Arriva Transport Solutions Limited

Arriva Transport Solutions - South West

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

Arriva Transport Solutions South West is part of Arriva Transport Solutions Limited, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Limited is part of an international transport group.

We did not rate Arriva Transport Solutions - South West as they have not yet had an announced comprehensive inspection. We carried out an unannounced focussed inspection on 19, 20 and 21 July 2016 to review the service's arrangements for the safe transport of patients. We did this following concerns raised by a number of patient organisations and hospital trusts after an increase in delays to travel times affecting both transport to appointments and return home.

Our key findings were as follows:

- We saw evidence of learning that directly benefited patients such as reviewing and developing patient feedback processes. There were plans for 2016/17 to continue working with commissioners on learning from the level of harm, as well as distress, caused by incidents of delayed transport, to ensure quality improvements improved patient experience
- Staff were aware of their responsibilities to report incidents to managers. We saw incident reporting that covered what staff did to manage resuscitation if patients needed it, safeguarding regarding staff, and patients, and injuries during transport.
- Staff we spoke with were aware of their responsibilities regarding duty of candour and understood the importance of being open and transparent with patients when things go wrong.
- Mandatory training for the coming months had been planned as mandatory training records showed that not all staff had received the yearly training. However targets and completion of mandatory training overall was high compared to other organisations.
- There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm. The patients we spoke with during this inspection told us they felt safe with the staff and in the vehicles.
- There was an infection prevention and control policy and system that described decontamination of medical devices, vehicles and workwear. Overall we found stations we visited to be visibly clean and tidy. We saw evidence of when vehicles and equipment were last cleaned and when it was next due.
- People's needs were assessed and transport provided to patients in line with national and local guidelines. The eligibility criteria required call takers to ask prompted questions about the patient's condition, health and mobility status, which determined the most appropriate type of transport required.
- We saw that people were treated with kindness, dignity, respect and compassion while they received care. We received positive comments about ambulance crew from patients, patient's relatives and from staff working at local hospitals we spoke with. Crew were described as 'wonderful' and 'brilliant.' Another patient described crew as 'lovely' and said they could not do enough to help.
- Crew encouraged patients to be as independent as possible and provided support where required. We observed crew members enabling and encouraging patients to move independently, providing support and advice where appropriate
- The service ensured that lessons were learnt when things went wrong and actions taken as result of complaints. Learning included, reflection on attitude even when complaints not upheld, acknowledging that increases in demand affected journeys and journey times.

Summary of findings

- There was a clear vision and credible strategy to support quality care. We saw evidence that the key to good non-emergency patient transport was understood by the relevant staff. There were governance frameworks in place to support staff to know their responsibilities and that quality, performance and risks were understood and informed action plans. However, senior managers acknowledged that there was some way to go in a number of areas. For example, achieving key performance indicators, reducing the number of complaints related to delays.
- Patients and others who used the service and staff were engaged and involved in several ways. Patients were engaged in a survey run by an external company and fed back to the service. The number of returns was small and the result of the patient feedback survey was mixed and reflected both positive and negative comments.
- Managers and others told us of a culture that encouraged candour, openness and honesty. We saw evidence of this and senior managers spoke broadly about the duty of candour and how it applied to service delivery.
- Patient records were created at the control centre and received by ambulance crew on the electronic tablet associated with each particular vehicle. Control staff collected relevant information during the booking process so that they recorded the information regarding patient's health and circumstances. Several of the provider's ambulance crews reported that the information provided on the patient record was sometimes incorrect, out of date or very limited which had been raised with the organisations that had supplied the information.

However

- Staff level was at 85% for road based staff and there was a recruitment plan in place. The service used bank and volunteer staff when necessary.
- Not all lessons were learned when things went wrong. Staff told us that it was difficult to report incidents on the electronic system. They said they frequently experienced long waits when calling the control room to report incidents so some potential for improvements were not identified when things went wrong.
- There was not a robust system in place to make sure defects in the vehicles were recorded and always actioned in a timely way and vehicles were not always taken off the road for repair.
- Delays and long waiting times for patient outbound journeys from clinics were a recurring theme amongst staff we spoke with at the local hospital and patients. We saw that the service had investigated all incidents or were in process of doing so. Themes included, the service arriving late and other organisations moving patients to a different location and not letting the service know or providing incorrect mobility information.
- Staff were not supported to be able to communicate with patients who were significantly hearing or vision impaired.
- Service delivery did not always meet people's needs. We saw evidence of mixed patient experience and missed key performance indicators in reports from external stakeholders such as Healthwatch Gloucestershire and clinical commissioning group reports. The service was working with stakeholders to improve the service and had recently undergone a management recruitment and restructure in order to deliver the requirements of their contract in 2016 and beyond.

We saw several areas of outstanding practice including:

- Control and road based staff recognised where they could help patients. Staff went out of their way to assist patients we were told by a patient of an example of staff amending their journey to help a patient who was delayed by another provider. There were other examples that we saw in the incident recording, where staff had identified issues that patients needed assistance with at home and had completed tasks before leaving to ensure the patient was safe as well as emotionally supported.

However, there were also areas of poor practice where the location needs to make improvements.

Importantly, the location must:

- Ensure that mandatory training observations, appraisals and yearly updates for all staff are carried out and up to date including the high dependency ambulance vehicle staff.

Summary of findings

- Ensure that the process in place to record defects in vehicles was recorded and actioned in a timely way was followed.

The location should:

- Ensure that the process for staff to be informed of updated policies, procedures and quality and governance updates is followed and records kept
- Ensure that all equipment and particularly those used to take measurements of patients' blood pressure and oxygen saturation levels are listed on equipment servicing records and serviced and maintained within specified dates.
- Ensure that systems for control to communicate between operational or road based staff enable timely communication via telephone calls and text messaging so that messages about patient's condition or incidents were able to be shared.
- Ensure that policies and procedures for disposal of clinical waste are followed.
- Ensure that battery life for equipment used for text and voice communication is fit for purpose and is reliable
- Ensure that the process for identifying poor performance that needed to be addressed and managed formally was followed.

In addition the location should:

- Consider how staff receive feedback from any incidents they report.
- Consider whether Mental Capacity Act 2005 and deprivation of liberty safeguards training meet staff needs.
- Consider aids for staff to be able to communicate with patients with significant sight or hearing impairment are available.
- Consider reviewing the process and questions for call taking for identifying mental health and other support needs a patient may have once scripted prompts are exhausted.
- Consider carrying out a review of patients comfort in vehicles.
- Consider whether electronic alerts that the planning and control room staff used on patient records that included the word complaint complies with records keeping best practice.
- Consider the method for journey time allocations and whether post code allocation is detailed enough.
- Consider increasing the opportunity for road based staff and control based staff to understand each other's role better.

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)		Our findings were as follows: • There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm. The patients we spoke with during this inspection told us they felt safe with the staff and in the vehicles. • There was an infection prevention and control policy and system that described decontamination of medical devices, vehicles and workwear. Overall we found stations we visited to be visibly clean and tidy. We saw evidence of when vehicles and equipment were last cleaned and when it was next due. • We saw that people were treated with kindness, dignity, respect and compassion while they received care. We received positive comments about ambulance crew from patients, patient's relatives and from staff working at local hospitals we spoke with. Crew were described as 'wonderful' and 'brilliant.' Another patient described crew as 'lovely' and said they could not do enough to help. • People who used services and those close to them were involved by Arriva staff as partners in their care. We heard appropriate responses given to callers when call takers answered questions and explained the eligibility criteria for non-emergency patient transport. This included calls to staff of organisations and patients • Mandatory training for the coming months had been planned as mandatory training records showed that not all staff had received the yearly training. However targets and completion of mandatory training overall was high compared to other organisations. • Staff were trained to recognise and respond to the needs of patients living with a learning disability, with mental health illness, living with dementia and bariatric patients. This was supported by the service's equality and diversity policy as well as equipment.

Summary of findings

- The service ensured that lessons were learnt and actions taken as result of complaints. Patients and people's complaints and concerns were listened to and used to inform action plans to improve the quality of care.
- There were governance frameworks in place to support staff to know their responsibilities and that quality, performance and risks were understood and informed action plans.

However:

- Not all lessons were learned when things went wrong. Staff told us that it was difficult to report incidents on the electronic system. They said they frequently experienced long waits when calling the control room to report incidents so some improvements were not identified when things went wrong.
- Mandatory training records showed that not all staff had received the yearly mandatory training.
- There was not a robust system in place to make sure defects in the vehicles were recorded and always actioned in a timely way and vehicles were not always taken off the road for repair.
- Delays and long waiting times for patient outbound journeys from clinics were a recurring theme amongst staff we spoke with at the local hospital and patients. We saw that the service had investigated all incidents or were in process of doing so. Themes included, the service arriving late and other organisations moving patients to a different location and not letting the service know or providing incorrect mobility information.
- Staffing was at 85% for road based staff transporting patients.
- We did not see any aids for staff to be able to communicate with patients who were significantly hearing or vision impaired.

Arriva Transport Solutions - South West

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to Arriva Transport Solutions - South West

Arriva Transport Solutions South West is part of Arriva Transport Solutions Limited, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Limited is part of an international transport group Deutsche Bahn (DB). Since December 2013 Arriva South West have provided non-emergency patient transport for Bath and North East Somerset, Wiltshire, Gloucestershire and Swindon. The service covers a mix of urban and rural areas including cities such as Bath, Salisbury and Gloucester, large towns such as Swindon, and rural areas such as Wiltshire. The aims and objectives of Arriva Transport Solutions Limited is to provide Private Ambulance Services for non-emergency patient transport on behalf of the NHS. The journey types and categories of patient they transport include, outpatient appointments, hospital discharges, hospital admissions, hospital transfers, renal, oncology, palliative care, intermediate care, mental health, paediatric, bariatric and transport from an acute hospital of high dependency patients who had received specialist treatment such as unblocking of cardiac arteries.

We inspected the five key questions whether the service was safe, effective, responsive, caring and well-led. We inspected the ambulance stations at Gloucester, Keynsham and Swindon. We inspected these locations in order to speak to patients and staff about the ambulance service.

We undertook a responsive unannounced inspection following concerns raised by a number of patient organisations and health trusts. Concerns were regarding patient experience and safety following an increase in complaints from service users to Healthwatch Gloucestershire about delays to travel times, affecting both pick up for transport to appointments and return home. There were common themes emerging from patient and public feedback following a report from Healthwatch Gloucestershire who received 197 pieces of feedback about Arriva Transport Solutions between December 2013 and May 2016. Delays in homebound journeys accounted for 28% of the feedback, 22% identified inconsistencies in eligibility criteria for patients, 21% accounted for delays on outbound journeys, 11% related to the condition of the vehicles and 3% identified difficulties in getting through to the booking centre. Also, 14% of the feedback collected accounted for the misunderstanding of Healthwatch Gloucestershire's role by Arriva staff and some patients.

Our inspection team

Our inspection team was led by:

Inspection Lead: Nigel Timmins, Inspection Manager, Care Quality Commission

The team included CQC inspectors and two specialist advisors who had extensive experience and knowledge of emergency ambulance services and non-emergency patient transport services.

Detailed findings

How we carried out this inspection

We undertook an unannounced inspection of Arriva Transport Solutions South West non emergency patient transport service on 19, 20 and 21 July 2016.

We visited three of the six ambulance stations run by Arriva South West in Gloucester, Keynsham and Swindon. We spoke with three patients and observed the care of three others. We inspected five ambulances including the High Dependency ambulance and an ambulance car to check they were clean and had been maintained and serviced.

We spoke with the head of the south region, the managing director who was the registered manager, and the quality and safety lead who was also the infection prevention and control lead. We spoke with managers, deputy managers and team leads at the three ambulance stations. We also spoke with control and planning staff including those who spoke with members of the public, road based crews, and locality managers who worked closely with hospitals and clinics. In total we spoke with 14 staff including ambulance crews, team leaders and managers. We spoke with three patients who were using the service.

We looked at five ambulances including the High Dependency Unit ambulance and an ambulance car.

We reviewed a range of evidence from Arriva Transport Solutions South West including policies and procedures, performance and quality reports, incidents and complaints, safeguarding referrals, training information and vehicle maintenance information. We also gathered information from other organisations including Healthwatch Gloucestershire, clinical commissioning groups and three NHS Foundation Trusts and a community care services trust. We did not accompany patients on journeys. We did not speak with any sub-contractors of, or volunteers for the service.

Facts and data about Arriva Transport Solutions - South West

Arriva Transport Solutions South West was part of Arriva Transport Solutions Limited a nationwide provider of independent, non-emergency patient transport services on behalf of the NHS. Arriva Transport Solutions Limited was part of an international transport group. They were registered to provide transport services and triage and medical advice provided remotely.

The journey types and categories of patient transported included outpatient appointments, hospital discharges, hospital admissions, hospital transfers and renal, oncology, palliative care, intermediate care, mental health, paediatric, bariatric and transport from an acute hospital of high dependency patients who had received specialist treatment such as unblocking of cardiac arteries .

- Arriva Transport Solutions South West undertook 254,920 patient journeys from June 2015 20 June 2016 in the South West Region.
- The service employed 27 staff in the Bristol control, 169 ambulance care assistants and 30 additional bank staff who provided the equivalent of 27 full time staff. The service provided transport services 24 hours a day from some of their stations in the South West.
- The ambulance control operated 24 hours a day with the Keynsham base also operating 24 hours a day. Gloucester station opened until 1am and some of the rest of the stations closed before or at 11pm.
- The service had a fleet of 89 vehicles in the South West, including ambulances that could cater for stretchers and wheelchairs, patient transport cars and bariatric ambulances.

Notes

1. We did not give a rating for Arriva Transport Solutions - South West as they have not yet had an announced comprehensive inspection

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Arriva Transport Solutions South West is part of Arriva transport solutions who are registered to provide transport services and triage and medical advice provided remotely. Arriva Transport Solutions South West is part of Arriva Transport Solutions Limited, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Limited work with clinical commissioning groups, hospital trusts, community health care trusts across Bath and North East Somerset, Wiltshire, Gloucestershire and Swindon. They provide non-urgent patient transport between people's homes and healthcare establishments.

- Arriva Transport Solutions South West undertook 25,4920 patient journeys between June 2015 and 2016 in the South West Region.
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Patient transport services (PTS)

Summary of findings

Our findings were as follows:

- There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm. The patients we spoke with during this inspection told us they felt safe with the staff and in the vehicles.
- Staff were trained to recognise and respond to the needs of patients living with a learning disability, with mental health illness, living with dementia and Bariatric patients. This was supported by the service's equality and diversity policy as well as equipment.
- We saw that people were treated with kindness, dignity, respect and compassion while they received care. We received positive comments about ambulance crew from patients, patient's relatives and from staff working at local hospitals we spoke with. Crew were described as 'wonderful' and 'brilliant.' Another patient described crew as 'lovely' and said they could not do enough to help.
- People who used services and those close to them were involved by Arriva staff as partners in their care. We heard appropriate responses given to callers when call takers answered questions and explained the eligibility criteria for non-emergency patient transport. This included calls to staff of organisations and patients
- The service ensured that lessons were learnt and actions taken as result of complaints. Patients and people's complaints and concerns were listened to and used to inform action plans to improve the quality of care.
- There were governance frameworks in place to support staff to know their responsibilities and that quality, performance and risks were understood and informed action plans. However, senior managers acknowledged that there was some way to go in a number of areas. For example, achieving key performance indicators, reducing the number of complaints related to delays.
- There was an infection prevention and control policy and system that described decontamination of medical devices, vehicles and workwear. Overall we found stations we visited to be visibly clean and tidy. We saw evidence of when vehicles and equipment were last cleaned and when it was next due.
- Mandatory training for the coming months had been planned as mandatory training records showed that not all staff had received the yearly training. However targets and completion of mandatory training overall was high compared to other organisations.. Arriva staff had been notified by a governance and quality mandatory training bulletin June 2016 that required them to attend either for a full one day mandatory training day (operational staff, including bank staff) or a half a day (control staff and non-operational managers).

However:

- There was not a robust system in place to make sure defects in the vehicles were recorded and always actioned in a timely way and vehicles were not always taken off the road for repair.
- Not all lessons were learned when things went wrong. Staff told us that it was difficult to report incidents on the electronic system. They said they frequently experienced long waits when calling the control room to report incidents so some improvements were not identified when things went wrong.
- We did not see any aids for staff to be able to communicate with patients who were significantly hearing or vision impaired.
- Delays and long waiting times for patient outbound journeys from clinics were a recurring theme amongst staff we spoke with at the local hospital and patients. We saw that the service had investigated all incidents or were in process of doing so. Themes included, the service arriving late and other organisations moving patients to a different location and not letting the service know or providing incorrect mobility information.

Patient transport services (PTS)

Are patient transport services safe?

Our findings were as follows:

- Mandatory training for the coming months had been planned as mandatory training records showed that not all staff had received the yearly training. However targets and completion of mandatory training overall was high compared to other organisations.. Arriva staff had been notified by a governance and quality mandatory training bulletin June 2016 that required them to attend either for a full one day mandatory training day (operational staff, including bank staff) or a half a day (control staff and non-operational managers).
- Evidence from the provider at the time of our inspection showed the compliance rates for mandatory training for each ambulance station at June 2016. The rates of completion were:
  - Gloucester 85%,
  - Lydney 90%,
  - Newport 90%,
  - Keynsham 88%,
  - Swindon 97%
  - and Salisbury 92%
- All except Swindon were below the 95% service target completion rate. The target of 95% was particularly high compared with other organisations.
- We saw evidence of learning that directly benefited patients such as reviewing and developing patient feedback processes. There were also plans for 2016/17 to continue working with commissioners on learning from the level of harm, as well as distress, caused by incidents of delayed transport, to ensure quality improvements improved patient experience
- Staff were aware of their responsibilities to report incidents to managers. We saw incident reporting that covered what staff did to manage resuscitation, safeguarding regarding staff, patients, and injuries during transport.
- Staff we spoke with were aware of their responsibilities regarding duty of candour and understood the importance of being open and transparent with patients when things go wrong.
- There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm. The patients we spoke with during this inspection told us they felt safe with the staff and in the vehicles.
- There was an infection prevention and control policy and system that described decontamination of medical devices, vehicles and workwear. Overall we found stations we visited to be visibly clean and tidy. We saw evidence of when vehicles and equipment were last cleaned and when it was next due. Vehicles were cleaned at the end of each shift vehicles we inspected were clean and tidy.
- The service made sure that up to date 'do not attempt cardio pulmonary resuscitation' (DNACPR) information and end of life care planning was appropriately recorded when patients were being transported. Arriva Transport Solutions South West carried out a comprehensive review of DNACPR in November 2015.
- Staffing was at 85% and there was a recruitment plan in place.
- The service had a major incident plan and was available on the instructions of the clinical commissioning group to provide additional transport services in the event of a major incident. The service had taken part in one telephone call exercise 25 August 2015.

However

- Not all lessons were learned and some potential for improvements were not identified when things went wrong. Some staff reported that they frequently experienced long waits when calling the control room to report incidents.
- There was not a robust system in place to make sure defects in the vehicles were recorded and always actioned in a timely way and vehicles were not always taken off the road for repair.
- Staff said it was a common occurrence for them not to get their breaks. They told us that this was because not enough time was allowed in the schedule for staff to take their breaks. We saw that on occasions journeys would be booked in to start immediately after the crew's break which did not allow time to travel to pick up.
- Oxygen cylinders were not stored safely and correctly and fire and risk assessments relating to control of substances hazardous to health were not completed for all stations. Action was taken to resolve the issue when it was raised.

- Ambulance crew and other staff had not had any specific training in respect to major incidents and the service had not engaged in regular table top or practice exercises for managing major incidents in 2015/16.

Incidents

- The content of the yearly mandatory training was changed depending on the needs of the service or incidents that had occurred. As an example, during 2015 there had been increased emphasis on driver training because of an increase in minor vehicle accidents. At the time of our inspection, the emphasis was on moving and handling. For control staff and non-operational managers, a session had been developed to refresh staff on incident reporting requirements and the use of electronic reporting systems.
- There had been two serious incidents investigated by the service in the year prior to our inspection; one safeguarding event October 2015, and one patient injury September 2015. The two incidents were investigated through root cause analysis and both notified to CQC..
- In total 128 incidents or other occurrences not requiring a level of investigation as for serious incidents were reported by the service between October 2015 and July 2016. Of those, seven were classed as transportation, admission or discharge, two were about patients home security, four about medical devices, 34 about patient injury or illness, one related to damage to a third parties property, three confidentiality issues and 25 abusive, violent, or disruptive behaviour/safeguarding concern. Seventy seven recorded incidents were closed, whilst all the rest were under investigation.
- Staff we spoke with were aware of their responsibilities to report incidents to managers. We saw incident reporting that covered action staff had taken following resuscitation, safeguarding of staff and patients, and injuries during transport. We spoke with staff who told us there was a policy and procedure in place for ambulance crews to report incidents involving patients and vehicles. We reviewed this policy and saw that it described the arrangements for reporting, managing and learning from incidents which arose from the activities of the service and any subcontracted or agency provider working for or on behalf of the service. It also defined the types of incidents that may occur and clarified the process of reporting and the classification of incidents.
- We saw evidence of some learning from incidents that directly improved patient care such as reviewing and developing patient feedback processes. There were plans for 2016 /17 to continue working with commissioners on learning from incidents relating to delayed transport and the level of harm and distress caused to ensure improvements were made.
- The incident reporting management process was supported by an electronic system. The system allowed electronic reporting of incidents by managers and staff in control centres on behalf of all staff, volunteers and third party providers. Staff described what would be classified as an incident and gave us examples of incidents that they had raised. Staff telephoned directly to the control room and the incident would be recorded on the electronic reporting system. Incidents would then be sent directly to the manager at the appropriate base to be dealt with. However staff told us that it was difficult to report incidents on the electronic system. They said they frequently experienced long waits when calling the control room to report incidents. As a consequence they did not always have the time to report incidents. This may have led to some staff not reporting incidents.
- Not all lessons were learnt and improvements were not always identified when things went wrong. Some staff told us they did not receive feedback from incidents they reported.
- There was a separate incident reporting procedure for incidents involving vehicles. Paper based vehicle incident reports had to be completed within 12 hours of the incident occurring and the manager of the base informed. A set of specific criteria was used by managers to identify the severity of the incident which determined the investigation process. We observed an example of a recent incident involving a vehicle collision and the investigation process that had been followed correctly.
- We saw example from October 2015 of when staff had reported a range of incidents including injuries to patients that had happened when patients were not under the care of the service, safeguarding concerns, and communication issues between control and staff who booked transport which had resulted in incorrect booking information being given. We reviewed one record of an incident which involved incomplete information being handed over to Arriva staff regarding the resuscitation status of the patient. The service had

not always had relevant information passed to them by the organisations that booked the transport. Whenever this occurred local managers worked with providers to try to prevent a reoccurrence.
- The incident reporting procedure was laminated and was available in a box which the crew took with them at the start of every shift.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, was introduced in November 2014. This Regulation requires organisations to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Staff we spoke with were aware of their responsibilities regarding duty of candour. They were aware of the regulation and when to use it and understood the importance of being open and transparent with patients when things go wrong. We asked one senior manager if duty of candour had been used and were told that it was mainly done at the time of the incident, patients were apologised to. We did not see evidence of letters meeting duty of candour.

Mandatory training

- Mandatory training included a safeguarding update (including deprivation of liberty safeguards and the Mental Capacity Act 2005), basic life support and oxygen therapy update, vehicle cleaning and infection control, patient handling update and practical, incident management, operational updates, information governance updates and fire safety update. The content of the yearly mandatory training was changed depending on the needs of the service or incidents that had occurred. As an example, during 2015 there had been increased emphasis on driver training because of an increase in minor vehicle accidents. At the time of our inspection, the emphasis was on moving and handling. For control staff and non-operational managers, a session had been developed to refresh staff on incident reporting requirements and the use of electronic reporting systems.
- Mandatory training records showed that not all staff had received their yearly mandatory training. However targets and completion of mandatory training overall was high compared to other organisations.. At the time of our inspection, 25 (8.4%) ambulance staff were overdue on their yearly mandatory training updates. For some of the 25 staff, the last time they completed mandatory training was in 2014. Documents requested from the provider at the time of our inspection showed the compliance rates for mandatory training for each ambulance station at June 2016. The rates of completion were:
  - Gloucester 85%,
  - Lydney 90%,
  - Newport 90%,
  - Keynsham 88%,
  - Swindon 97%
  - and Salisbury 92%
- All except Swindon were below the 95% service target completion rate. The target of 95% was particularly high compared with other organisations. We saw records of dates planned and named staff for training later in the year for those who were not up to date with mandatory training. Staff were aware of the dates.
- The training records showed not all staff had not received first aid at work training or infection control training for the previous year.
- Staff were not required to attend mandatory training if they had attended a full induction course in the last year.
- Service managers had action plans in place to monitor attendance rates throughout the rest of 2016 to ensure all staff received the correct mandatory training by March 2017.
- Arriva staff had been notified by a governance and quality mandatory training bulletin in June 2016 that they were required to attend either a one day mandatory training update (all operational road based staff, including bank staff) or a half day mandatory training update (control staff and non-operational managers).
- The control room staff were due to have mandatory annual training, but the training records were blank for this group of staff. It was not clear when this training had last occurred.

Safeguarding

- There were reliable systems, processes and practices in place to protect adults, children and young people from avoidable harm. Staff had received training in the safeguarding of adults and children but not all had received updates. Staff understood the different forms

of abuse and could recognise the potential signs of abuse. Staff we spoke with knew how to report safeguarding concerns and where to seek additional advice when necessary.

- We saw evidence from incident reporting of safeguarding alerts raised about staff, other organisations and home circumstances. The patients we spoke with during this inspection told us they felt safe with the staff and in the vehicles.
- We saw in the Gloucester and Swindon stations, contact details for the local safeguarding team were on display for staff to use if necessary. The information was also in the box assigned to the vehicle taken by road staff on every journey.
- Disclosure and barring service (DBS) checks for all staff were carried out including taxi drivers and staff from other independent ambulance services used by Arriva Transport Solutions South West. The service had a policy and checklist to complete for ensuring staff had up to date DBS. Other providers used were expected to carry out their own checks on staff before they were used and they were then entered onto Arriva's approved list. Additionally independent hire drivers had to have had a current DBS through their local authority as part of the licensing programme. For volunteer drivers, the service conducted the DBS checks in the same way as for Arriva Transport Solutions South West employees. When agency staff were used, the service would also check that the agency had completed the relevant employment checks.
- The majority of staff had received 'prevent' training. Prevent training is the counter-terrorist programme which aimed to stop people being drawn into terrorist-related activity.
- Volunteers and third party transport were issued safeguarding flowcharts and policies. If they were engaged on patient journeys with Arriva Transport Solutions South West they were required to report all incidents including any safeguarding referrals they made through the Arriva control room and this information was managed through the electronic reporting system.
- The head of quality was the safeguarding lead for the service and had access to external support and advice if needed through local authority safeguarding contacts.

Cleanliness, infection control and hygiene

- There was an infection prevention and control policy and system that addressed all relevant aspects including decontamination of medical devices, vehicles and workwear.
- The Swindon, Gloucester and Keynsham bases had cleaning products and disposable mop heads available at bases to support staff with this task. Staff had access to cleaning sprays, cloths, wipes and disposable gloves. These could all be replenished at the bases when required. Cleaning products on ambulances were kept in an overhead storage locker. We saw there was a system of using colour coded mops with different cleaning products to avoid cross-contamination. Safety information and instructions for use of the cleaning products were on display to ensure staff safety when using the products. Sluice areas at stations were clean and tidy. Vehicles contaminated beyond crews ability to clean it between patients or when needing equipment not routinely available on return to station would be cleaned by an external company. We saw audit of vehicle cleaning completed 12 July 2016 which demonstrated that the service had achieved 95% although the sample was small (20% of vehicles) .
- Overall, we found stations we visited to be visibly clean and tidy. However, in one corner of Gloucester station in the garage we found bags of salt for use in icy conditions. These bags were stacked on a wooden pallet and on the floor. It appeared that some of the bags had spilt out onto the floor and had not been cleaned up.
- Clinical waste bins were present at stations we visited. In Gloucester this was in the garage for staff to dispose of any soiled waste. The bin was kept locked. We saw that at Gloucester staff did not always dispose of clinical waste appropriately. It should be put in a bag and tied before being put into the clinical waste bin. We saw that items had been put into the bin without being put into a bag first. This resulted in a possible risk of cross infection. We raised this during inspection.
- We inspected five vehicles and found them to be visibly clean and tidy. Clean linen was available for patients.
- We saw evidence of when vehicles and equipment were last cleaned and when cleaning was next due.
- Staff were regularly audited for infection prevention and control awareness and practice. Both audit achieved 100% although the sample size was small for both (30%

and 5%). This was due to availability of staff on station and staff to carry out audit. We saw staff use personal protective equipment appropriately including gloves and aprons.

- The head of quality was the infection control and prevention lead for Arriva Transport Solutions South West. We saw evidence of national guidance followed by the lead in infection prevention and control policy.

Environment and equipment

- There was not a robust system in place to make sure defects in the vehicles were recorded and actioned in a timely way. Daily vehicle safety checks were carried out by operational road staff who used electronic tablets assigned to each individual vehicle to record them. A new electronic format had been introduced in April 2016 which some staff were still getting used to. Information was recorded and individually stored for each vehicle on a database. Managers would check this daily to identify any issues with vehicles which required repair and action this as appropriate. There was still work to be done around the use of the electronic system around improving the order of the vehicle check requests for example, from the front to the back of the vehicle to make the process more streamlined and efficient.
- We saw that one vehicle had not been taken off the road for repair despite the repair being highlighted several times. We looked at the checklists for June 2016 for all vehicles and cross checked this against maintenance records. We found on one vehicle, staff had reported that the emergency doors did not open from the inside which posed a risk to patients and staff in the event of an accident. Staff documented this issue on the checklist on the 30 June 2016 and again on the 19 July 2016. This issue had not been picked up or actioned for repair. We raised this with a manager during our inspection and they were unsure as to why it had been missed. The vehicle was taken off the road and booked in for repair once we had raised this with a manager.
- We asked how staff kept track of vehicles when they were due for a service and we were shown a board indicating the service date for each vehicle. During inspection we were told that there was no central recording and that staff relied on the individual service indicators in each vehicle displaying when a service was due. We were also told that records were held centrally following inspection. We looked at the board with the vehicle servicing dates and found it to be inaccurate. As an example, one ambulance showed that it was last serviced on the 30 December 2014 when the fleet department confirmed it was serviced on the 2 March 2016. This meant that it was not clear to all staff when all vehicles had been serviced and so the staff couldn't be assured if the information was correct.
- We reviewed records of equipment and maintenance schedules including vehicles and medical devices. The fleet at the Gloucester station consisted of 25 vehicles. At the time of our inspection, five of these vehicles were not in use because they were being repaired. We looked at five vehicles and found that they had been serviced according to manufacturer's instructions. The first aid kit and fire extinguishers were all in date. Equipment such as wheelchairs, ramps, carry chair and stretchers had all be serviced appropriately.
- Arriva Transport Solutions South West could not assure themselves that equipment on their high dependency unit vehicle was maintained. One ambulance at the Gloucester station was used as a High Dependency Unit vehicle to transport patients with heart problems between the Gloucester and Cheltenham acute hospitals. The ambulance was equipped with additional equipment such as a defibrillator and machines for taking blood pressure and monitoring oxygen levels in the patient's body. The majority of equipment carried on this ambulance had been serviced regularly and stickers were in place to confirm the next service. Other equipment such as the first aid kit and fire extinguishers were all in date. The exception was that the blood pressure machine and the machine for recording oxygen levels. Both of these pieces of equipment did not have any information as to when they were last serviced and calibrated; this was normally undertaken by a third party provider. Neither of these pieces of equipment were listed on the service's equipment servicing records for 2015 or 2016. We raised this with managers during the inspection who said they would address it.
- Car seats were available for children using patient transport at each base although staff told us that parents usually brought their own child's car seat. Arriva staff told us that staff should carry out a visual check of the seat and ensure it is safe and securely fitted into the vehicle. If there were any doubts over the safety or condition of the child seat staff were aware they should not complete the journey.
- Each ambulance was fitted with a tracking system which performed several different functions. When staff logged

in, the system enabled managers at the bases and the dispatch team to view the status of the ambulance for example location, whether they were driving or stationary so could allocate work more efficiently it also monitored the performance of the driver. Each Arriva staff member had their own fob to enable them access to the system, with spare fobs for agency staff who had to sign the fobs in and out for their shifts.

- There was a system in place to ensure stock on the ambulances could be replenished at the start or end of a shift. There was a store at each base which held items such as personal protective equipment, for example aprons, gloves, hand gel and other items such as disposable blankets, disposable sheets for stretchers and water that may be required during a journey. A system with staff signing out stock items that had been taken to replenish vehicles was in use. This helped managers to identify current stock levels and when new stock needed ordering.
- There were 92 vehicles based in the south west a mix of stretcher, seated and high dependency ambulances (three). The service had vehicles and equipment for bariatric patients. The Keynsham base had one bariatric vehicle, a stretcher and two wheelchairs to accommodate bariatric patients. The vehicles met patient's needs.
- Electronic tablets used to send and receive patient information were reliable in sending and receiving information. The battery life on the tablets was considered poor by ambulance crew. They reported that using the tablet and making telephone calls drained the battery very quickly. Charging the device was slow due to having to do this on board the ambulance. We were not aware of any patient harm from this and battery life had been reported

Medicines

- No emergency medication was carried on the ambulances and staff did not administer medication. Staff would ensure that any medicines provided to patient by the hospital to take home arrived safely with the patient.
- Each ambulance was equipped with oxygen which staff were able to administer to patients if it had already been prescribed by a doctor. Staff were not allowed to alter the flow rate of the oxygen.
- Staff working on the high dependency unit ambulance had received additional training in oxygen therapy in relation to resuscitation.
- We looked at where the oxygen cylinders were stored in the Gloucester and Swindon stations. When we started our inspection, the cylinders in Gloucester were stored in a corner of the garage, however, on the third day of the inspection they had been moved into a store room and another locked metal cabinet. The Health and Safety Executive (Oxygen use in the workplace, INDG459) states that 'oxygen cylinders should be stored in a well-ventilated storage area or compound, away from combustible materials'. The metal cabinets did not appear to be ventilated and they were stored next to combustible materials and chemicals. The cabinets were provided by a third party for the service's use. We asked if a risk assessment had been carried out for the storage of the oxygen cylinders but the managers were unaware if one had ever been completed. We saw managers begin enquiries about whether cabinets were safe to use or not and we were given assurance that all issues were resolved following inspection.
- In Swindon, the storage of oxygen cylinders was in a store room. The cylinders were immediately adjacent to combustible materials including paper and flammable liquids and cleaning products hazardous to health. The door was not a fire door. There were no door signs to identify the room contents for example compressed gas. We saw that seven full cylinders were restrained with a thin nylon strap in racking that staff had to bend forward to manoeuvre the cylinders. One empty cylinder was free standing close to the door. The empty cylinder was a hazard and could cause harm to staff if it fell. The empty cylinder was not stored with a clear division between it and full cylinders. We brought these issues to the attention of the station manager. We also asked them for the latest risk assessment for medical gas storage and one for the control of substances hazardous to health. The risk assessments provided were generic and did not address the specific issues we identified. The general manager responded by instigating a risk assessment for medical gas storage and one for control of substances hazardous to health and informed senior management of the issues immediately and we were given assurance that all issues were resolved following inspection. The issue was also entered onto the risk register.

- Oxygen was appropriately stored on the ambulances. Each ambulance carried one large oxygen cylinder and one portable cylinder which was secured appropriately on the vehicle. An electronic system using barcode on oxygen cylinders was used to monitor stock. This was replaced frequently by the medical gas company.

Records

- Patient records were created at the control centre and received by ambulance crew on the electronic tablet associated with each particular vehicle. Control staff collected relevant information during the booking process so that they recorded the information regarding patient's health and circumstances. For example any information regarding access to property or illness issues. The process ensured crews were informed about any needs or requirements the patient may have during their journey.
- Several ambulance crews reported that the information provided on the patient record was sometimes incorrect, out of date or very limited. Crews reported that information regarding patients' mobility status was sometimes not updated or incorrect from organisations booking transport and information regarding access to a property was often inaccurate. We saw evidence of this in minutes and incident reports. There had been 11 incidents where issues of incorrect or missing information had occurred in the previous six months. These occurrences had been raised with the organisations that had supplied the information.
- The service made sure that up to date 'do not attempt cardio pulmonary resuscitation' (DNACPR) information and end of life care planning was appropriately recorded when patients were being transported.

Assessing and responding to patient risk

- Risks to people who used services were assessed, and their safety was monitored and maintained. All staff working on the ambulances had been trained in basic first aid which gave them initial skills to notice if a patient was deteriorating and when to call emergency help. Training records showed that subsequently not all staff had had refresher training for basic first aid.
- There was a standard operating procedure for road based staff to follow in the event of a patient deteriorating during a journey. Staff we spoke with reported that they would pull over and stop the vehicle, and safely call 999 to request the emergency services. They would then inform managers at their base of the situation, in line with the procedure and would support the patient as best they could until help arrived. We were told that this situation had not arisen recently.
- Risk assessments were carried out by team leaders and managers when required. If control staff identified a risk to crew and patients due to poor access at a property, managers would visit the property to assess this risk. We were provided with an example where a risk assessment around access to a property had been carried out recently. The information was then fed back to control and added to the patient record. Managers were able to speak with road crew directly if necessary to provide further advice and information.
- Policies and procedures were in place to manage violent or aggressive patients but not all staff felt they were trained and equipped to deal with aggressive patients. We did not see any evidence of 'breakaway training' or how to escape someone's grip. Staff we spoke with said a small part of the training programme focused on a discussion around the management of aggressive and violent patients. Newer members of staff reported that this was helpful but felt that they learnt on the job about how to manage these situations. Staff reported that in these cases, they tried hard to listen to and talk to the patient to try and diffuse any escalating situation.

Staffing

- Arriva Transport Solutions South West had a recruitment plan in place and had employed a recruiting coordinator to fill vacancies.
- We reviewed the services human resources dashboard, which showed us that for the service the full staffing establishment was 198 whole time equivalent (WTE) posts. At the time of our inspection there were only 169.6 WTE of actual staff in post or 85%. The vacancy rate had remained reasonably consistent since January 2016 ranging from 15% to 11%. Control staff moved vehicles and staff as necessary between ambulance stations when shifts were unfulfilled due to staff absence. In addition they would also use extra volunteers and taxi services if needed.
- The service employed 27 staff in the Bristol control, 169 ambulance care assistants and 30 additional bank staff who provided the equivalent of 27 full time staff.
- Some of the staff covered shifts throughout a 24 hour period. Staff working out of normal office hours were supported through the control centre. Staff never

worked alone at night. The ambulance control operated 24 hours a day with the Keynsham base also operating 24 hours a day. Gloucester station opened until 1am and the rest of the stations closed before or at 11pm.

- We saw recruitment records for July 2016 including numbers of staff leaving and the reasons for this. For example some recruits had not met the requirements of the probation period. We saw forward planning for a specific need to increase staffing levels for a part of the service due to a third party provider discontinuing with the service.
- We saw evidence that staff sickness rate had significantly reduced to one of the lowest level seen by the service. A process was in place with manager reviews and occupational health referrals where appropriate.
- Station managers at local level managed anticipated resource risks by scheduling rotas in advance and managing pre-planned holidays and other leave. Staff said the resource planning to take booked holidays into account had significantly improved. Staff were able to take holidays or days off at short notice if they negotiated this with colleagues or other staff where available. Those staff we met said they were able to take unplanned time off (such as for funerals or medical appointments) and the managers were helpful and sympathetic towards this. We saw action plans that covered a range of response to this for example the implementation of electronic assisted planning and despatch.

Anticipated resource and capacity risks

- There was good joint working between the service and local hospitals. There were daily conference calls and other calls between the locality manager and hospitals. This allowed issues to be picked up in each area to assist planning for the day and be escalated to senior managers as necessary. For example areas of particularly high demand or a shortfall in vehicles due to maintenance. The calls enabled staff to contact hospital and other organisations if they needed to highlight difficulty in meeting appointment times.
- Staff planned journeys around roadworks however there was sometimes a lack of information on current traffic alerts. Major road works were noted, but we did not see that daily traffic alerts were communicated to staff on a consistent basis. This would have allowed the journey planners or the road staff themselves to avoid road closures, accidents or road works to reduce any possible delays. It was expected that staff rely on their own local knowledge to avoid traffic congestion although central planning did not necessarily have local knowledge.
- Staff said it was a common occurrence for them not to get their breaks. They told us that this was because not enough time was allowed in the schedule for staff to take their breaks. We saw that on occasions journeys would be booked in immediately after the crew's break which meant they then had to drive during their break. This issue was on the risk register where it was recorded as an issue from a staff survey, but not recorded as one of the top five negative issues in the most recent staff survey we saw from 2015.
- There was an electronic system that was used to give staff up to the moment overview of staff driving style, duration and breaks which would provide evidence to managers of who was unable to take a break and this information could be used to inform discussions with short notice planning of journeys. There had been changes made in the electronic planning system to enable planned meal breaks. Opportunities to take breaks had been agreed and the situation was being monitored by control managers.
- Other companies were used on a sub-contract basis by the provider. These companies ranged from other independent ambulance companies to independent taxi companies. We saw evidence of Sub-contractor status and a monitoring spreadsheet, so staff using them could see who was approved for use or not. However, the record did not have a date of review or last editing or who had amended it.
- Some risks to the service were not always anticipated and planned for in advance. There was a major incident policy that had guidance for staff to follow in the event of changes in demand, seasonal or weather changes, loss of services or infrastructure, disruption to staffing levels or disruptions to hospitals receiving patients. We did not see any evidence of Arriva Transport Solutions South West conducting internal business continuity testing for example, a process for managing extreme numbers of staff sickness or vehicles being unserviceable due to contaminated fuel.

Response to major incidents

- As an independent ambulance service, the provider was not part of the NHS major incident planning. However, the provider had a major incident plan in place and they

were available on the instructions of the clinical commissioning group to provide additional transport services in the event of a major incident. Staff understood their role in major incidents was to transfer suitable patients from and between hospitals to make capacity available for emergencies.

- Arriva Transport Solutions South West's policy stated they would be expected to join a healthcare teleconference and during that call it would become clear whether the service had a role to play or not. The request for support would come from the local involved ambulance trust and would require approval from local commissioner.
- The managers of the service were aware that any involvement in supporting a major incident would have a direct impact on their routine, core business – and might affect patients belonging to another clinical commissioning group which was otherwise unaffected. For this reason Arriva Transport Solutions South West policy stated, communication and commissioner approval was an important first step.
- The service had taken part in one telephone call exercise 25 August 2015.
- Ambulance crew and other staff had not had any specific training in respect to major incidents and the service had not engaged in regular table top or practice exercises for managing major incidents in 2015/16.

Are patient transport services effective?

Our findings were:

- Performance in achieving targets for pick up, drop off and journey time on vehicle was mixed. However, the service was working with commissioning groups and other organisations to address this and meet the increase in demand and to operate as efficiently as possible to ensure patient safety and comfort.
- Delays and long waiting times for patient outbound journeys from clinics were a recurring theme amongst staff we spoke with at the local hospital and patients. Hospital staff provided us with examples when patients had still been waiting for transport to take them home from clinic appointments long after the clinic had closed. Staff recalled incidents where members of staff had waited with patients after their shift finishing times until transport arrived to collect the patient.
- Arriva Transport Solutions South West took over 61% of patient transport booking over the telephone which was above the target figure of 40%. This had an effect on control staff not being able to answer telephones effectively at all times. Although work was being undertaken to work with stakeholders on this.
- The service received 25% of 'on the day bookings' compared to its target of 10%. This indicator was not within the service's control. Locality managers had seen varying engagement between the different hospitals and clinics within the locality on these issues.
- Staff told us they had received training in the Mental Capacity Act 2005. The training took approximately 20 minutes to complete. Staff told us that the training had been useful but had not given them enough information for them to judge people's capacity to give consent. Staff we spoke with did not have the confidence to undertake basic mental capacity assessments.

However,

- People's needs were assessed and appropriate transport provided to patients in line with national and local guidelines.
- Risk assessments were completed for complex patients or patients with body weight or bariatric needs.
- There were arrangements in place to have something to drink for those patients that were on a vehicle for a long period of time. Water was available at each ambulance station for the crews to take on the ambulances and bottles were carried on ambulances and could be provided if required on long journeys or hot days.
- We were told the planning system was set to include time for comfort breaks and take account of patient needs for meals.

Evidence-based care and treatment

- People's needs were assessed and transport provided to patients in line with national and local guidelines. This happened through eligibility criteria assessed electronically using a specific set of questions based on DoH guidelines. Patients had to confirm they were registered under a GP in the commissioning area and that they required transport to or between NHS funded providers before the call takers continued to assess the eligibility of the patient to use the service. Commissioners of the service had decided that all

patients attending dialysis or chemotherapy appointments were eligible to use the patient transport service. Dialysis transport represented 41% of Arriva Transport Solutions South West's total activity.

- We saw two different sets of eligibility questions used by the call takers. One for adults over 18 years of age and one for children up to 18 years of age. The questions asked, helped to determine the most appropriate type of vehicle required for the individual.

Assessment and planning of care

- Control staff followed scripted prompts to understand a patient's condition in order to plan transport appropriately. The eligibility criteria required call takers to ask prompted questions about the patient's condition, health and mobility status, which determined the most appropriate type of transport required. There were stretcher vehicles, wheelchair assisted vehicles, seated ambulances, bariatric vehicles, taxis and volunteer car drivers available depending upon the patients individual need.
- Risk assessments were completed for complex patients or patients with bariatric needs. The World Health Organisation describes people who have a body mass index greater than 30 as obese, and those having a body mass index greater than 40 as severely obese (WHO, 2000). Bariatric needs are those that make supporting patient's mobility, moving and handling needs hazardous to staff and to patients due to the patients weight Risk assessments were recorded on paper at the control centre and contained important information about complex access issues, mobility issues and any issues with bariatric patients that may pose a risk to staff or the patient. The assessment would then be passed on to the manager at the appropriate base to carry out a more detailed assessment. This was then shared with the crew via the manager and also reported back to control to store on the patients record. Crew had access to this information via their electronic tablets carried on each vehicle during each shift.
- Staff generally identified any mental health needs of patients but this was dependent on the call takers experience. The booking form prompted the call taker to ask if the patient had any mental health problems, but did not prompt staff to request any further detail. Staff were taught during the call taker training programme to follow up, independently of the scripted questioning, on any mental health issues a patient may have to support them as much as they could. There was also the opportunity for callers to provide other information when prompted to do so by the call takers at the end of the prompts. However this relied on staff experience and knowing when to move away from the scripted prompts in order to gain all relevant information.
- New mobility codes were introduced by Arriva Transport Solutions South West developed in conjunction with organisations that used the service. This enabled the service to plan better and those booking transport to enable a better understanding, assessment and plan for patient care. In February 2016, the mobility code list had increased to 21 codes. The codes enabled the call takers to gain a better understanding of the mobility status of a patient with 21 categories under four general headings, whilst enabling the planners and dispatchers to allocate the most appropriate resource and crew to the job. Call takers, planners and dispatchers we spoke with felt the codes had improved their ability to provide a more thorough assessments and effective use of resources. Staff of other organisations were also able to understand the best response to give when booking transport.
- Pre-booked transport was planned and arranged a minimum of one day in advance. The planning team used an electronic system to plan and allocate the most appropriate resources to the patient identified, by the booking information collected by the call takers. The assisted planning and dispatch system introduced in August 2015 had key performance indicators for the service embedded into the assisted planning system to ensure that journeys planned met expected targets. Planners felt that the system was effective when organising and planning shorter journeys although there were still problems in delayed journeys both to and from appointments. We saw that some journeys still had to be planned manually.
- The service aimed to provide continuity for patients making regular weekly journeys to the hospital for dialysis. It was a challenge to arrange the same crew to transport patients regularly due to a rotating rota allocating different shift patterns. However, planners were able to initiate a 'carry by' or named a driver or crew status on the system for dialysis patients attending regular weekly appointments, to enable them to

continually travel on the same transport and where possible, with the same patients to and from their dialysis appointment. However, there were still problems in achieving this at time of our inspection.

Nutrition and hydration

- There were arrangements in place to provide drinks for those patients that were on a vehicle for a long period of time. Water was available at each ambulance station for the crews to take on the ambulances and bottles were carried on ambulances and could be provided if required on long journeys or hot days. Water bottles could be replenished at each of the bases.
- No food was carried on board the ambulances for patients. We were told the planning system was set to include time for breaks and take account of patient needs for meals. Some complaints to Arriva Transport Solutions South West and others received were about missed meals due to overly long journeys resulting in patients not being able to have something to eat during this time.

Patient outcomes

- The service's performance in achieving their targets was mixed. However, they were working with commissioning groups and other organisations to address this and meet the increase in demand and to operate as efficiently as possible to ensure patient safety and comfort.
- Delays and long waiting times for patients returning home from clinic journeys were a recurring theme amongst staff we spoke with at the local hospital and patients. Hospital staff provided us with examples when patients had still been waiting for transport to take them home from clinic appointments long after clinic had closed. Staff recalled incidents where members of staff had waited with patients after their shift finishing times until transport arrived to collect the patient. These incidents were reported on the electronic reporting system and given to the service locality manager at the hospital to investigate. We saw that Arriva Transport Solutions South West had investigated all incidents or were in process of doing so. Themes included, Arriva transport arriving late and organisations moving patients to a different location and not letting Arriva know and incorrect mobility information.
- In Arriva Transport Solutions South West's most recent combined performance report for June 2016:
  - Arriva achieved their target for patients travelling less than 10 miles not spending more than 60 minutes on the vehicle on either an outward or return journey for six of the 12 months to June 2015/16. This meant that for 50% of journeys, patients were not on the vehicles for over the locally agreed length of time
  - The service achieved the target for patients travelling more than 10 miles and less than 35 miles and not spending more than 90 minutes on the vehicle on either an outward or return journey all 12 months to June 2016.
  - The service achieved their target for patients travelling more than 35 miles and less than 50 miles and not spending more than two hours on the vehicle on either an outward or return journey for the 12 months to June 2016.
  - Arriva Transport Solutions South West did not achieve the target for all 12 months to June 2016.For patients dropped off between 45 minutes earlier than booked arrival time and 15 minutes later than booked arrival time,
  - For, patients picked up within 1 hour of being 'booked ready' for collection, the service did not achieve the target for all 12 months to June 2016. There was a commissioning for quality and innovation target set for the indicator to provide further incentive to improve.
  - For patients picked up within 4 hours of being 'booked ready' for collection, Arriva Transport Solutions South West achieved their target for December 2015, and January and March 2016. There was a commissioning for quality and innovation target set for the indicator to provide further incentive to improve. The service also had an end of life target for pick-up of patients within two hours of being 'booked ready' for collection. In Arriva's combined report June 2016 for this performance indicator, the service had achieved their target for December 2015 only. However for six other months they were over 70% and five months over 60% with an overall target of 85%.
- Data from the performance dashboard for the Gloucestershire dialysis units from July 2015 to June 2016 showed that on average, 3,515 patients were conveyed every month to the dialysis units. The Gloucestershire clinical commissioning group had set four key performance indicator (KPI) targets in relation to the dialysis units. These were :

Patient transport services (PTS)

- Journey arrival time (target 95%).The service was falling below the 95% target of ensuring patients were arriving 45 minutes before or 15 minutes after their designated arrival time for their inbound journey. Between July 2015 and May 2016, the service was achieving between 82% and 87% of inbound journeys arriving within the allocated time compared to its target. However, 5% of patients in April 2016 and 4% of patients in May 2016 arrived 30 minutes prior to the specified 45 minute arrival time one hour and 15 minutes before their appointment leaving patients waiting for long period of time prior to their appointment.
- Pre-planned outward pick up times (target 85%). Performance was worse than the target of 85% for the majority of months between June 2015 and May 2016 for pre-planned pick up for patients to be returned home. The service aimed to pick patients up within 60 minutes from their 'booked ready' time (the time they were deemed to be ready to be collected and returned home). The service met its target of 85% in November and December 2015 and January 2016. The dialysis units logged when patients were supposed to be picked up against when they were actually picked up. This showed examples of where patients waited a long time to be picked up. In one example, we saw the patient was due to be picked up from home at 8am for their dialysis appointment. The patient was picked up five hours later. In another example, the patient had a delay of four hours waiting for transport. Whilst these lengthy delays were exceptions, the log showed patients regularly waiting in excess of an hour for their transport. The log recorded 107 patient journeys of which 53 (49.53%) waited in excess of one hour to be collected.
- On the day outward pick up times (target 85%) The service demonstrated a varying ability to meet its 85% target of picking up patients within four hours when transport was booked on the day of travel between June 2015 and May 2016. In November 2015, December 2015 and February 2016, the service met its target, however fell below its target for the other months. The contract expected that less than 20% of bookings would be made by telephone. The service took over 25% of patient transport booking over the telephone which was above the target figure of 10%. This had an effect on control staff to able to answer telephones effectively at all times. This indicator was not totally in control of the service who had supported education of call handlers to change this. They were also working on a draft proposal requested by a commissioning group that could be used with other stakeholders to reduce telephone bookings.
- Number of calls answered within 30 seconds (target 85%). Arriva had a target of answering 85% of all calls within 30 seconds. The ability of call takers to answer calls following an automated introductory message within 30 seconds was inconsistent. Between July 2015 and January 2016 the service at its worst was well below the target. In August 2015, only answering 39.6% of calls in 30 seconds, compared to January 2016 where they were performing above their target and answering 88% of calls within the allocated time frame. During our inspection, on 18 July 2016, the rate of call answering within 30 seconds was 24.88% and for the month previous 50.62%. The percentages were displayed on a board in the control room so that staff could see how they were performing. The call takers we spoke with confirmed that this data was reviewed daily by the team lead and discussed informally with them on a daily basis where they fell short of targets.

- For journey arrival times, the service had failed to meet its target every month during this reporting period. For the other two KPI's, pre-planned outward pick up times and on the day outward pick up times, these were consistently met and exceeded the targets for every month during the reporting period.
- The service received 25% of 'on the day bookings' compared to its target of 10%. This indicator was not in the service's control. Locality managers had seen varying engagement between the different hospitals and clinics within the locality on these issues. The service relied on posters and reinforcing online booking and working with stakeholders to increase online booking.
- Locality managers for the service had been working with staff at the local hospitals on a 'train the trainer' scheme in order to increase the ability of hospital staff to use the online booking system. The aim was to train one member of staff in each department who would be able to train other members of staff at the local hospitals. Local hospitals favoured using the telephone booking

system over the online booking system. We were told this was partly down to staff possibly not having to remember passwords or take time to access a computer terminal that was free.

- Arriva managers provided data to a range of stakeholders and we saw evidence of discussion between parties to improve efficiency of patient transport.
- Overall Arriva managers action plans to address performance issues were outlined in the risk register and involved, increasing control staff so the service could answer phones more responsively, maintaining recruitment for road based staff and working with other stakeholders to ensure that non-emergency patient transport was as efficient as possible.

Competent staff

- There was a framework to support staff to have the skills, knowledge and experience to deliver effective care. All crews that worked on the ambulances were supposed to have six monthly observations by a mentor, team leader or manager. We were told and saw evidence that at the Gloucester station, 70% of staff had not received an observation of their care. At the Swindon station 17% of staff had not received an observation.
- Staff at the Keynsham station had not carried out observed practice for most ambulance crew from January 2016 to June 2016. Three had been completed out of 43 staff during this time period. The targets had not been met due to having to cover for absence. We were told the service was trying to improve compliance with this and showed us rotas for August 2016 with allocated times for observed practice for the ambulance crew. Staff had received mentor training and the team lead had also been recruited to support with the drive to achieve compliance with observed practice.
- At the Gloucester station, five members of staff had received additional training to become mentors. This meant they would be able to mentor other staff and undertake the six monthly observations of other staff including those outstanding before March 2017
- The personal development review documentation was comprehensive. Staff self-assessed themselves against the target expected by the provider. The assessment was then agreed between the manager and member of staff. The review covered various topics such as health and safety, attitude and conduct, vehicle maintenance, patient care, quality, service improvement and safeguarding and information governance. Future development needs were discussed.
- Staff competence of delivering patient care was monitored and assessed several ways. The driving of each ambulance was constantly monitored electronically. This took account of the speed travelled, cornering, late breaking or quick acceleration. These aspects of driving had a direct impact on patient comfort during the journey. Each driver received scores which could be accessed at any time by the team leaders or managers. These scores were then rated as green, amber or red. We were told the scores were sometimes discussed with each driver at the end of their shift or during their performance meetings. This helped to make sure the patients were being driven safely and as comfortably as possible to their destination.
- When we inspected Swindon station there was a driving assessor waiting to go out with a crew member who had recently had a road traffic collision and was going to reassess the crew member's driving.
- A training programme was provided for new staff. The course lasted two weeks and incorporated driver training, mandatory training, manual handling and two days of being an observer member of staff on a vehicle with the crew. New employees were assigned a mentor who had received a one-day mentoring training course. Seven shifts were completed with a mentor present and a 'new employee' booklet provided and completed once the new member of crew had completed a task successfully. The mentor programme could be extended if required if a new member of crew needed extra support and was decided by the manager and mentor in conjunction with the new member of staff. A new employee we spoke with praised the quality and depth of information provided during training. Following this new staff had three and six monthly probationary reviews with their mentors. At these reviews, the individual staff performance was discussed alongside health and safety and flexibility of working practice.
- Assistant general managers were responsible for carrying out the appraisals for all staff they managed. Not all appraisals were up to date. We asked if team leaders were able to undertake staff appraisals and we were informed they were allowed during periods of manager absence, but not otherwise. This meant that 69 staff (41%) in Gloucester had not received their

annual appraisal or a six monthly review at the time of our inspection. At the Swindon station, 19% of staff had not received their annual appraisal and 9.7% of staff had not received a six month review. There was an action plan in place to address this, by March 2017.

- Staff who worked on the High Dependency Unit (HDU) ambulance were required to have additional training in airway management, suctioning, use of the defibrillator and use of a bag and mask in a resuscitation situation. Some of the staff we spoke with told us that they should receive yearly updates for this training, but had not had any. We looked at the training records and asked for a list of staff suitably qualified to work on the HDU ambulance. This showed that 32 staff were trained to work on the ambulance, however, 21 (65.62%) had not received training since July to September 2014. We also found that the training matrix had not been updated in a timely way. Staff who had received HDU ambulance training in March 2016 were shown on the training matrix as not having received the training.
- There was no structured approach to regularly monitor the call takers competence with call handling and patient assessment. The call taker team lead would listen into a live call and assessed competence to take and manage calls only when a call taker had demonstrated poor performance identified through a complaint or had not met key performance indicators. We observed completed call monitoring checklists. Actions were identified and discussed with the call taker in order to improve practice. There was no follow up and reassessment to ensure actions were carried out and implemented into practice
- One to one supervision sessions between call takers and the team leader were inconsistent and did not demonstrate quality. There was no formal system or plan in place to ensure call takers were getting regular supervision sessions. However, there was a framework for discussions held during one to one sessions looking at any issues raised, attendance, performance, conduct and complaints and compliments. We saw examples of two records from one to one sessions. The form lacked detail and some boxes were incomplete. The team leads aim was to provide consistent, monthly one to one sessions for all call taking staff.
- There were no specific triggers to identify when poor performance needed to be addressed and managed formally for call takers. Formal management of poor performance was at the discretion of the call taker team lead. At the time of our inspection, none of the call takers were under formal management for poor performance. We were told that informal discussions around performance were not documented and there was no formal framework available if formal performance management situations arose. We were shown an example of one word processed paragraph documenting a conversation between a team lead and the call taker who had been under review for poor performance. The document contained no action plans to work on improving performance.
- The service was not assured that all front line staff were aware of changes to policy and procedure that had been made following patient safety and other alerts. Staff were expected to sign a form once they had read the information however; the form demonstrated 50% compliance. Information about changes to policies and procedures for reporting incidents was available on the staff notice board at bases we visited. Staff had access to paper copies of updated policies and procedures as well as access to these electronically on the staff intranet. Quality and governance updates were also available for staff in the staff room and on notice boards.

Coordination with other providers

- Arriva Transport Solutions South West shared comprehensive information with other agencies regarding their mobility coding and changes as well as what influenced booking procedure and times. This occurred through meetings such as ambulance operating groups which involved hospital trusts.
- Service locality managers were part of a daily conference call with the local hospital and community services. The call aimed to ensure clear communication and pressures faced by each service so that everyone was aware of the current status of services and impact this may have on the transport service. We saw emails from locality managers that shared resource and demand information for the service and suggestions to trusts about planning when they could not meet demand.
- We saw minutes of performance meetings that Arriva managers attended for the trusts they transported patients to and from .The minutes and other evidence showed when the service met its key performance indicators and when it didn't.
- The service had developed an action plan with a local dialysis unit to improve patient experience. There were

21 actions, including work specifically to improve journey quality by taking data that Arriva Transport Solutions South West held and sharing it with the unit so that they could allocate patients better and reduce patient delays. The managers of the local dialysis units told us that they had regular meetings with the service to improve the service to its patients.

- We saw the daily summary about capacity provided to local hospitals to keep them informed of the service's status and ability to provide transport within targets. The summary was shared with each of the four local commissioned areas which was sent to senior managers, locality hospital managers, dispatch team and the operations team. The information provided summarised recent key performance indicators, current work with any significant work that may affect capacity and the contact details of the dispatch team on shift and contact telephone numbers. Arriva locality hospital managers took this information to daily escalation meeting at local hospitals to keep them aware of the service's status. There had been positive feedback about this addition to the daily summary from partners. There was ongoing work to support local hospital staff to provide better risk assessments and information about access to patient property. The service locality manager for a local hospital had worked closely with physiotherapists and occupational therapists from hospitals to provide a set of criteria that staff could use to provide a comprehensive overview of the access to a patients property to enable the service to plan more effectively for journeys. We saw the checklist, however at the time of our inspection there was no date for implementation of this tool to improve communication and information provided to the service by the hospital staff booking transport.
- Locality managers were working closely with local hospitals and community clinics and trusts to build relationships and improve communication in order to improve the quality of the service provided. Education and training had been provided to different locations to ensure an understanding around the service's targets and challenges. Senior managers acknowledged turnover of staff and long term unplanned absence had disrupted communications and their efforts to work better with other organisations. They knew it had affected other organisations quality of service as well as their own. We also saw evidence that some recent meetings with other organisations had been cancelled preventing them working together as efficiently as possible to solve problems with service delivery that affected patients. Arriva were clear as to why there had been some disruption in attending meetings, but were also being as flexible as possible to meet with others.
- We saw evidence of joint training plans with some trusts the service had worked with in 2015. Training included improving online booking by trusts. There were also individual action plans for the service, improving their data quality and sharing with others and issuing a single point of access telephone number for the key role of locality manager for better access to communicate with the service.

Multidisciplinary working

- We observed a good level of communication among the call takers and dispatchers in the control centre. We observed the call takers frequently going to discuss issues and clarify information with the dispatch team. We received positive feedback from staff in the control centre about the how well the wider team worked together.
- Staff felt supported by their team leader and their colleagues in the call taking team and their manager. Staff told us that they often discussed things with each other and felt supported by their team.
- There was a lack of communication at times between the control room and the road based staff. Many of the crew stated that when they sent a text message to the control centre, it was rarely acknowledged and responded to. The control centre informed us that there were service issues with the text message service, but that the systems team were aware and trying to find the root cause of the problem. The crews seemed unaware of this problem, however, the control centre had sent the crew a text message to make them aware of the problem.
- Staff and stakeholders told us how difficult it was to get through on the telephone to the control room. One stakeholder showed us their own log which indicated they were on hold for the control room for 15 minutes whilst trying to find out when a patient was being collected.
- Staff we spoke with said they faced challenges to speak directly to a member of staff at the control centre. Arriva staff told us that they regularly encountered waiting time between 30 and 40 minutes to speak to a member of the control team. Road based staff consistently told

us that text messages were rarely acknowledged or answered. This posed a risk to staff if they needed to speak to control urgently. This was being monitored and was on the risk register.

Access to information

- There were information and record systems that supported delivery of effective care.
- Each vehicle had an allocated electronic tablet that was carried by the crew during each shift. The tablet enabled crew to see the patient record, provide information to dispatch as to their status during their shift, for example if they were mobile or waiting to pick up a patient. The crew could also use the tablet to telephone and send text messages to the control centre.
- The service made sure that up to date 'do not attempt cardio pulmonary resuscitation' (DNACPR) information and end of life care planning was appropriately recorded when patients were being transported. The staff confirmed they would ask for the original copy of the DNACPR documentation from ward staff or hospital staff would show documentation and the crew signed to say they had seen the original forms. This paperwork then accompanied the patient. Information regarding a patient's DNACPR status would also be recorded on the patient's electronic record by control staff when taking details for bookings and was available to crew via the electronic tablet. Forms were disposed of in confidential waste and this was managed by an external company.
- The electronic system used by the service allowed text messages to be sent to crews. The system could send alerts to crews only in one part of the region or across the whole region depending on the nature of the message. This system was used to alert staff to important information such as road closures that could affect their journeys or a major incident at a local acute hospital.
- Each vehicle had its own individual information box which was carried by the crew during each shift. The box contained information that crews may have needed when out on the road for example how to report incidents, information about translation services and vehicle incident reporting forms.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient's consent to care and treatment was sought in line with legislation and guidance. Staff understood the need to have valid consent when supporting patients. Examples included staff asking patients for their consent to be moved, placed into a wheelchair or a stretcher. The ambulance care assistants said they also knew they could not expect a patient to do anything against their will. If they were supporting a patient who they felt did not have the mental capacity to make their own decisions, they would support them as much as possible. Staff said, they would act in the patient's best interests and would not expect a patient to comply with anything they clearly did not want to do. We were given an example when a patient who appeared confused and anxious refused to board a vehicle at the hospital. The ambulance care assistants took the decision to return the patient to the hospital where they could be cared for. They requested the control team to rebook the journey for later that day when the patient was then able to travel without anxiety.
- Staff told us they had received training in the Mental Capacity Act 2005. The training took approximately 20 minutes to complete. Staff told us that the training had been useful but had not given them enough information for them to judge people's capacity to give consent. Staff we spoke with did not have the confidence to undertake basic mental capacity assessments. Where staff had concerns, they said they were able to phone the control room for advice. The control room staff however did not have any additional training to be able to advise crews.
- We found that staff we spoke with had no working knowledge of the Deprivation of Liberty Safeguards (DoLS) or how they applied it in practice. There was no training for staff in understanding the way in which DoLS might relate to their services. For example an awareness of the implications of transporting or transferring patients who lack capacity to make specific decision about their care and where it is delivered.

Are patient transport services caring?

Our findings were:

- We saw that people were treated with kindness, dignity, respect and compassion while they received care. We received positive comments about ambulance crew from patients, patient's relatives and from staff working

at local hospitals we spoke with. Crew were described as 'wonderful' and 'brilliant.' Another patient described crew as 'lovely' and said they could not do enough to help.

- Some of the organisations we requested information from about also told us that ambulance crews were thought of highly by patients and staff.
- Staff knew of and responded to patients needs whilst being transported. Staff displayed care for patient's wellbeing during the journeys "Fantastic staff, very kind and friendly with a smile on their face."
- Staff told us they were aware that some patients, particularly elderly and frail patients and patients with back problems sometimes found the journeys uncomfortable and bumpy.
- People who used services and those close to them were involved by staff as partners in their care. We heard appropriate responses given to callers when call takers answered questions and explained the eligibility criteria for non-emergency patient transport.
- Patients who used services and those close to them received the support they needed to cope emotionally with their care. For example two patients said "the crew always look after me, they are brilliant and I can't fault them."
- Crews encouraged patients to be as independent as possible and provided support where required. We observed crew members enabling and encouraging patients to move independently, providing support and advice where appropriate

However

- The result of a patient survey was mixed and reflected both positive and negative comments. For example for those patients very satisfied patients said the crews are wonderful, helpful, very polite and professional and make you feel safe, Good service all round. However those who answered dissatisfied or very dissatisfied in the patient survey described a range of issues including delays and cancellations.

Compassionate care

- We saw that people were treated with kindness, dignity, respect and compassion while they received care. We received positive comments about ambulance crew from patients, patient's relatives and from staff working

at local hospitals we spoke with. Crew were described as 'wonderful' and 'brilliant.' Another patient described crew as 'lovely' and said they could not do enough to help.

- Some of the organisations we requested information from about Arriva Transport Solutions South West's performance also told us that ambulance crews were thought of highly by patients and staff.
- Staff ensured dignity was maintained travelling to and from their vehicle. We observed crew providing compassionate care towards the patients they were assisting off and onto vehicles. Crew explained clearly to patients what they were going to do and did not rush patients to get on and off the vehicles.Patients were clothed and covered appropriately.
- Staff knew of and responded to patients needs whilst being transported. Staff displayed care for patient's wellbeing during the journeys, "Fantastic staff, very kind and friendly with a smile on their face." Staff told us they were aware that some patients, particularly elderly and frail patients and patients with back problems sometimes found the journeys uncomfortable and bumpy. This was due to the nature of the route or at times due to the ongoing problem with the feel of some vehicle suspension which was reported by several crews. The staff we spoke with explained how they tried to make patients as comfortable as possible by providing pillows for extra support and drove as slowly as possible to ensure that patients did not become uncomfortable or distressed during the journey.
- The managers of one of the dialysis units told us that the staff were excellent, very helpful and supportive to the patients they looked after and had a great rapport with patients
- When Arriva Transport Solutions South West planners were allocating work, they tried wherever possible to ensure patients went with drivers they knew however this was sometimes difficult to achieve. They had a 'carry by' section on the planning system for this purpose. We saw evidence of some patient's complaints where this was not possible.
- Staff encouraged and ensured that patients respected other patients where they could. We saw evidence of staff having intervened and then recorded circumstances as an incident when patients complained about the behaviour of another or when they thought patients had been spoken to rudely by other patients.

Patient transport services (PTS)

Understanding and involvement of patients and those close to them

- People who used services and those close to them were involved by Arriva staff as partners in their care. We heard appropriate responses given to callers when call takers answered questions and explained the eligibility criteria for non-emergency patient transport. This included calls to staff of organisations and patients.
- Language line was available for staff to use but aids for patients with significant sight or hearing impairments were not available.

Emotional support

- Patients who used services and those close to them received the support they needed to cope emotionally with their care. We spoke with two patients who had been transported to a local outpatients department. Both patients were very positive about the staff they had met. Their comments included, "the crew always look after me, they are brilliant and I can't fault them."
- Staff told us how they might support other patients if someone died whilst in their care. The ambulance crew would contact their office to alert their manager and would then be given time, to support the family until other people arrived to help. Staff knew where to access the bereavement policy.
- Staff recognised where they could help patients. As an example, a patient we spoke with said how the crew who were taking them home saw a patient who appeared frail and who was waiting for transport which they found out would be some time in arriving. The staff contacted the control team who arranged to transfer the patient onto their vehicle. The patient was then taken home much earlier than they would have been. The patient said they had been asked if it was okay if another patient joined the journey they said they were only too happy to have seen this patient helped. There were other examples that we saw in the incident recording where staff had identified issues that patients needed assistance with at home and had competed tasks before leaving to ensure the patient was safe as well as emotionally supported.

Supporting people to manage their own health

- Crew encouraged patients to be as independent as possible and provided support where required. We observed crew members enabling and encouraging patients to move independently, providing support and advice where appropriate, to help patients to complete the transfer from the wheelchair as independently and safely as possible
- Pathways were used by Arriva staff to signpost callers to other transport services. This included referral to patient advocacy and liaison services or Healthwatch teams. However Healthwatch Gloucestershire had recorded a number of incidents where Arriva staff had given the impression that Healthwatch booked alternative transport when people were told they were not eligible by Arriva Transport Solutions South West. It was clear from reading the feedback and complaints that these events caused significant frustration and distress to patients.
- Referrals occurred when patients did not meet eligibility criteria used in assessment for transport. Patients had to confirm they were registered under a GP in the commissioning area and that they required transport to or between NHS funded providers before the call takers continued to assess the eligibility of the patient to use the service.

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

Our findings were as follows:

- The service aimed to take account of the needs of different people, including those in vulnerable circumstances and an equality and diversity policy was in place.
- The needs of patients living with a learning disability or dementia those with a mental health illness and bariatric patients were identified in training and supported by the service's equality and diversity policy as well as equipment. For example, the service had vehicles and equipment for bariatric patients.
- For those patients whose first language was not English, language cards were available on each ambulance for patients to identify the language spoken. A telephone interpreting service was then available when staff needed to communicate further with a patient.

- The service ensured that lessons were learnt and actions taken as result of complaints. Learning included, reflection on attitude even when complaints were not upheld.
- Patients and people's complaints and concerns were listened to and used to inform action plans to improve the quality of care. The main source of complaints continued to be related to pick and drop off and journey times both inward and outward which the service were hoping would be addressed by action plans in place.
- commissioners had asked the service to assess booking behaviour and to assist in promoting a reduction in same-day bookings. Arriva Transport Solutions South West accepted that there was a responsibility on them to lead good booking behaviour. However, they were also clear that they were looking to commissioners to support behavioural change across other NHS provider organisations.

However

- Patients could access care and treatment, but there were delays. For example some patients who were pre booked were sometime displaced by bookings that were requested by trusts and others on the day. Delays were a common feature of complaints to Arriva Transport Solutions South West and organisations such as Healthwatch. Delays also featured as an issue for healthcare trusts when we asked them for their experiences of the service.
- There were times when the planning team and system did not take sufficient account of local geography including temporary traffic disruption. Crews we spoke with said that often journey time allocations were unrealistic and unachievable.
- The systems used to enhance planning were still developing and this included an assisted planning tool, an assisted despatch tool supported by manual journey management.
- For patients who were had a learning disability or were significantly hearing or vision impaired staff were not supported with devices or aids to be able to communicate with them. For example the service did not have any information in Braille. The service's induction training did not include enhanced communication methods or options.
- There were common themes emerging from patient and public feedback following a report from stakeholders which included homebound journeys, inconsistencies in eligibility criteria for patients, and difficulties in getting through to the booking centre.

Service planning and delivery to meet the needs of local people

- Services planned were aimed to meet the needs of people. The journey types and categories of patient the service had been contracted to carry out included, outpatient appointments, hospital discharges, hospital admissions, hospital transfers, renal, oncology, palliative care, intermediate care, mental health, paediatric, bariatric and transport from an acute hospital of high dependency patients who had received treatment such as unblocking of cardiac arteries .
- Service delivery did not always meet people's needs. We saw evidence of mixed patient experience and missed key performance indicators in Arriva, Healthwatch Gloucestershire and clinical commissioning group reports. The service was working with stakeholders to improve the service and had recently undergone a management recruitment and restructure in order to deliver the requirements of their contract in 2016 and beyond.
- We saw recruitment records and forward planning for a specific need to increase staffing levels for a part of the service due to a third party provider discontinuing with the service.
- Staff were trained to recognise and respond to the needs of patients living with a learning disability, with mental health illness, patients living with dementia and bariatric patients. This was supported by the service's equality and diversity policy as well as equipment provision. There were 92 vehicles based in the south west a mix of stretcher, seated and high dependency ambulances (three). The service had vehicles and equipment for bariatric patients. The Keynsham base had one bariatric vehicle, a stretcher and two wheelchairs to accommodate bariatric patients. The vehicles met patient's needs. Risk assessments were completed for complex patients or patients with bariatric needs.
- During induction staff received a presentation 'the big picture' which put into context how the patient transport service fitted into the rest of Arriva's corporate business and structure of the parent company. Senior

managers were open when talking about deployment of vehicles and staff to meet patient need. Regular meetings and engagement took place to ensure key performance indicator data was accurate which supported the planning of services.

- Arriva Transport Solutions South West had two commissioning for quality and innovation targets (CQuIN) for 2016/17 agreed with commissioners of services April May 2016:
  - The aim of the first CQuIN was intended to improve patient experience and engagement with acute trusts. It was to be achieved through improved experience of patients through working together with patients who use the patient transport service and organisations that booked it. The service had achieved the target April September 2016.
  - The aim of the second CQUIN was to improve Arriva's performance against the key performance indicators PTS05 and PTS06. This would improve timeliness of service and contribute to a better patient experience. This target had been partially achieved.
- Previous CQuIN for 2015/16 were:
  - CQuIN 1 – Improving performance measures for performance improvement. This included PTS05: which required 85% or more pre-planned outbound patients should be collected within 60 minutes of the 'ready' time and PTS06: which required 85% or more patients booked on the same day of travel should be collected within 240 minutes of the 'ready' time.
  - CQuIN 2 – Improving patient experience and CQuIN 3 – Reducing on-day bookings.
  - For CQuIN 3, commissioners asked the service to assess booking behaviour and to promote a reduction in same-day bookings. Whilst the core non-emergency patient transport service contract provided for journeys which were booked on the day of travel, there was recognition that the volume of this part of the workload exceeded a sustainable level.
  - Arriva Transport Solutions South West accepted that there was a responsibility on them to lead good booking behaviour. However, they were also clear that they were looking to commissioners to support behavioural change across other NHS provider organisations.
- We saw evidence of regular engagement with clinical commissioning groups and other organisations to try to improve the service provided by Arriva Transport Solutions South West. This was done through meetings in person as well as telephone conferences. Some progress was evident for example work on joint performance indicators between trusts and the service.
- There were times when the planning team and system did not take sufficient account of local geography including temporary traffic disruption. Crews we spoke with said that often journey time allocations were unrealistic and unachievable. Staff felt that control staff did not understand the geography of the area they covered and the challenges the crews faced. It was felt that journeys were based on the time taken to get between postcode to postcode on a clear run. Crews told us that they were able to predict when their shift started at what point they were going to face a challenge with meeting planned journey times which would then create a knock on effect for the remainder of the day making them late for subsequent jobs.
- We saw examples where times given to crews to pick a patient or a number of patients up and drop them to a community or acute hospital were not achievable. Staff felt the times given to complete these journeys did not take into account the frailty or mobility of the patient and the time that was needed for them to board the ambulance.
- The systems used to enhance planning were still developing. These included an assisted planning tool, an assisted despatch tool supported by manual journey management.
- We saw evidence on the service risk register of the need to change shift patterns to meet operational demand. The management team were in consultation with unions to change working patterns so the service could improve by meeting the demand.
- The planners used volunteer drivers and local taxi companies routinely and when bookings exceeded planned vehicle availability. The use of taxis as an alternative when demand exceeded capacity was being reduced due to cost and extra staff were being recruited.

Meeting people's individual needs

- The service aimed to take account of the needs of different people, including those in vulnerable circumstances. Arriva Transport Solutions South West had an equality and diversity policy. The aim of the policy was to define and promote all the company's employees approach to equality and diversity, and to ensure there were defined guidelines for employees to

follow. It stated the company is committed to equality of opportunity for all regardless of race, gender, gender identity, religion, belief, sexual orientation, age, physical/mental capability or offending background. The service recognised that promoting equality and diversity was essential to deliver quality, culturally appropriate ambulance and support services to all sections of the communities that they served. The policy clearly described that the approach in the policy applied to staff and to users of their service.

- Control staff tried to ensure that journeys were planned to account for comfort breaks, feeding and hydration if journeys were long for example in rural areas. However we saw evidence of complaints regarding journeys being too long and people missing meals. Clinics that patients went to that might offer drinks and snacks such as tea or biscuits could not always plan ahead to ensure patients had eaten, if they did not get enough notice of lengthy journeys delays.
- The needs of patients living with a Learning disability, with mental health illness, living with dementia and bariatric patients were identified in training and supported by the equality and diversity policy as well as equipment. For example, the service had vehicles and equipment for bariatric patients. The Keynsham base had one bariatric vehicle, a stretcher and two wheelchairs to accommodate bariatric patients. However, for those patients who were significantly hearing or visually impaired, we did not see any aids for staff to be able to communicate with them. For example, the service did not have any information in Braille, a system of reading and writing using raised dots. We did not see any enhanced communication aids either, for example, for those with a learning disability that require additional support for example 'easy read' guides. The service's induction training did not include enhanced communication methods or options.
- For those patients whose first language was not English, language cards were available on each ambulance for patients to identify the language spoken. A telephone interpreting service was then available when staff needed to communicate further with a patient.

Access and flow

- Patients could access care and treatment but there were delays. The computer and paper based system for bookings allowed for staff to book different priority for patients. For example, some patients who were pre booked were sometime displaced by bookings that were requested on the day. The planners and controllers tried to ensure that all vehicles and staff where in the place they needed to be when they needed to be there. This did not always happen. Delays were a common feature of complaints to the service and Healthwatch Gloucestershire. Delays also featured as an issue for healthcare trusts when we asked them for their experiences of the service. Locality managers worked with organisations to address reasons for delay where they could and feedback to Arriva managers about any problems not immediately fixed.
- There was a system to support booking and plan where vehicles needed to be at the correct time to ensure key performance indicators were achieved. The assisted planning and dispatch system had the organisations key performance indicators embedded which supported planners and dispatchers to plan journeys to achieve required targets. The planning and dispatch team aimed to make the best use of resources available to them, whilst being mindful to leave some gaps to manage on the day bookings.
- An issue for the service was delayed journeys due to late pick-ups. If crew were running late or delayed to a clinic they would contact either control or the clinic directly to inform them of this delay. We observed the dispatch team managing several calls of this nature and calling directly to clinics to ensure that the clinic could have an opportunity to alter the appointment time of the patient when clinically appropriate so that they did not miss their appointment completely. However, crews stated that getting through to speak to staff at control or gaining a response via text message was challenging.
- Another issue was that all outbound patients leaving clinics and hospitals needed to be 'booked ready' for collection before Arriva Transport Solutions South West would start the journey. However, patients not being ready when Arriva staff arrived was a frequent problem. An analysis of April 2016, data indicated that over 110 hours of Arriva staff time was wasted waiting for patients who were not ready on arrival at one trust's wards and departments.
  - For journeys cancelled by Arriva Transport Solutions South West. The highest rate of cancellations were in December 2015 (0.4%) or 118 patients.

  - There was no report/data in Arriva Transport Solutions South West's combined report June 2016 for non-aborted journeys for which no collection is made.
- For call answer times the service achieved the target for December 2015 and January 2016 only.

Learning from complaints and concerns

- The service ensured that lessons were learnt and actions taken as result of complaints. Learning included reflection on attitude of staff even when complaints were not upheld. The service had developed an action plan with a local dialysis unit to improve patient experience. There were 21 actions, including work specifically to improve journey quality by taking data that Arriva Transport Solutions South West held and sharing it with the unit so that they could allocate patients better and reduce patient delays.
- One manager told us that when they got things wrong for the same patient a number of times, a flag was added to their patient record. We were told this flag alerted the planning and control room staff in an attempt to reduce the transport problems experienced by the patient.
- Patients and people's complaints and concerns were listened to and used to inform action plans to improve the quality of care. The service acknowledged in May 2016, that complaints figures had reduced in Bath, North East Somerset and Gloucester. However, they had seen an increase in Wiltshire and a small rise in Swindon. The main source of complaints continued to be related to pick and drop off and journey times both inward and outward which the service expected would be addressed by performance action plans in place. Service managers recognised that some complaints were received as a result of incidents.
- We saw examples where staff had apologised to a patient if they arrived late and explain the reasons why. Following any incidents, the managers would make a follow-up call to the patient the next day to apologise and to check on the patient's welfare. We saw evidence of written apologies and communication about complaints with detailed explanations of where things had gone wrong and detailed actions to try to ensure it did not happen again. We saw evidence that staff had called patients relatives within 20 minutes of incidents such as disruption to transport arrangements to personally discuss issues raised.
- The locality managers for each area managed the complaints process. If information provided about the complaint was limited, the complainant was called in order to get a clearer picture of the issue. We saw evidence of how a complaint was dealt with through the process where a letter was sent to the complainant once an investigation had been carried out. If the complainant was not satisfied with the response, the complaint would be escalated and dealt with by the management team. There were two complaints during the time of our inspection that had been escalated to management to deal with. Staff were clear that people who complained could appeal any outcome to Parliamentary Health Service Ombudsman.
- All complaints were logged within the electronic reporting system so linking could take place between incidents and complaints. The process for dealing with complaints was detailed within the service management of complaints policy.
- Staff said they provided information to patients that wished to complain. Information on how to raise concerns or complaints was available in leaflets on each ambulance. Although it was above and behind patients who were travelling on a stretcher so may not have been seen by all patients. This might have made it difficult for some people to start a discussion about complaining. Staff told us that they would try and resolve any concerns at the time. Where they were unable to resolve them they would give the patient details of the patient experience team who would assist with their complaint. A large sticker in the vehicle provided patients with telephone numbers and an address of where they can make a complaint..
- We saw patient information leaflets that had been revised with the assistance of Healthwatch Gloucestershire following an increase in inappropriate transport request calls to them. Initially, callers had been redirected to Healthwatch Gloucestershire by Arriva staff under the misapprehension that they would arrange to provide a transport service. Healthwatch are an independent champion for consumers and users of health and social care in England and they ensure the patients' voice is heard by those who make the decisions.
- There were common themes emerging from patient and public feedback following a report from Healthwatch Gloucestershire who had received 197 pieces of feedback about Arriva from December 2013 to May 2016.

Delays in homebound journeys accounted for 28% of the feedback, 22% identified inconsistencies in eligibility criteria for patients, 21% accounted for delays on outbound journeys, 11% related to the condition of the vehicles and 3% identified difficulties in getting through to the booking centre. Also, 14% of the feedback collected accounted for the misunderstanding of Healthwatch's role by Arriva staff and some patients. Although the service managers had spoken with Healthwatch Gloucestershire to address the problem. Part of the solution was correcting patient information leaflets and training call handlers better.

Are patient transport services well-led?

Our findings were:

- There was a clear vision and credible strategy to support quality care. We saw evidence that the key to good non-emergency patient transport was understood by the relevant staff.
- The leadership team and culture of senior managers reflected the vision and values of the organisation.
- Senior and other managers encouraged openness and transparency. We saw this in responses to complaints as well as engagement with others sharing key performance indicator data. Leaders encouraged appreciative, supportive relationships among staff.
- Senior leaders were visible and approachable within the control room. Control room staff described their managers and team leaders as visible, approachable and supportive. Staff told us that managers were very supportive and they felt valued and respected. Operational role staff were able to see their manager on a daily basis at their base station.
- All staff groups or roles described the importance of apology and honesty regarding reporting incidents but were sometimes frustrated in reporting when they could not contact control quickly before having to continue on with their scheduled work.
- Staff were engaged with the vision and strategy through several ways. During induction staff received a presentation 'the big picture' which put into context how the patient transport service fitted into the rest of Arriva's corporate business and structure of the parent company. Senior managers were open when talking about deployment of vehicles and staff to meet patient need. Regular meetings and engagement took place to ensure key performance indicator data was accurate.

However

- There were governance frameworks in place to support staff to know their responsibilities and that quality, performance and risks were understood and informed action plans. However, senior managers acknowledged that there was some way to go in a number of areas. For example, achieving key performance indicators and reducing the number of complaints related to delays and developing supporting and monitoring staff through appraisal and one to one.
- There were no specific triggers to identify when poor performance needed to be addressed and managed formally for call takers. Formal management of poor performance was at the discretion of the call taker team lead. At the time of our inspection, there was no formal framework available if formal performance management situations arose.
- Patients and others who used the service and staff were engaged and involved through a survey. Patient responses to an external survey was poor with a 5% return rate.

Vision and strategy for this service

- There was a clear vision and credible strategy to support good quality care. The vision was to provide safe, compliant and high quality service to customers and to accept and embrace personal accountability for work. The strategy was to acknowledge change as a permanent feature of work and recognise that change brings opportunities. The managers that we spoke with were clear of the overall objectives for the patient transport service. The objectives were to provide an effective and safe service with consistent quality. Senior managers acknowledged that there was some way to go in a number of areas. For example, key performance indicators and creating an environment with others to influence change. We saw evidence that the vision and strategy was understood by the relevant staff.
- Staff were engaged with the vision and strategy through several ways. During induction staff received a presentation 'the big picture' this put into context how the patient transport service fitted into the rest of the corporate Arriva Transport Solutions South West's

business and structure of the parent company. Staff were also aware of the vision which had been reinforced in a booklet given to all staff detailing their role in achieving the service's set aims and objectives. All staff we spoke with wanted to provide the best possible service to patients.

- Senior and other managers were aware what the risks, plans, goals and pressures for the service were. These were summarised in the quality account for 2015/16 as aiming to provide a safe, compliant and high quality service to our customers; Achieve continuous operational improvement in call centres, control rooms and on the front line; Accept and embrace personal accountability for our work; Build a sustainable business that consistently delivers value for money.

Governance, risk management and quality measurement

- There were governance frameworks in place developed by the registered manager and other managers in the South to support staff to know their responsibilities. Quality, performance and risks were understood and informed action plans, however, some were not effective. The service was managed by a head of non-emergency patient transport for the south region who was previously the companies' director of governance and quality. They reported to the managing director who was the registered manager. They were supported by a head of quality and standards, head of operations and heads of control and planning. A number of general managers, assistant general managers and locality managers were responsible for various bases in the region. The governance procedures in place were regularly reviewed, and some demonstrated change and learning.
- Systems were in place to notify staff of changes to policies, although the systems did not provide assurance that all staff were aware of changes at the same time. Governance and Quality notices were shared with staff through the managers to all staff. We saw in the Gloucester station that these were displayed in the crew room along with signature sheets for the crew to sign once they had been read. The manager told us that they followed the issue of notices up with all staff who had not signed to make sure that all staff would be aware of change.
- There were no specific triggers to identify when poor performance needed to be addressed and managed formally for call takers. Formal management of poor performance was at the discretion of the call taker team lead. At the time of our inspection, none of the call takers were under formal management for poor performance but there was no formal framework available if formal performance management situations arose. We were shown an example of one word processed paragraph documenting a conversation between a member of staff who has been under review for poor performance and their line manager The document contained no action plans to work on improving performance.
- A system called 'checkpoint' was used for each member of staff at the end of their shift. This meant that most staff had conversations with their managers on a daily basis, most on the day they ended the shift. The checkpoint forms were provided at the start of each shift and used to confirm vehicle checks were made, the crews driving scores were recorded and any issues that they had encountered during their shift could be shared.
- There was a systematic programme of audit to monitor and manage quality and ensure performance data was accurate, valid and relevant. The service was working with one local trust to review validity of delay data. We saw evidence of the monthly review of a range of performance and risk indicators.
- Following the appointment of a new head of south region at end of May 2016, a review of operations had occurred. This included a review of all aspects of operational performance and quality particularly the performance improvement plans currently in place in recognition that some plans had not produced the level of improved performance.
- Progress with addressing the vacancy rate across the area had been taking place since the appointment of a dedicated recruiter for the service. The staff needed for the area had been reviewed to match current levels by station and compared with revised service demand data. This had led to Salisbury and Keynsham bases being the focus for recruitment.
- Performance was discussed regularly at the operational quality performance group. This group had representatives from all the service's areas. This group reported to the senior management team**.** Locally, monthly policy performance and senior management meetings took place. A trading review meeting took

place each month. The trading review looked at complaints, performance and any action plans. The risk register was also discussed and fed through to the overall provider's risk register.

- We reviewed the risk-register for non-emergency patient transport services. It reflected most of the risks voiced by staff and by outside organisations. For example, the issue of long waits for staff to speak to a member of control staff, staff claiming they did not get meal breaks and the potential for damage to Arriva Transport Solutions South West's funding from reduced income due to not meeting key performance indicators. Three risks of the 17 had been escalated to the corporate risk register, not meeting key performance indicators and the two most recent identified by CQC regarding oxygen storage and related fire risks. The risk register was updated. Action was being taken on all issues that were still open.

Leadership of service

- The senior leadership team consisted of a managing director who was the registered manager, a newly appointed head of south region, head of operations, head of planning and control . The senior managers reflected the vision and values of the organisation. Senior and other managers encouraged openness and transparency. We saw this in responses to complaints as well as engagement with others sharing key performance indicator data. They had a clear aim to provide and promote good quality care regardless of the issues they were dealing with. For example, the increase in demand and some performance indicators being outside of their control such as 'on the day bookings'.
- The service was managed by a head of non-emergency patient transport for the south region who was previously the companies' director of governance and quality. They reported to the managing director who was the registered manager. They were supported by a head of quality and standards, head of operations and heads of control and planning. A number of general managers, assistant general managers and locality managers were responsible for various bases in the region.
- We spoke with the head of the south region, the managing director who was the registered manager, and the quality and safety lead who was also the infection prevention and control lead. They understood the challenges within the service and could produce actions which had been implemented to deliver some change and improvement. However, crucial information did not always get shared in a timely way to all people in the organisation. We spoke with some key staff members who were not aware of a Healthwatch Gloucestershire report received by Arriva Transport Solutions South West regarding delays and other transport issues. They were surprised that it existed but said that they would read the report as soon as was possible.
- Leaders encouraged appreciative, supportive relationships among staff. Senior leaders were visible and approachable within control. Control room staff described their managers and team leaders as visible, approachable and supportive. Staff told us that managers were very supportive and they felt valued and respected. Operational role staff were able to see their manager on a daily basis at their base station. Senior managers were available when needed in the South West. The team leaders, managers and senior managers that we spoke with told us how proud they were of their teams and the care they provided to their patients.
- The service supported staff to develop by encouraging further education and training. A member of staff had been enabled to undertake a leadership course to support development and increase ability to lead. Staff had commented on how support and leadership for the organisation had improved.

Culture within the service

- Managers and others told us of a culture that encouraged candour, openness and honesty. We saw evidence of this and senior managers spoke broadly about the duty of candour and being open generally and how it applied to service delivery. All staff groups or roles described the importance of apology and honesty regarding reporting incidents but were sometimes frustrated in reporting when they could not contact control quickly before having to continue on with their scheduled work.
- We observed that support was available to staff. This included occupational health, discussions with a manager or team leader and the availability of counselling should the member of staff need it.
- Senior managers were open when talking about deployment of vehicles and staff to meet patient need.

They were clear that they had to meet targets set by commissioners but were clear that ultimately they were in response to meet patient need and so were one and the same.

- Staff we spoke with felt respected and valued. Staff told us that it was a great and positive organisation to work for and felt well supported. They said they were able to put forward ideas and that they were listened to. Managers told us that the provider was progressive and adaptive to change despite operating in a difficult environment. During our inspection, it was evident from staff that they were very patient focused and wanting to provide every patient with a good experience.
- Some staff told us that they wished the company looked after them better. When we explored this further, it seemed to be in relation to pay rates. An employee satisfaction survey was carried out in 2015/16.Out of 291 employees, there were 155 responses (53% response rate).
- We saw evidence of action taken to address behaviour and performance below the expected standards although processes for monitoring the performance of control staff were informal and not all staff were up to date with appraisal and one to one meetings.
- There was a perceived lack of understanding around the challenges faced by different teams, between the control centre and ambulance road crew and base staff. The relationship between the ambulance road crew and control room team was disjointed. There was a perception from ambulance crews that the dispatch and planning team did not understand the challenges of their role and vice versa. Both sides felt that it would be beneficial for each side to spend a day with the opposite team in order to gain more of an understanding of each other's role and the pressures they were under. The dispatch manager informed us that where possible they tried to accommodate this but this had been challenging recently due to demand and staffing levels.

Public engagement

- Patients, staff and others who used the service were engaged and involved. Patients were engaged in a survey run by an external company and fed back in a document called Arriva Patient Transport Survey South Region. Data was gathered from February 2016 to April 2016. There were 3306 questionnaires distributed and 159 (5%) returned. The total return for ambulance bases in the South West was as follows. Of the 457 questionnaires distributed, there were 48 returned from Swindon (11%), of the 990 questionnaires distributed 53 were returned from Gloucester (5%), of the 134 questionnaires distributed there were 7 returned from Newport (5%). None were returned from Lydney (500 questionnaires distributed).
- The result of the patient feedback survey was mixed and reflected both positive and negative comments. For example, a sample of comments from those who answered very satisfied in the patient survey described a range of issues, the crews are wonderful, helpful, very polite and professional and make you feel safe, Good service all round. The driver was very caring and considerate during our journey to the RUH. Although comments of those very satisfied in Gloucester did feature a theme of delays.
- A sample of comments from those who answered dissatisfied or very dissatisfied in the patient survey described a range of issues. On two occasions - failed to arrive. Previously faultless performance. Two hours late, I was late for my appointment, the department stayed open until I got there
- Arriva Transport Solutions South West promoted Healthwatch Gloucestershire as a contact in information leaflets as well as patient advocacy and liaison services.

Staff engagement

- Staff felt safe to raise concerns and leaders understood the value of staff raising concerns. Staff felt engaged with their employer in planning and delivery of their service. An employee satisfaction survey was carried out in 2015/16.Out of 291 employees, there were 155 responses (53% response rate). The response rate for Arriva Transport Solutions, which was the national organisation, was 56%. Arriva Transport Solutions South West had a 3.1 rating out of a total of 5 on an employee satisfaction index, the national rating was 3.2.
- Key positive responses were:
  - that staff understood what they could do to help deliver an excellent service 89%,
  - my responsibilities suit my personal skills and expertise 86%,
  - I can rely on my colleagues when I need support 84%,
  - I work beyond what is required to help the company succeed 78%
  - I enjoy my work 76%.
- However, the five lowest rated question responses were:

  - My pay is appropriate 20%,
  - I am satisfied with the additional benefits I am offered 24%,
  - there are good opportunities for career development here 23%,
  - employees interests are taken into account in important decisions at the company 22%,
  - I feel I am part of an international group 22%
- Staff team meetings were held monthly at the Keynsham base at 6.30pm and staff were paid if they attended outside of their shift. Attendance was low due to staff not being able to get back to base due to work demands, with just 10 out of the 43 staff attending the meeting in June 2016. We reviewed minutes of the team meeting, the discussions held and the action plan. Action plans from the meeting had already been completed by the station manager.
- Checkpoint was a newly introduced method of enabling ambulance crew to provide daily feedback. Checkpoint was introduced in March 2016 and enabled crew to provide feedback about different aspects of their day. Feedback included vehicle issues, analysis of late journeys, patient feedback and other issues raised by staff. There was a varied response to the new system with some crew feeling that parts of the checkpoint were a duplication of the vehicle checks completed at the start of each shift.

Innovation, improvement and sustainability

- We saw evidence of plans to promote the continuous improvement and sustainability of the non-emergency patient transport service. However there were many factors being considered as to why the improvement desired had not been seen across all plans for all key performance indicators. Plans had been affected by inability to recruit new and turnover of experienced staff. Also, Arriva staff were still learning the limitations of implementing the electronic systems that assisted planning and despatch.
- The effectiveness of the service delivered by Arriva Transport Solutions South West was not completely within their direct control. Factors included the proportion of on the day bookings, avoidable aborted journeys by other organisations and some organisation's reluctance to use online booking. . Arriva Transport Solutions South West was working with stakeholders to improve the service and had recently undergone a management recruitment and restructure in order to deliver the requirements of their contract in 2016 and beyond. Managers were confident they could address all these issues and work with partners to meet the demands
- A significant issue was the service depended upon accurate information at the point of booking. Inaccurate mobility information could lead to an aborted journey, delay for the patient, inconvenience for acute trust staff and a waste of the service's resource. The use of new mobility codes was intended to address this. Also, a review of mobility re-grading trends across all treatment locations showed that on some occasions the original mobility type was incorrect. The analysis was being introduced into planned transport working group (TWG) meetings. Locality managers would also address the issues as they arose as well as report to the TWG.
- The impact on quality and sustainability was measured through key performance indicators. The service was continuously learning and trying to improve with some innovation, for example, systems to monitor driving style as well as automated planning and despatch systems.
- There had been a recent implementation of a staff bonus scheme to try to affect the key performance indicator PTS04 or the percentage of patients arriving 45 minutes earlier to 15 minutes after that scheduled appointment time. Road based staff were encouraged to collect better data and commence journey from base station more promptly.
- The service implemented new software at the end of 2015, which assisted in planning journeys at the control. Over time, it was expected that this would be fully automated and more efficient so that patient journeys were as short as possible. This would give call centre staff the time to make more calls should they need to in times of high demand. The software was a learning piece of software that we were told would take time to fully take on the thousands of journeys that were planned successfully each day.
- Each ambulance was fitted with a tracking system which performed several different functions. When staff logged in the system enabled managers at the bases and the dispatch team to view the status of the ambulance for example whether and how they were driving or whether they were stopped. The system also monitored the driver's performance which was reviewed by managers.

Patient transport services (PTS)

- We saw recruitment records and forward planning for a specific need to increase staffing levels for a part of the service due to a third party provider discontinuing with the service.
- Arriva Transport Solutions South West carried out a comprehensive review of do not attempt cardio pulmonary resuscitation procedures in November 2015. This was done with the support of quality commissioners in another area of the country; however, the new process had been applied across all of the contracts nationally.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- Control and road based staff recognised where they could help patients. Staff went out of their way to assist patients we were told by a patient of an example of staff amending their journey to help a patient who was delayed by another provider. There were other examples that we saw in the incident recording, where staff had identified issues that patients needed assistance with at home and had completed tasks before leaving to ensure the patient was safe as well as emotionally supported.

However, there were also areas of poor practice where the location needs to make improvements.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the location must:

- Ensure that mandatory training observations, appraisals and yearly updates for all staff is carried out and up to date including the high dependency ambulance vehicle staff.
- Ensure that the process in place to record defects in vehicles was recorded and actioned in a timely way was followed.

Action the hospital SHOULD take to improve

- Ensure that the process for staff to be informed of updated policies, procedures and quality and governance updates is followed and records kept
- Ensure that all equipment and particularly those used to take measurements of patients' blood pressure and oxygen saturation levels are listed on equipment servicing records and serviced and maintained within specified dates.
- Ensure that systems for control to communicate between operational or road based staff enable timely communication via telephone calls and text messaging so that messages about patient's condition or incidents were able to be shared.
- Ensure that policies and procedures for disposal of clinical waste are followed.
- ensure that battery life for equipment used for text and voice communication is fit for purpose and is reliable
- Ensure that the process for identifying poor performance that needed to be addressed and managed formally was followed.

In addition the location should:

- Consider how staff receive feedback from any incidents they report.
- Consider whether Mental Capacity Act 2005 and deprivation of liberty safeguards training meet staff needs.
- Consider aids for staff to be able to communicate with patients with significant sight or hearing impairment are available.
- Consider reviewing the process and questions for call taking for identifying mental health and other support needs a patient may have once scripted prompts are exhausted.
- Consider carrying out a review of patients comfort in vehicles.
- Consider whether electronic alerts that the planning and control room staff used on patient records that included the word complaint complies with records keeping best practice.
- Consider the method for journey time allocations and whether post code allocation is detailed enough.
- Consider increasing the opportunity for road based staff and control based staff to understand each other's role better.

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 18 HSCA (RA) Regulations 2014 Staffing **18. (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of** **this Part.** **(2) Persons employed by the service provider in the provision of a regulated activity must—** **(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,** • 25 (8.4%) staff were overdue on their yearly updates. For several of those 25 staff, the last time they completed mandatory training was in 2014. The control room staff were also due to have annual refresher training, but the training records were blank for this group of staff. The training records also showed a large number of staff had not received first aid at work training or infection control training. • Not all appraisals were up to date. 69 or 41% of the staff in Gloucester had not received their annual appraisal or a six monthly review at the time of our inspection. At the Swindon station, 19% of staff had not received their annual appraisal and 9.7% of staff had not received a six month review. • Staff who worked on the High Dependency (HDU) ambulance were required to have additional training in airway management, suctioning, use of the defibrillator and use of a bag and mask in a resuscitation situation. We looked at the training records a list of staff suitably qualified to work on the HDU ambulance. 32 staff were trained to work on the ambulance, however, 21 (65.62%) had not received training since July to September 2014. We also found that the training matrix had not been updated.

This section is primarily information for the provider

Requirement notices

- At the Gloucester station 70% of staff had not received an observation of their care. At the Swindon station 17% of staff had not received an observation. The Keynsham based had not carried out observed practice for ambulance crew from January to June 2016.
- Staff had access to paper copies of updated policy and procedures as well as access to these electronically on the staff intranet. Quality and governance updates were also available for staff in the staff room. Staff were expected to sign a form once they had read the information however, the form demonstrated that only around half the staff had signed.

There was no structured approach to regularly monitor the call takers competence with call handling and patient assessment.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include: 2) (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; • Decisions were not always made to take a vehicle off the road when defects were identified and reported. We found on one vehicle, staff had reported that the emergency doors did not open from the inside which posed a risk to patients and staff in the event of an accident. Staff documented this issue on the checklist on the 30 June 2016 and again on the 19 July 2016 Both the machine for recording a patient's blood pressure and the machine for recording oxygen levels did

This section is primarily information for the provider

Requirement notices

not have any information on them as to when they were last serviced and calibrated. Neither of these pieces of equipment were listed on Arriva Transport Solutions South West's equipment servicing records for 2015/16.