IT interventions to the booking system, to reduce waiting times, delays and minimise cancellations. For example, the 'Patient Ready' function was developed. This function was used when the patient was ready to be collected. Once this function was activated by the hospital staff, the information was received by the control centre and an appropriate vehicle was dispatched. The aim was to minimise waiting times and delays. At the time of the inspection, no data was available to show the effectiveness of this initiative. However, the SDS's team told us that they had received positive feedback from both patients and clinical staff.
- In addition, an 'Instant Messaging' facility was introduced, which allowed SDSs and control centre staff to quickly and effectively co-ordinate patient journeys. It also allowed staff This supported staff to easily share vital information about patients and the status of a journey effectively, and reduced telephone traffic to the demand centre
- The renal team were piloting an email to the Short Messaging Service (SMS), which enabled them to communicate with renal crew members to minimise delays. It also allowed crew members to communicate with the demand centre about operational issues (e.g. break down, unable to locate patient) or to query job details. The provider told us the use of SMS as a second and relatively instant communication route had been welcomed by the crew members. The management team told us that these initiatives had improved communication between the disparate teams and supported the increase in patient satisfaction.
- The service had not completed any audits to assess the effectiveness of the measures put in place to address access concerns. However, evidence from recent patient satisfaction scores, reduced number of complaints, and improvements in the KPI targets, indicated these measures were having some positive impact.
- A dedicated staff member contacted patients a day before their appointment to confirm transport requirements and to ensure the appointment had not been cancelled or changed by either the healthcare provider or patient. If a patient had three appointments in one week, they were reminded via one telephone call to confirm whether they were still able to attend and if circumstances or requirements had been changed.
- From the patient survey information we reviewed we noted patient satisfaction scores had increased around timely access. Patients were asked questions on how satisfied they were with the timeliness of the journey. The responses were graded between 1-5, with 1 being very poor and 5 very good. Between April and May 2016, 275 surveys had been completed and the average scores for timeliness of the journey was 3. In June 2016 the average score was 3.6. In July 2016 a total of 409 surveys had been completed, and the average score for timeliness of journey was 3.9. In August 2016 502 surveys were completed and a average score of 4.2 had been achieved.

- Staff told us they directly contacted the patient, spoke with the service delivery specialist or by communicated with the clinician at the hospital if there were delays with the transport provision.
- When crew members encountered signal issues with their PDA, they were able to use the text facility to send information. The system at the control centre also notified the staff on site whether a patient had been picked up. In the event of this happening the demand centre would make contact with the crew member and provide necessary support.

Learning from complaints and concerns

- The service did not have a robust system for handling, managing and monitoring complaints and concerns.
- During the inspection, we found the service did not employ a centralised system of handling complaints. For example, three staff members were handling this process and there was no consistent form of communication between them. Due to this approach, no particular individual was responsible for overseeing the complaints process in its entirety.
- There were inconsistent ways in which some complaints were being recorded, as some control centre staff members logged the information on the computer system and others on a piece of paper, with no evidence to confirm that the paper complaints were being logged on to the electronic system.
- There was also inconsistency among the Specialist Delivery Service (SDS) team, as conflicting information was provided to patients and staff at the hospitals regarding who they should raise their complaint with. For example, some staff members told patients that they should raise their complaint with Coperforma Limited and others said to go to the Commission directly.
- During the inspection, we reviewed the complaints that the provider had received from April 2016 to July 2016. At the time of the inspection, we were provided with 13 complaints. We saw evidence that three complaints were responded to in line with the complaints policy. However, for the other 10 complaints there was no evidence to confirm acknowledgement, investigation or response, in line with the requirements of the complaints policy.
- We were unable to confirm if the complaints we saw at the time of the inspection were an accurate reflection, of all the complaints received from the period of April 2016-July 2016. This was because the minutes of May 2016 remedial action plan weekly meeting discussed that in April 2016, the service had received 32 complaints each day. There was no assurance that all complaints were managed and monitored appropriately.
- Between April 2016 to July 2016 the Care Quality Commission (CQC) received 64 complaints, directly from patients, relatives, the service staff and hospital staff. The common themes from these complaints included: timeliness, delays in pickups, cancellations without notification, inappropriate vehicles dispatched, vehicles not arriving leading to missed appointments, difficulties in getting through to the control centre, difficulties in accessing the complaints process and lack of response to complaints.
- Due to the lack of robust systems to handle and manage the complaints, patients had felt their complaints and concerns had not been taken seriously, were being ignored and others had approached the Commission directly to share their concerns.
- There was no system in place to analyse trends and patterns and for feedback and learning from complaints, across the organisation.
- The management team was aware of these concerns. As a result, a complaints manager was appointed, to oversee the investigation of each complaint, with a formal written response provided to the complainant, identifying the outcome and any actions taken. At the time of the inspection, the complaints manager had commenced work on the complaints backlog. The manager told us that they had plans to introduce a robust process, which ensured trends, and patterns were identified and to ensure learning from complaints was disseminated to all staff. The complaints manager had recognised a uniform approach was needed in order to ensure that every complaint was being recorded and dealt with appropriately.
- Patients, carers and members of the public could provide feedback via the Coperforma Limited website, by email, letter, and telephone and through the service delivery specialists. The SDS team told us that each

hospital had a Coperforma Limited poster displayed, which included information about how to raise a complaint and with contact details. The website provided information on the complaints process and the expected response times to acknowledge a complaint and provide a written response. This included three days for acknowledging a complaint and within 30 days the complainant would receive a written response. These timeframes matched with information contained within the service's complaints policy and procedure, which was in date.

Are patient transport services well-led?

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Vision and strategy had not been developed and embedded across the organisation.
- The service did not always proactively engage all staff, to ensure that the voices of all staff were heard and acted on.
- The service had not taken all measures to identify, assess and manage risks when taking on a new contract. The risk register did not reflect the risks relating to poor complaints management.
- The service was not routinely managing safety and risk consistently was unable to demonstrate a safe track record.
- There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes. Monitoring systems had not identified these issues.

However,

- Performance issues were being reviewed, and joint work with other organisations had commenced to address these concerns.
- The management team were aware of quality issues and priorities, understood what the challenges were and took appropriate action to address these.
- The service was looking for ways to develop, improve and sustain the service and had introduced a number of IT interventions improve care for patients.

Vision and strategy for this service

- Vision and strategy had not been developed. At the time of the inspection, the management team acknowledged that a written statement of vision, strategy and guiding values had not been prepared and that work was needed with staff to develop this. Staff members we spoke with, were also unsure of the organisations vision and strategic goals.
- Following the inspection, a vision statement was provided to us. This incorporated Coperforma Limited.'s values, which included: to continuously deliver innovation, to provide excellent customer service, to develop and recruit staff, and to have the integrity to do the right thing for service users.
- We saw there was clear information for all staff about the key performance indictors expectations and what was required from each member to achieve these. Staff told us they understood the expectations and the importance of meeting these targets.

Governance, risk management and quality measurement

- The service had not taken all measures to identify, assess and manage risks. In response to the concerns of the performance of Sussex contract, the CCG had commissioned an enquiry into the adequacy of the mobilisation arrangements for the new PTS contract. This was carried out by an independent organisation and the report was issued on 19 July 2016. This report concluded that the PTS contract was not successful in delivering the required level of service during April and early May 2016.
- The provider had not identified, considered and assessed the risks to patient welfare before confirming their readiness to deliver patient transport services.
- The provider was not routinely managing safety and risk consistently was unable to demonstrate a safe track record. There was no system in place to disseminate learning from incidents, safeguarding and complaint outcomes. Monitoring systems had not identified these issues.

Patient transport services (PTS)

- Coperforma Limited was receiving support and assistance from the CCG to improve their governance process. They were working in a collaborative and transparent manner with the CCG to address the performance concerns. The CCG had added further mechanisms to the provider's governance processes to support the mobilisation of the new PTS contract, and was overseeing the improvements. There were weekly conference calls between Coperforma Limited and the CGG when the impact of the service on acute and community trusts was discussed and actions taken were reviewed. There was a weekly data exchange between the provider and the CCG to inform improvement actions. The CCG was supporting the provider to review their complaints process and how they handled complaints and communications. An escalation phone line had been put in place for out of hours operational issues. Coperforma Limited and the CCG had developed specific remedial action plan to address and promote improvements.
- We reviewed the remedial action plan that had been jointly developed by Coperforma Limited and the CCG. The remedial action plan included, a clear definition of what the issues were, how these issues would be addressed and clear timescales for achieving targets and compliance. It also included the requirement of weekly progress update for each issue to the CCG, with a named person who was responsible in ensuring compliance.
- At the time of the inspection we found the issues documented on the remedial action plan included; additional staff required to deliver call handling targets, staff training to ensure staff worked to service specification and Coperforma Limited values, communications plan for staff and external stakeholders, additional vehicles, address issues around incidents data and management structure. At the time of the inspection, Coperforma Limited was on target to address all issues within the remedial action plan.
- From the period of 13 May to 7 July 2016, we reviewed a set of 11 meeting records between the CCG and Coperforma, where the remedial action plan was reviewed and monitored. It was evidenced from these meetings, that Coperforma Limited was making continuous improvement in ensuring they met the contractual requirements of the contract.
- From the meeting minutes dated 7 July 2016, it was agreed that performance had improved across all remedial action plan measures.
- The service carried out robust quality assurance processes for each of their transport providers. An I-Auditor tool was used, which produced a comprehensive and detailed quality assurance report. The quality assurance checks covered the following areas: if the organisation was registered with the Commission, appropriate training, qualifications and recruitment checks for all staff, business continuity plans, information governance, staff appraisals, consent and understanding of Mental Capacity Act 2005 and complaints process. The report also included further checks on cleanliness of the vehicles, vehicle maintenance records, review of the equipment and medicines carried on vehicles. Coperforma Limited ensured all transport providers met the requirements for each regulation, before they came on board as a transport provider.
- The quality assurance reports included photographic evidence of the transports policies and procedures, training records and amongst other documentation.
- We sampled a set of five quality assurance reports, and found each report had comprehensive and thorough checks on each of the transport providers.
- The management team told us these quality assurance checks on the transport provider were on going. Additional checks were completed every 6 to 8 weeks, to ensure provider was continuously meeting with each requirement. However, although we had requested, this data was not shared us.
- These quality assurance checks were completed prior to the transport provider joining Coperforma Limited to provide patient transport service.
- The results from these quality assurance reports were presented and discussed at the Coperforma Limited board, on a monthly basis.
- There were weekly senior management team meetings. These were attended by the chief executive officer, commercial director, HR and IT managers, and the chief finance officer. We reviewed records of eight of these meetings and found the following were discussed: financial update, information governance and sales and operations reports. There was minimal record of the

discussion that took place for each of these areas. We noted there was no input by the quality and governance lead in these meetings. There was no record of discussions on learning from incidents and complaints.

- There was a corporate risk register in place, which overall mirrored concerns and risks that would affect the business. The risk register was very business orientated and did not include clinical risks. The risk register did not include the poor compliance with complaints management.
- The management team were aware of quality issues and priorities, understood what the challenges were and took appropriate action to address these. For example, the service had identified concerns about one of their transport providers, resulting from on-going quality assurance checks. Following some further quality checks, where it was established the provider was unable to continue to provide transport service, all contractual obligations were terminated with immediate effect.
- The service had contingency plans to address this issue, as two new providers had been lined up to provide patient transport service in the East and West Sussex areas. At the time of inspection, the provider was completing necessary quality assurances with the prospective transport providers.
- In response to the issues concerning the complaints process, a designated complaints manager had been appointed. This person had the appropriate qualifications and experience to manage complaints at a large scale. The management team told us they would now be responsible for overseeing all complaints, identifying themes and patterns and report to the senior management team.

Leadership of service

- At the time of the inspection, Coperforma Limited did not have a manager who was registered with the Commission, to carry out the day to day running of the service. The Health and Social Care Act 2008 requires the Commission to impose a registered manager condition on organisations that requires them to have one or more registered managers for the regulated activities they are carrying on. This meant, at the time of the inspection, Coperforma was in breach of their registration conditions. We met the member of staff who was going to submit an application to be registered with the Commission as manager. However, conversations with this member of staff evidenced they only worked two days a week for the company and it was unclear how they would be in day to day management of the service.
- It was unclear whether the provider fully understood their legal requirements with regard to the Health and Social Care Act 2008. The Care Quality Commission (Registration) Regulations 2009 requires providers to notify the Commission of events affecting the providers ability to run the service, such as insufficient number of staff. The provider had not notified the Commission about the effect not having sufficient staff and vehicles had on delivering the service. The provider is required to notify the Commission about any abuse or allegations of abuse in relation to a service user. The Commission was made aware from other sources that an incident of suspected abuse had been reported by the provider to the local safeguarding authority. However, the provider had failed to notify the Commission about this. The provider had not assessed the two centres in Sussex against the Commission's "What is a location" criteria to identify whether they needed to follow the Commission's legal requirements to add the locations to the providers registration.
- The management structure at Coperforma Limited was split across four tiers. The chief executive officer led the team. The second tier included a chief financial officer, commercial director, senior operations manager, HR manager, project manager and IT manager. The team was also supported by a clinical quality manager, business unit manager and service delivery are manager.
- A governance lead had been appointed, in response to the concerns relating to the underperformance of the contract. Although this person was due to commence their position officially in October 2016, the management team had made decision for them to start earlier. This would allow the individual to address the immediate concerns in a timely manner. During the inspection we spoke with the governance lead, who discussed us with us their plans in regards to governance and quality assurance systems and processes they would ensure are in place.

- Staff spoke positively about the leadership of the service. They felt leaders had the appropriate skills and knowledge for their role and managed their aspect of the service well. Although staff felt the management team was approachable, some staff felt leaders were not always visible.
- None of the staff we spoke with raised concerns about not being able to access or speak with their immediate line manager.

Culture within the service

- Staff told us and we observed a positive culture within the service. Staff commented they were happy working for Coperforma Limited. They wanted to make a difference to patients and were passionate about performing their role to a high standard. Staff clearly cared for and supported each other.
- Staff told us and we saw there was good team working between different teams.
- Staff felt confident to raise concerns to a more senior manager when appropriate.
- Team leaders and senior staff were competent to manage staff performance. Action was taken if staff did not perform or conduct themselves to the expected standard.

Public and staff engagement

- The service did not always proactively engage all staff, to ensure that the voices of all staff were heard and acted on. Some demand centre staff we spoke with told us that they did not have a platform to provide feedback. Although a daily brief took place, this was used as a forum to give information, and did not enable staff discussion and for staff to express their views and share concerns.
- Staff told us they had a number of suggestions on how the organisation could improve the services, but did not feel they were actively engaged or involved to share their ideas. Some staff commented they were frustrated with the time it took to see change and improvement.
- The management team had held a meeting with all staff who had been transferred under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). TUPE staff are employees who are employed in the undertaking which is being transferred and have their employment transferred to the new employer. The aim of this meeting was to welcome staff to Coperforma Limited, to discuss their importance in the organisations success, and to outline expectations. This was the only meeting that had taken place since April 2016.
- The management team acknowledged more was required with all staff to engage them and ensure their voices were heard. The management team told us they had planned engagement activities for all staff, which included get together events for all the three control centres to participate in. The management team had also planned to provide an update to all staff on performance and to acknowledge and reward the hard work.
- Staff told us that when they encountered difficult or upsetting situations at work they could speak confidentially with their team leader or manager.
- Coperforma Limited had a system in place to obtain views of people who used the services. The service delivery specialist team carried out patient satisfaction surveys. Patients were asked questions around five areas: how polite were the crew members, was the vehicle safe, was the vehicle clean, the timeliness of the journey and how helpful were the crew members. The patient survey information we reviewed showed patient satisfaction scores had increased in all these areas.

Innovation, improvement and sustainability

- The service was looking for ways to develop, improve and sustain the service. For example, the service delivery specialists used mobile IT systems to access 'live' information from the patient booking system when visiting areas such as wards or outpatients rather than having to come back to their office or base. This enabled them to address issues more quickly and give accurate information to staff and patients on arrival time or delays.
- The service had developed a 'Simultaneous Translation Service'. This service would enable an interpreter to dial into the booking call, and speak with the patient directly and simultaneously translate for the control centre staff. At the time of the inspection, this service had not yet been implemented.
- The service also had plans to introduce the British sign language via a video, as feature into the booking

system. This would improve access for these patients groups and promote their independence. The management team acknowledged there was a need for these services for the patient demographics they cater for. A timescale of when this service would be implemented was not provided.

- The service did not have systems to share learning from incidents which potentially impacted on the safety and effectiveness off patient care. For example, we found no evidence of learning from incidents and complaints being disseminated to staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must ensure

- A robust system is in place and followed for handing, managing and monitoring complaints and concerns.
- Robust systems are in place and followed to assess, monitor and improve the quality and safety of services provided.
- Vehicles and equipment used by contracted services are appropriate for safe transportation of patients, including wheelchair users.
- There is learning from incidents and changes to practice are shared across all staff.
- Transport provider staff always have essential information about patient's needs so care is delivered safely and risk to patients are minimised.
- Systems and processes are in place and followed to ensure Duty of Candour legislation is compiled with.
- A vision and strategy for the service is developed and embedded across the whole organisation.
- A manager for the regulated activity is registered with the Commission.
- They demonstrate they understand their legal requirements with regard to the Health and Social Care Act 2008. They must assess the two centres in Sussex against the Commission's "What is a location" criteria to identify whether they needed to follow the Commission's legal requirements to add the locations to the provider's registration. They need to confirm they have carried out this assessment in writing to the Commission.
- The Commission is notified of safeguarding incidents and incidents affecting the running of the service.

Action the hospital SHOULD take to improve

The provider should

- Proactively engage and involve all staff to ensure their voices are heard and acted on.
- A system is in place and followed to monitor and review staff training needs.
- All staff are trained about the Duty of Candour legislation.
- Continue to develop and embed the service delivery specialist role in the local hospitals.
- Ensure the 'Simultaneous Translation Service' or any similar system is implemented so translation services are always available.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have robust systems in place to assess, monitor and improve the quality and safety of the servicers provided.** **The provider did not ensure learning from incidents, complaints and feedback was disseminated to all staff.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not have robust systems in place for handling, managing and monitoring complaints and concerns.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Vehicles and equipment was not always appropriate for the safe transportation of patients.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Requirement notices

Systems and processes were not in place to ensure the provider complied with Duty of Candour legislation.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients did not always access health services for assessment, diagnosis and treatment when they needed to because patient transport either failed to arrive or was significantly delayed. Patient transport staff did not always have essential information about patient's needs to ensure care was delivered safely and risks to patients was minimised.

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider failed to notify the Commission about incidents , including incidents affecting the running of the service and safeguarding incidents.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 5 (Registration) Regulations 2009 Registered manager condition There was no manager registered with the Commission.