Arriva Transport Solutions Limited

Arriva Transport Solutions - South West

Quality Report

3rd Floor,
The Crescent,
Temple Back,
Bristol.
BS1 6EZ
Tel: 0117 943 9910
Website: www.arrivatransportsolutions.co.uk

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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 known 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 operated by Arriva Transport Solutions Limited. The service provides non-emergency patient transport services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11, 12 and 13 December 2017, along with an unannounced visit to the provider on 21 December 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by Arriva Transport solutions South West was patient transport services. Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport services core service.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following issues that the service provider needs to improve

- Not all incidents were being captured and some safeguarding concerns had been missed and lessons from complaints and incidents were not shared effectively with frontline staff.
- Children (with escorts) and adults were being transported in mixed vehicles with no evidence of a risk assessment for this.
- Operational staff did not have access to all policies and procedures necessary, there was no accessible deteriorating patients policy for staff out on the road or a policy to advise staff on the safe transportation of wheelchairs or the use of wheelchair seatbelts.
- Arrangements to protect staff who were lone working were not sufficient, staff did not always receive call backs from control when requested in an emergency and staff who worked alone did not always receive welfare calls from the control room during and at the end of their shifts.
- Control room staff did not always inform operational bases of staff sickness.
- Only 23% of staff had received updated level 2 safeguarding training against a target of 85% and control room mandatory training was 62% against a target of 85%.
- Only 51% of control room staff had received an appraisal in the 12 months to October 2017 against an 85% company target.
- Staff vacancy reports showed 26 full-time equivalent (FTE) vacancies at the time of our inspection.
- There was no embedded process to assess or monitor observed practices amongst call centre staff and dispatchers.
- When crews were not made aware of specific infection risks by hospital staff they did not escalate them beyond the service.
- Crews did not always have up to date information about patients' resuscitation decisions as part of the booking form and other key information such as mobility status was sometimes missing or incorrect.
- Best practice guidance had been used to develop some policies and procedures but staff had no awareness of any best practice guidance beyond this.
- The service was consistently missing some key performance indicators for renal dialysis patients and oncology patients.

Summary of findings

- Data provided in Clinical Commissioning Group reports did not reflect the actual number of cancelled journeys that were attributable to Arriva and there were discrepancies in data.
- Some data related to serious incident reporting was not accurate and did not give assurances all information used to monitor and manage quality and performance was accurate.
- There were no communication aids or information for patients who were visually impaired, hard of hearing or who had learning disabilities.
- The governance framework and management systems did not provide assurance that all third party providers had been reviewed for assurance of Disclosure and Barring Service checks (DBS), driving licences and vehicle insurance.
- There were no individual risk assessments to support decisions to not carry out disclosure and barring service checks (DBS) for roles that were not eligible for DBS checks, including the financial director and some call centre staff.
- Staff had been involved in the development of the Arriva values although some staff were unaware of them.
- A senior manager acknowledged they needed to be more aware of the requirements of the registered manager post they had applied for.

However, we found the following areas of good practice:

- A new incidents and complaints manager had been employed to oversee the quality, communication and was starting to share learning from incident investigations.
- A computer system allowed all vehicle defects to be monitored both centrally and at a local level.
- A new recruitment coordinator had reduced staffing vacancies and produced weekly monitoring reports of recruitment progress.
- There was an effective business continuity plan that prioritised patients with the greatest needs.
- Crews were dedicated and resilient when faced with adverse weather and worked to get to patients with greatest needs.
- The service had recently implemented a day before and on the day text messaging service and was monitoring its effectiveness as part of its engagement with the CCGs.
- Significant changes had been made in transport for patients for renal dialysis that included a coordinator and dedicated vehicles.
- The service was achieving its target in five out of six key-performance indicators (KPI) for renal dialysis patients.
- The service was achieving its target in four out of six KPIs for oncology patients.
- Most operational staff had received an appraisal in the 12 months to October 2017, and all ambulance stations met the company target of 85%.
- Staff were respectful to patients and kind in their interactions with patients, taking time to confirm names and destinations.
- Staff ensured they did all they could to maintain patients' dignity.
- Staff accommodated additional family members or carers for the most vulnerable patients including children.
- Staff understood the eligibility criteria and made sure patients understood who was eligible for non-emergency patient transport services and why.
- Staff talked with patients during their journeys which patients said 'made their day'.
- The service engaged with commissioners and there was evidence of service improvements for the dialysis group of patients as a result.
- The service was working towards two Commissioning for Quality and Innovation (CQUINs) targets and had recently implemented a day before and en-route text service for some patients.
- Most complaints were responded to within the 25-day target company target.
- Senior managers had a realistic strategy for achieving their vision and priorities in order to deliver good quality care, and understood the key drivers for providing effective non-emergency patient transport service.
- The governance framework and management systems had recently been reviewed and improved following a lapse in governance that had led to disciplinary action and restructure.

Summary of findings

- There were comprehensive assurance and service performance measures, which were reported and monitored. Action was taken to improve performance.
- We saw that assurances for volunteer car drivers for DBS, insurance, vehicle roadworthiness or MOT and licence to drive were effective.
- Most staff we spoke with felt respected and valued and those we were able to speak with felt that managers demonstrated openness and honesty. Organisational change was handled openly.
- Most full and part time staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.
- Most leaders and managers had the capacity, capability and experience to lead services effectively.
- Leaders tried to ensure that people who used services, those close to them and their representatives were actively engaged and involved in decision-making and improving the quality of services.
- All staff we spoke with were focused on continually improving the quality of care. When leaders considered developments to services or efficiency changes, they used both quantitative data and patient experience to inform the change.
- Leaders and staff strived for continuous learning, improvement and innovation. The service sought to innovate and explore new ways of working with CCG and other stakeholders.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with five requirement notices that affected patient transport services. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals

On behalf of

The 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)		**Arriva Transport Solutions South West primarily provided non-emergency patient transport services.** **We found the provider had some good governance arrangements covering some sub contracted work and recruitment. There was also improved communications between the service and patients through text messaging. the service needed to make further improvements around observed practices for control room staff to further assure itself of the consistency and quality of the services they provided, and needed to continue to capture, review and learn from incidents.**

Arriva Transport Solutions - South West

Detailed findings

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Detailed findings

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Background to Arriva Transport Solutions - South West

Arriva Transport Solutions- South West is operated by Arriva Transport Solutions Limited, a nationwide provider of independent, non-emergency patient transport services. Arriva Transport Solutions Limited is part of Arriva group. 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 are 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, renal transport and transport of high dependency patients who had received unblocking of cardiac arteries.

The service has had a registered manager in post since 17 October 2013. At the time of the inspection, a new manager had recently applied to take over the post and was going through the CQC application process.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and four other CQC inspectors, an inspection manager and one specialist advisor with expertise in patient transport service management. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection

Facts and data about Arriva Transport Solutions - South West

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.

The service is registered to provide the following regulated activities:

-Transport services, triage and medical advice provided remotely.

Detailed findings

During the inspection, we visited four stations run by the services located in: Swindon, Lydney, Gloucester and Keynsham. We also inspected the control and dispatch centre, based at the head offices in Bristol.

We spoke with 51 staff including; patient transport drivers, administrative and call centre staff and management. We spoke with 12 patients and one relative. We also received 24 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed six electronic patient booking records, eight incident reports, six root cause analysis investigations, 10 complaints records and inspected nine vehicles.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in July 2016, which was a responsive unannounced inspection. This inspection found that the service was not meeting all standards of quality and safety it was inspected against and identified areas of poor practice where the location needed to make improvements around training observations, appraisals and vehicle defect recording processes.

In the reporting period October 2016 to September 2017, the service undertook 223,941 patient transport journeys. The most frequently used journey categories were:

-85,928 outpatient appointments.

-85,344 dialysis appointments.

-18,059 oncology appointments.

-4,423 discharges.

In addition, between December 2016 and November 2017, the service transported 1,100 children under the age of 18.

175 full time equivalent (FTE) patient transport drivers and ambulance care assistants worked at the service, which also had a bank of temporary staff that it could use. The service also employed 26 staff as call takers and dispatchers in their control centre. The service did not store or administer any medications such as controlled drugs to patients.

Track record on safety

-The service reported no never events between August 2016 to October 2017.

-The service reported six serious clinical incidents between August 2016 to October 2017.

-The service reported 31 patient harm incidents between August 2016 to September 2017.

-The service reported 731 complaints between August 2016 to September 2017.

Services provided at the unit under service level agreement:

-The service reported that between October 2016 and September 2017 78,451 (35%) journeys were subcontracted to other patient transport service providers.

-Call centre services for incident management since July 2017.

-Medical gases.

-Medical devices and mobility equipment maintenance.

-Confidential waste disposal.

-Disclosure and barring service checks.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by Arriva Transport Solutions South West was patient transport services.

Summary of findings

We found the following areas of good practice:

- A new incidents and complaints manager had been employed to oversee the quality, communication and was starting to share learning from incident investigations.
- A computer system allowed all vehicle defects to be monitored both centrally and at a local level.
- A new recruitment coordinator had reduced staffing vacancies and produced weekly monitoring reports of recruitment progress.
- There was an effective business continuity plan that prioritised patients with the greatest needs.
- Crews were dedicated and resilient when faced with adverse weather and worked to get to patients with greatest needs.
- The service had recently implemented a day before and on the day text messaging service and was monitoring its effectiveness as part of its engagement with the CCGs.
- Significant changes had been made in transport for patients for renal dialysis that included a coordinator and dedicated vehicles.
- The service was achieving its target in five out of six key-performance indicators (KPI) for renal dialysis patients.
- The service was achieving its target in four out of six KPIs for oncology patients.
- Most operational staff had received an appraisal in the 12 months to October 2017, and all ambulance stations met the company target of 85%.
- Staff were respectful to patients and kind in their interactions with patients, taking time to confirm names and destinations.

Patient transport services (PTS)

- Staff ensured they did all they could to maintain patients' dignity.
- Staff accommodated additional family members or carers for the most vulnerable patients including children.
- Staff understood the eligibility criteria and made sure patients understood who was eligible for non-emergency patient transport services and why.
- Staff talked with patients during their journeys which patients said 'made their day'.
- The service engaged with commissioners and there was evidence of service improvements for the dialysis group of patients as a result.
- The service was working towards two Commissioning for Quality and Innovation (CQUINs) targets and had recently implemented a day before and en-route text service for some patients.
- Most complaints were responded to within the 25-day target company target.
- Senior managers had a realistic strategy for achieving their vision and priorities in order to deliver good quality care, and understood the key drivers for providing effective non-emergency patient transport service.
- The governance framework and management systems had recently been reviewed and improved following a lapse in governance that had led to disciplinary action and restructure.
- There were comprehensive assurance and service performance measures, which were reported and monitored. Action was taken to improve performance.
- We saw that assurances for volunteer car drivers for DBS, insurance, vehicle roadworthiness or MOT and licence to drive were effective.
- Most staff we spoke with felt respected and valued and those we were able to speak with felt that managers demonstrated openness and honesty. Organisational change was handled openly.
- Most full and part time staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.
- Most leaders and managers had the capacity, capability and experience to lead services effectively.
- Leaders tried to ensure that people who used services, those close to them and their representatives were actively engaged and involved in decision-making and improving the quality of services.
- All staff we spoke with were focused on continually improving the quality of care. When leaders considered developments to services or efficiency changes, they used both quantitative data and patient experience to inform the change.
- Leaders and staff strived for continuous learning, improvement and innovation. The service sought to innovate and explore new ways of working with CCG and other stakeholders.

However, we found the following areas where the service needs to make improvements:

- Not all incidents were being captured and some safeguarding concerns had been missed and lessons from complaints and incidents were not shared effectively with frontline staff.
- Children (with escorts) and adults were being transported in mixed vehicles with no evidence of a risk assessment for this.
- Operational staff did not have access to all policies and procedures necessary, there was no accessible deteriorating patients policy for staff out on the road or a policy to advise staff on the safe transportation of wheelchairs or the use of wheelchair seatbelts.
- Arrangements to protect staff that were lone working were not sufficient, staff did not always receive call backs from control when requested in an emergency and staff who worked alone did not always receive welfare calls from the control room during and at the end of their shifts.
- Control room staff did not always inform operational bases of staff sickness.
- Only 23% of staff had received updated level 2 safeguarding training against a target of 85% and control room mandatory training was 62% against a target of 85%.
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- Staff vacancy reports showed 26 full-time equivalent (FTE) vacancies at the time of our inspection.

Patient transport services (PTS)

- There was no embedded process to assess or monitor observed practices amongst call centre staff and dispatchers.
- When crews were not made aware of specific infection risks by hospital staff they did not escalate them beyond the service.
- Crews did not always have up to date information about patients' resuscitation decisions as part of the booking form and other key information such as mobility status was sometimes missing or incorrect.
- Best practice guidance had been used to develop some policies and procedures but staff had no awareness of any best practice guidance beyond this.
- The service was consistently missing some key performance indicators for renal dialysis patients and oncology patients.
- Data provided in Clinical Commissioning Group reports did not reflect the actual number of cancelled journeys that were attributable to Arriva and there were discrepancies in data.
- Some data related to serious incident reporting was not accurate and did not give assurances all information used to monitor and manage quality and performance was accurate.
- There were no communication aids or information for patients who were visually impaired, hard of hearing or who had learning disabilities.
- The governance framework and management systems did not provide assurance that all third party providers had been reviewed for assurance of Disclosure and Barring Service checks (DBS), driving licences and vehicle insurance.
- There were no individual risk assessments to support decisions to not carry out disclosure and barring service checks (DBS) for roles that were not eligible for DBS checks, including the financial director and some call centre staff.
- Staff had been involved in the development of the Arriva values although some staff were unaware of them.
- A senior manager acknowledged they needed to be more aware of the requirements of the registered manager post they had applied for.

Are patient transport services safe?

Incidents

- Between September 2016 and August 2017, the provider reported no never events. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There had been six serious incidents requiring investigation between September 2016 and October 2017 which we reviewed. An example of a serious incident reported was an inappropriate vehicle being dispatched to collect an immobile patient. The root cause analysis (RCA) showed the computer system used to allocate vehicles had flagged a warning to the dispatcher, but this had been overridden three times. As a result of the investigation, the senior managers reviewed the overall supervision of dispatchers through a new observed practice methodology and a process to identify 'at risk' patients was also implemented.
- We spoke to staff about the improvements made following this incident and staff were able to demonstrate how they identified patients who were at risk. Staff used a day board to display the names of patients who had experienced problems with the service in the past, such as incorrect mobility or significant delays in either pick up or drop off. Staff told us this process only worked for patients who had used the service in the past. The planners reviewed the booked journeys for the day at the start of their 6am shift and updated the board accordingly.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. Between September 2016 and August 2017, the service reported 197 incidents. The most frequently reported incident category was illness or injury, accounting for 94 (47.7%) of the incidents reported.
- Incidents were further categorised by whom they affected. For the same reporting period, 31 (15.7%) incidents were classified as patient harm incidents. These incidents were not divided according to severity of harm, and managers told us they covered a broad spectrum of harm.

Patient transport services (PTS)

- We reviewed all incidents reported between December 2016 and November 2017 and found eight incidents that were not initially categorised as potential safeguarding concerns, but saw that for five of the incidents, a safeguarding alert had further been raised on the same day. Managers told us incidents were sometimes reported where the safeguarding concerns were not always obvious. Incidents were further reviewed by the incidents and complaints manager to pick up any safeguarding concerns not initially categorised as safeguarding.
- We saw one incident where a safeguarding concern had not been raised, which showed the crew had been informed by paramedics that they would raise a safeguarding concern, but the service had not followed this up. We escalated this to the complaints manager who immediately contacted the other ambulance service involved.
- Incidents were not being reported and captured effectively. We saw an incident log from a disused communication system that allowed operational staff to alert the control room to non-urgent delays and issues. The disused log had been replaced by a new system and we saw daily reports of messages and faults reported by staff and reviewed by the control room. We saw that since July 2017, 48 messages had been received on the old system including one message from November 2017, reporting a three-hour delay in pick up for three dialysis patients. We raised this with the manager for the control room, who raised it as an incident. The manager told us the system was no longer in use, and they would review the entire log. However we saw that the log was still being used despite the manager telling us the system was no longer in use.
- In most cases, people who used services were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. We reviewed six incident investigations that showed patients had been contacted either verbally or in writing in five out of the six cases reviewed. However; in one case, we saw that a voluntary car driver had failed to start a shift and a member of staff had incorrectly informed a patient waiting for collection that the driver was on their way. As a result, the patient missed a follow up appointment. Actions recorded in the RCA were still ongoing at the time of our inspection, but included the introduction of a 'day before' text to remind voluntary drivers of their shifts. An action to reinforce correct procedures for advising patients of estimated time of arrival (ETA) was also recorded. We saw posters displaying the process for advising patients of ETAs and staff we spoke to demonstrated how they were recorded in the booking system.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour 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 that 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.
- Staff and managers were clear as to who had responsibility for duty of candour in the event of joint responsibility between Arriva and the subcontracted company. Managers told us they retained overall responsibility, but involved and updated subcontracted services in investigations. We saw evidence of this in two investigations we looked at.
- When things went wrong, reviews or investigations were carried out. We reviewed eight investigations and found the quality of the investigations varied. We saw that most relevant staff were involved in investigations, however in one incident around a safeguarding referral, we saw several sections of the reporting form that were blank, including the actions taken as a result and if there was any police involvement. We escalated this to the incidents and complaints manager to obtain assurances that the taxi driver mentioned in the incident had been dealt with appropriately. The manager was able to show us separate emails to confirm the driver had been dismissed from the subcontracted company.
- The service attempted to share learning from incidents. The service had recently introduced a weekly call for all operational managers and senior managers to discuss recent complaints, incidents and any subsequent learning. We reviewed minutes from calls which showed discussions around incident reporting, however, the meeting minutes did not contain any details of any learning from the incidents discussed, so we were not assured staff received effective updates or shared learning from these meetings.

- Frontline staff were told about changes in policy or procedure through a series of governance and quality updates. These were emailed to staff individually and we saw copies printed and displayed in the stations we visited. However, in July 2016, an updated patient medical emergencies update was set out to staff. We asked staff where they would look for guidance on deteriorating patients and medical emergencies, and none of the three staff we spoke to could show us the governance and quality update.
- Front-line staff were able to report incidents through a dedicated 24-hour incident reporting telephone line, run by a third party provider. This had been introduced in July 2017 following the introduction of an electronic reporting system in October 2016. Initially staff reported incidents through the Arriva call centre who inputted details into the system. However, call centre staff were often too busy, which resulted in missing information from the incident records. Staff and managers told us that since the incident reporting had been outsourced to another company, the quality of the information had improved, with the incident manager reviewing the content of incident reports on a daily basis. Feedback was also received from the third party company if there were any concerns around an incident reported, and call recordings had been requested by the incidents and complaints manager. We listened to one recorded incident call from another area, to demonstrate how the service used the calls, but the manager explained there had not been a need to do this yet within the service.
- Some work was subcontracted to other providers and we saw investigations involving drivers and staff from those providers. In one instance, we saw interview notes from a driver following their failure to pick up a patient from a scheduled appointment. Actions recorded in the investigation showed the service was now alerting drivers to remind them of their shift start times and the importance of alerting the call centre if they were not able to undertake their planned shift.
- The service did not have a process to ensure third party providers were reporting incidents through Arriva reporting systems. We saw that third party subcontracted staff received the same training as Arriva staff around reporting incidents, however there was no process or evidence to show third party providers were reporting incidents to Arriva.

Clinical Quality Dashboard or equivalent

- The service used multiple dashboards to display progress against quality and safety indicators. Between July 2016 and September 2017, data had been analysed to show positive and negative trends. For example, the numbers of complaints received across the four clinical commissioning group (CCG) contracts had been analysed and had shown an increase in two contract areas, but a decrease in the other two areas. Monthly updates showed the service had investigated the increase to establish any further themes, and had identified staff shortages in one month as a contributing factor to the increase.

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 updates. The content of the yearly mandatory training was changed depending on the needs of the service or incidents that had occurred. As an example, another inspection of Arriva transport solutions elsewhere in the country had identified that the content of the safeguarding training delivered to staff was not sufficient to meet level two requirements. As a result, safeguarding training had been updated and rolled out across the whole organisation.
- Staff received annual mandatory safeguarding training updates in a one-day course, which incorporated many other subjects as well as safeguarding. One staff member we spoke to did not know if they had received safeguarding training but could describe situations they would report as incidents.
- Mandatory training records showed that most staff had received their yearly mandatory training. For all southwest locations, the provider had an overall compliance of 88.5% of staff being in date for their annual mandatory training update. Data submitted showed the compliance rates for mandatory training for each ambulance station in December 2017. The rates of completion were: Gloucester 90%, Lydney 91%, Newport 85%, Keynsham 95%, Swindon 96%, Salisbury 84% and Bristol Control room 62%.

- All stations except the Bristol control room and Salisbury were above the 85% service target completion rate. This target had been changed since out last inspection, where it was 95%, which was particularly high when compared with other similar organisations. We saw records of dates planned for named staff to compete training later in the year for those who were not currently up to date with mandatory training. This was an improvement since the last inspection where only one station had been above the then 95% target.
- An annual mandatory training package for all subjects, including adult and paediatric first aid and safeguarding was delivered to staff in a one-day course. A small number of staff we spoke with felt training was not delivered in a way that allowed crews to practice and update essential skills to deliver a high quality service.
- The service had a dedicated training lead who had been trained as an instructor and assessor and was appropriately qualified to deliver training.
- Mandatory training was delivered to front line staff and other remote workers in a series of station based days over the course of a week. During our inspection, trainers were present at the bases we visited to deliver training updates to front line staff.
- Compliance against mandatory training requirements was monitored in monthly reports and monitored centrally. Non-compliance with training was acted upon locally and we saw plans held at individual stations to address and staff who were not up to date with their required training.
- Manual handling refresher training was given to staff when requested, when new equipment was introduced or when there were changes to manual handling operations. Manual handling training was included as part of the annual mandatory training day, but staff reported it was an update rather than refreshing current safe practices. At the time of our inspection, 88.5% of all staff had received their manual handling mandatory training update.
- On our previous inspection we saw that a significant number of staff trained to transport patients who had under gone cardiac artery unblocking procedures, had not had updated training in the 12 months prior to the inspection. We reviewing training records and saw that 21 out of 24 staff were now up to date with this enhanced training.
- All staff were suitably trained and assessed to carry out driving duties safely upon appointment, and received mandatory driver training as part of their induction training. Driver update training was carried out as part of the annual mandatory training update and in October 2017 the provider reported 81% of staff were up to date with their required annual driver training. In addition, 64% of staff had undergone an observed practice within the previous six months. However, this was still below the 85% company target.
- Systems were in place to identify and support drivers who displayed driving behaviours that could place patients at risk such as heavy braking or acceleration. We saw how a real-time computer monitoring displayed such behaviour and alerted staff to unsafe driving that may require a review.
- The service had a mentorship programme to ensure staff were competent and supported during their probation period as a new crewmember. Mentors passed on support to new crew through a competency based system of achievement's and operational procedures.

Safeguarding

- We were not assured 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 some of 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.
- As a result of another inspection of Arriva services elsewhere in the country, changes had been made to the content of the safeguarding training to ensure it met the legal requirements of level two adult and child safeguarding training. Following the other inspection, Arriva had brought an external company in to review the content of the safeguarding training. The company had reported the content did not meet the requirements of level two training and made recommendations to Arriva on how to amend the training. We looked at the syllabus of the safeguarding training provided to staff and found that it covered female genital mutilation (FGM) and radicalisation as part of PREVENT training. However, some staff had not heard the term FGM before and had to ask what it was.
- At the time of our inspection, 23% of staff had received the updated level two safeguarding training. For those

staff still waiting to receive the updated training, managers told us they planned to ensure all staff were trained by the end of August 2018. A risk had been recorded on the Arriva Transport Solutions South risk register with evidence of regular reviews and a risk owner.

- We reviewed all safeguarding incidents reported between December 2016 and November 2017 and found eight incidents reported which were not initially classified as safeguarding. Out of the eight incidents, five had then been raised as safeguarding concerns, which we saw clearly documented within the incident file on the computer system. We raised the other three incidents with managers who reviewed them and followed up one immediately with the local authority. Managers told us incidents were sometimes reported where the safeguarding concerns were not always obvious. Incidents were further reviewed by the incidents and complaints manager to pick up any safeguarding concerns not initially categorised as safeguarding.
- Staff all carried plastic cards on a key ring, which contained quick reference information for reporting incidents such as safeguarding.
- The implementation of safety systems, processes and practices were monitored and improved when required. In May 2017 representatives from the contract clinical commissioning groups (CCGs), local authority safeguarding representatives and one of the dialysis units served by Arriva, met to discuss ongoing transport issues for dialysis patients. Discussions focused on the impact of delays in transport on the care, treatment and wellbeing of dialysis patients.
- Following the safeguarding investigation, the service appointed a renal coordinator and established a renal working group with one main trust to trial and pilot new ways of working. At the time of our inspection the service had made several changes including weekly reviews of patient mobility and new patient information posters.
- There were not sufficient arrangements in place to safeguard children from abuse that reflected relevant legislation and local requirements. We saw in the commissioning contract and in Arriva policies that children under the age of 18 were required to travel with a parent or authorised guardian. However, we also saw that children (with an escort) were often transported in vehicles with other adult patients. We raised this with the senior management team, who were unable to show us any evidence that the potential risks associated with this had been captured or mitigated.
- We reviewed the commissioning contract and saw that the Arriva escort policy reflected the requirements set out in the contract. We approached all CCGs and two confirmed they had no concerns and had not had any incidents reported around the transportation of children.
- There was an effective system in place for front line staff to report safeguarding incidents. We saw in all of the stations we visited, 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.
- Between July 2016 and September 2017, the service reported 63 adult safeguarding concerns, and two child-safeguarding concerns to the local authorities. Staff told us on several occasions they had encountered patients who were struggling to take care of themselves, or who did not have the appropriate level of support in place. Staff told us they reported their concerns as safeguarding alerts or within other incidents for managers to review.
- Staff we spoke with were clear as to who was responsible for reporting safeguarding concerns in the event of sub-contracted care. 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.
- Staff could identify whom they would contact for further advice or clarification, and we saw these details clearly displayed in all of the stations we visited. 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.
- Staff did not receive feedback from the contract provider about safeguarding concerns they had raised, however the six reported safeguarding incidents we reviewed included contact with the local authorities for updates.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained through a series of daily, weekly and monthly checks. Ambulances were subject to manager's weekly checks to ensure staff were following correct procedures. We could see this was being completed by evidence on the computer log and condition of the vehicles. All vehicles we inspected were visibly clean and free from contamination.
- There was a clear understanding by staff of their roles with regard to infection control. We found that staff followed the service's infection control policies, and showed us the single use colour coded mop system for cleaning vehicles, which we saw was being followed.
- Personal protective equipment was available for staff to use, and we saw vehicles were stocked with hand sanitiser, gloves, hard surface wipes, labelled pump bottles of bacterial cleaner, spill kits, and clean, single use fleece blankets and sheets. Staff were able to describe how and when they would use this equipment and understood the importance of handwashing over the use of anti-bacterial gel. We saw staff use hand gel where available in the hospitals where they picked up or dropped patients off. They also used plastic gloves when moving patients from a hospital bed to the ambulance stretcher and vice versa. The crew members used disinfectant wipes to clean each stretcher after use.
- Staff were able to explain to us how a vehicle would be cleaned following exposure to an infection risk. Staff were aware of the manufacturer's instructions for the use of the chemical they used to clean their vehicles, which was displayed on the wall at the dispensing stations. However, one staff member told us they were sometimes encouraged to use the wipes they carried in the ambulance to clean if a patient had been sick in the vehicle, although managers stated this was acceptable and in line with policy if adequate cleaning was able to take place.
- The service had an infection prevention and control policy and employee manual, which addressed all relevant aspects of infection prevention and control, including decontamination of medical devices, vehicles and workwear.
- In addition, the provider carried out an unannounced annual audits of staff, premises and vehicles, which compared the locations performance against that in the previous year. We reviewed data provided which showed that in the 2017 premises infection prevention and control report, six out of seven stations (including the control room) had 100% compliance. This was an improvement on the 2016 report which showed only four out of seven stations were 100% compliant. Areas inspected included clinical waste disposal, cleaning, chemical storage and general cleanliness of all areas.
- In the vehicle infection prevention and control audit, across the six stations, of the vehicles inspected, two stations were 100% compliant. This was an improvement on the 2016 report, where no stations had been compliant. Areas covered included general cleanliness of vehicles and equipment, consumable stock date checks and servicing and cleanliness checks of emergency equipment such as portable suction.
- Clinical waste was securely managed. Crews would bag and bin clinical waste appropriately and an approved waste management company collected clinical waste every 14 days.
- Crews were not always made aware of specific infection and hygiene risks associated with individual patients. We saw an incident recorded where a patient with suspected influenza was transported alongside other patients and staff. We raised this with managers, but there was no evidence to show this had been raised with the hospital transferring the patient.

Environment and equipment

- The maintenance and use of equipment was arranged to keep people safe. Regular services were undertaken and crewmembers carried out daily vehicle checks. Faults were reported to vehicle manufacturers and tyre centres that the service had contracts with. Compliance with MOT testing and vehicle servicing scheduling was prompt. We could see evidence of recent and upcoming servicing and MOT's. This was both on a whiteboard in the base office and online with fleet services.
- The provider held a central record of all vehicles including their lease, servicing and MOT dates where applicable. This information was monitored centrally to and showed vehicles were sent for servicing well ahead of these dates to ensure they were not off the road unnecessarily. On our previous inspection, we found there had been no central oversight of vehicles servicing and MOTs, and information held at stations had been out of date. Since our last inspection, the service had implemented an electronic fault monitoring system. Crews inspected their vehicles at the start of the day and logged any faults. The individual station operational

managers took the decision to remove vehicles from use, based on the information reported. Managers showed us that a central Fleet team also had oversight of the vehicles removed from operation and sampled a percentage of these removals to check they were appropriate.

- An external company was contracted to maintain and service medical devices in accordance with manufacturer's guidelines. We saw evidence that equipment such as the trolleys in the ambulances had been serviced by an external company.
- The systems, processes and practices that were essential to keep people safe were not always followed. When a crew started a shift, they were required to use an electronic system to 'log on' to a vehicle to show who was driving the vehicle. This was not always happening, and station managers told us they reminded staff to do this, but it continued to be a problem. The location of each vehicle was monitored remotely from the control centre through global positioning software (GPS).
- Staff were suitably trained, assessed and equipped to safely carry out manual handling tasks as part of their induction programme. The service had a minimal lifting policy, which covered the roles and responsibilities of staff to report all manual handling incidents through the electronic reporting system, which we saw.
- The station environment was not designed and maintained in way which kept people safe. Where crews used motor oils and other engine fluids we found no safety information displayed. This meant crews would not be aware of potential health issues when using them or what personal protective equipment to use. When we highlighted this to the service, it was rectified the following day across all bases we inspected.
- All vehicle keys were stored in a locked key safe with coded access by crews only, which was checked daily by the operational managers.
- Most patients in wheelchairs were safely secured whilst they were being conveyed, and we saw additional wheelchair seatbelts in use. However, meeting minutes from a staff meeting in August 2017, recorded that some crews did not have these additional seatbelts on vehicles, and they were to escalate this to control so that the seatbelt could be ordered. The minutes also recorded that where patients were in their own wheelchair, the staff felt they could not force them to use the additional seatbelt, as the wheelchair was not Arriva equipment. It was not clear that staff knew their responsibilities under road traffic law ensuring fit and use of seat belts. We raised this with managers who had not been aware of the conversation recorded in the meeting minutes. There was also no formal policy for staff to refer to about the use of wheelchair seatbelts, but managers showed us it was clearly mentioned in the driver's handbook.
- Some equipment was standardised across the service, including the electronic tablets crews took out on the vehicles with them. However, one member of staff told us the tablet's battery life was short and that it often stopped working at some point during a shift. However, charging cords were used to charge the tablets in the vehicle during the shift. One member of staff told us charging cords were not always available at the start of the shift, so had purchased their own.
- The service managed the replenishment of vehicles, equipment and supplies. We inspected a storage area for the service where we saw staff uniforms and various consumable items. All items were in date. Consumables included personal protective equipment such as gloves, gowns and facemasks. Relevant equipment was available for both adults and children.
- Staff sometimes undertook transportation of patients who were voluntarily detained under the Mental Health Act, and transported them from one ward to another within the boundaries of one hospital. We did not see any risk assessments of any risks to patients or staff and the service did not have a policy or guidance for staff to follow.

Medicines

- No emergency medication was carried on the ambulances and staff did not administer medication. Staff ensured that any medicines provided to patients by the hospital to take home arrived safely with the patient. Staff did not store or administer controlled drugs.
- Each ambulance was equipped with oxygen which staff were able to administer to patients if a doctor had already prescribed it. Staff were not allowed to alter the flow rate of the oxygen and could not administer more than four litres, in any circumstance including emergencies, which was in line with company policy. We saw that where staff had given patients oxygen, there was no way for them to document this; however, this is not unusual in patient transport services. If a patient with oxygen pre prescribed had to receive oxygen mid

journey or in response to becoming unwell, staff documented this as an incident. However, we saw one incident reported where staff had given six litres of oxygen to a patient whilst being transported which was not in line with company policy.

- Staff working on the high dependency unit ambulance had received additional training in oxygen therapy in relation to resuscitation.
- Oxygen was appropriately stored on the ambulances. Each ambulance carried one large oxygen cylinder and one portable cylinder that were secured appropriately on the vehicle. An electronic system using a barcode on oxygen cylinders was used to monitor stock. Levels of stock were reviewed and replaced frequently by the medical gas company under a service level agreement with Arriva.

Records

- People's individual electronic care records were not always written and managed in a way that kept people safe. Patient records were created at the control centre and received by ambulance crews on the electronic tablets. The service was limited by the information received at the point of booking and work was on-going to highlight to healthcare staff and patients the importance of providing as much information as possible to enable the call centre to dispatch appropriate resources. Control room staff collected relevant information during the booking process about the patient's health and circumstances. For example any information regarding access to property. The process was designed to ensure crews were informed about any needs or requirements the patient may have during their journey. However, several members of staff reported that the information provided on the patient record was sometimes incorrect, out of date or very limited. Crews reported that information about patients' mobility status was not always correct and information about access to a property was often wrong. We saw evidence of this in incident reports, and logs and reports to commissioning groups. Between 1 September 2017 and 30 September 2017 across all reported contracts, wrong mobility recorded featured as one of the top five reasons for an aborted journey in 41 instances. However, staff told us they often did not report minor issues with information accuracy.
- The service was not always aware if patients had up-to-date Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. We saw one incident reported for a patient who became unresponsive whilst being transported onto the vehicle. The crew were not aware of a DNACPR decision, and were only stopped from performing resuscitation by the patient's relative who was able to produce the documentation to show to paramedics once they attended. However, the provision of this information was often reliant on the health care professionals informing the booking staff, and we saw one incident where a crew had asked a nurse when they were collecting a patient, if they had a DNACPR decision, and were told they did not know.
- We listened in to three bookings calls and saw that the call takers had multiple prompts to ask for information about learning disabilities, mental health issues and dementia, which had to have an answer before the call taker could progress the booking. However, we saw that information about DNACPR decisions was an optional field, which could be ticked if the call taker asked for that information. In one of the three calls we listened to, the healthcare professional booking the call did not know the patients mobility status or DNACPR decision outcome. Call takers also confirmed they only asked healthcare professionals for this information as families found it upsetting.
- Staff told us when they collected a patient form a hospital or clinic, they were made aware by hospital staff if a patient they were transporting had a DNACPR decision. The service had a policy on DNACPR, which set out the protocol for patients with DNACPR decisions and recommended that the DNACPR paperwork should travel with the patient whenever possible.
- Data with patient information were securely stored on password protected electronic devices. Staff returned these devices to the office at the end of each day. Staff were aware of the need to protect patient data.
- Crews could be made aware of "special notes" to alert them to patients with pre-existing conditions or safety risks, and we were told' flags' were placed on the electronic job sheet. Staff we spoke to confirmed this and showed us two records where 'flags' had been added to alert them to challenging behaviours or where patients living with dementia had increased needs.

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 and basic life support, so they could respond if a patient was deteriorating and when to call emergency help. This was also captured in a quality and governance update, however staff did not know where to locate this document and it was not part of the information box contents held on every vehicle. Arriva had a resuscitation policy, which stated that in all medical emergencies, staff were to pull over their vehicle and call 999. We saw evidence of this happening in multiple reported incidents. Staff told us if a patient became distressed or if their condition deteriorated staff either called 999 or took the patient to the nearest accident and emergency department (A&E) department.

- Comprehensive risk assessments were carried out for people who used services, however staff did not know where to find them in patient electronic records. We saw an example where a detailed risk assessment about access to a patient's property had been carried out, but operational staff did not know how to access it.
- Staff were reliant on risk assessments and information gathered by call centre staff at the point of booking. Staff followed a script to obtain as much information as possible, however we saw an incident reported where a crew had attended a patient's home and been bitten by dogs at the property. Crews told us there was often information missing from jobs. We observed three bookings being taken, and saw that in one case the call taker had to review the patient's mobility status on previous booking as the healthcare professional booking the transport did not have this information.

Staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. The service had a recruitment plan in place and had employed a recruitment coordinator to fill vacancies. The coordinator ran a weekly report on the numbers of staff in post, vacancies and staff in training to give an accurate picture of staffing levels and the areas affected by any shortages.
- The most recent data submitted showed that across all ambulance station locations, the provider had a planned establishment of 201 staff. There were 175 full time equivalent (FTE) staff in post leaving 26 FTE(12.9%) vacancies across all ambulance stations. The report also showed 10 staff booked on either assessment or induction, who were 'in the pipeline'. Control staff moved vehicles and staff as necessary between ambulance stations when shifts were unfulfilled due to staff absence. Bank staff, overtime and subcontractors were also used to support and increase available resources.
- The service had a planned establishment of 26 staff in its call centre. Data submitted showed this was split into 12 dispatchers and 14 call takers. Actual staffing levels showed 26.7 full time equivalent staff in post with no vacancies. We found the vacancy rate had increased since our last inspection to 42 FTE (21%) staff in October 2017.
- Managers told us recruitment was an on-going challenge and the service held regular assessment centres to recruit staff. In September, the service had recruited 10 new ambulance drivers. Arriva Transport Solutions Limited had also recently begun to advertise vacant posts on the NHS jobs website.
- The service had recently employed a new recruitment coordinator who had made a number of changes to the recruitment process to try and improve the process. These included personal phone calls upon receipt of an application, regular updates for potential staff included a clear overview of the role and expectations, and personal involvement in the assessment centres and interviews. We saw that of the nine candidates booked onto the centre, all nine attended, and six passed the process.
- On our last inspection we saw evidence that staff sickness rate had significantly reduced to one of the lowest levels seen by the service. A process was in place to monitor sickness through manager reviews and occupational health referrals where appropriate. In September 2017, the provider reported an overall sickness rate of 4% for both driving staff and non-driving staff, which included two long-term sickness absences. This was good when compared to other similar services.
- On the day of our inspection, operational managers told us a member of staff had called in sick that day, but the message had not been passed on to the base. There was a policy for staff to follow which told them to contact their line manager, however, control room staff told us operational staff did not always follow this. Operational staff told us they had to reshuffle staff vehicles and workloads to accommodate the jobs for the day.
- Staff were adequately supported out of office hours and 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.

- All staff we spoke with told us they were usually able to get hold of the operational manager out of hours when working late or on nights. However, two staff voiced concerns that they did not feel safe as lone workers or confident in the systems to protect them. When we explored this, they said that often the system for requesting a call back would not work. Additionally if they telephoned the call centre it would go unanswered and wellbeing calls from control to check that lone workers were safe never occurred. For example, a member of staff had been completing a transfer out of area and had returned 45 minutes after the end of their shift. They contacted the control room to check in but had been unable to speak to anyone, and had not received a welfare call.
- We saw that operational staff could request a call back from control by pushing a button on their electronic tablet. Managers told us they carried out an informal audit into the number of button pushes and had found that control did not always respond promptly, and in some cases not at all. Data for this audit had not been recorded; however, the audit manager told us there were plans to review the lone working policy and the use of this call back button.
- Staff told us they did not always get adequate breaks. Staff reported they often found it hard to get adequate breaks due to demand for the service during a shift. We saw staff meeting minutes, which showed this issue had been discussed in meetings, reminding staff where they should be taking their breaks during their shifts. Staff we spoke with said breaks had improved and they were now able to take these on most shifts. However, staff also told us the breaks were sometimes scheduled about two hours after the crew left the base, which meant the crew would work many hours after the break until the shift ended.

Anticipated resource and capacity risks

- The business continuity plan for the service covered loss of information systems, building security, staff and vehicles. The service had identified the risks in relation to these aspects of the service and set out what the potential impact on the organisation would be and identified what resources would be needed for the recovery of each aspect of the business.
- During our inspection, winter contingency planning had been utilised due to several days of snow and cold weather. This had proved to be challenging to the services affected but the majority of patients were transported to appointments and home again with minimal delays.
- We saw that ambulance crews understood the importance of some patients' treatment. This was reflected in the determination they showed to reach patients to get them to treatments such as dialysis. We saw one crew try multiple routes to reach one patient whose road had become impassable due to snow.

Response to major incidents

- There were arrangements in place to respond to emergencies and major incidents, which were practised and reviewed. 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. The service had last practised a table top exercise to respond to a major incident in July 2017.
- The service had a major incident policy which 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 clinical commissioning groups.
- Ambulance crews understood their role in major incidents but were not involved in planning and rehearsals. Crews knew there was a policy, which involved coordination with other NHS ambulance providers, but told us senior managers would instruct them if they ever needed to use the plan.

Patient transport services (PTS)

Are patient transport services effective?

Evidence-based care and treatment

- Patients had their eligibility for the service assessed by call taking staff, who used standardised questions to continually assess eligibility criteria. The eligibility criteria was not set by the service, but set by the clinical commissioning groups who commissioned the service. There were two different sets of eligibility questions, one for adults 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 based on their mobility and individual needs.
- 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 Department of Health 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. 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 85,344 (38.1%) of journeys between October 2016 and September 2017.
- Policies and procedures had been developed using some best practice guidance, for example, the infection control manual referred to guidance from both the Control of Substances Hazardous to Health Regulations 2002, and the Department of Health. We found minimal reference to best practice guidelines by staff. We did not find evidence of practice guidelines, which would normally be referred to by patient transport services such as the National Institute for Health and Care Excellence (NICE) guidelines, or the National Patient Safety Association. Staff we spoke with were unable to tell us what evidence based guidance they could refer to in their work beyond their local policies and procedures.
- Staff who worked remotely did not have easy access to all relevant guidelines and protocols they needed to do their job. Policies were located in the staff area at bases and were easily accessible and included safeguarding, infection control, DNACPR, incident reporting and lone working. However, staff had no way of remote accessing electronic polices and updates while out on the road.

Assessment and planning of care

- Patient journeys were planned and delivered using a booking system to provide staff with sufficient information to effectively plan for patients' 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.
- Staff reported they were not always given adequate information to allow them to appropriately deliver care. An example given was staff arriving at a hospital site to collect a patient then finding out the patient was bariatric, and they did not have the appropriate equipment. As a result the journey was abandoned and an alternative ambulance was dispatched with appropriate equipment. Managers and control centre staff told us that although the call centre staff asked if patients were bariatric, healthcare staff making the booking sometimes did not know this, so crews were sometimes dispatched with missing or incorrect information.
- Patients, who were identified as having bariatric needs, often had risk assessments completed. 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 (World Health Organisation, 2000). Risk assessments were recorded on paper at the control centre and contained important information about any issues with bariatric patients that may pose a risk to staff or the patient. This assessment was passed on to the manager at the appropriate base and shared with the crew. Risk assessments were also stored on the patients records, but staff we spoke with did not know how to access them on their electronic tablets.
- Pre-booked transport was planned and arranged at least one day in advance. The planning team used an electronic system to plan and allocate the most appropriate resources to each patient based on the 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 it to ensure that journeys planned met expected targets. On our previous inspection, planners had 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. This was still the case, and operational crews told us of an example where two crews had been dispatched to the same road to pick up two different patients for the same time and destination.

- Technology and equipment was used to enhance the delivery of effective care. The service had an on-going project to introduce a text messaging system to alert patients the day before their planned journey and to let patients know when the crew was on their way on the day of their planned journey. This initiative was being implemented as part of a Commissioning for Quality and Innovation initiative (CQUIN). At the time of our inspection, the service had very recently been implemented and its effectiveness was being assessed.
- People's hydration needs were met, and crews carried bottled water on the ambulances. A stock of bottled water was available at each of the bases for crews to stock up between journeys.

Response times and patient outcomes

- Information about the outcomes of patient's care and treatment was routinely collected and monitored on a weekly, monthly and yearly basis. The service compiled monthly reports for each Clinical Commissioning Group based on 10 key performance indicators (KPIs) or standards to achieve.
- The service's performance in achieving their targets continued to be mixed and had led to some anxiety and distress for a number of patients receiving dialysis treatment. The service continued to work with CCGs and other organisations to address this and meet the increase in demand.
- Staff at local hospitals, patients, and local Healthwatch told us delays and long waiting times for patients returning home from clinic journeys remained a recurring theme.
- The most recent South West contract review meeting minutes were from September 2017 and covered the 12 months prior to this date. The minutes showed intended outcomes for patients were not always being achieved, but some improvement had been made since the last inspection. The service had achieved its KPI target for;

-Patients travelling less than 10 miles not spending more than 60 minutes on the vehicle. This had improved since our last inspection and was currently 95.6%.

-Patients travelling more than 10 miles and less than 35 miles and not spending more than 90 minutes on the vehicle. However, this had worsened since our last inspection and was currently 93.6%.

-Patients travelling more than 35 miles and less than 50 miles and not spending more than two hours on the vehicle. This was the same as our last inspection and was currently 96%.

- The service had not met its KPI targets for;

-Patients dropped off between 45 minutes earlier than booked arrival time and 15 minutes later than booked arrival time. This was the same as our last inspection but worse since July 2017 and was currently 84.3%.

-Patients picked up within 1 hour of being 'booked ready' for collection. This was the same as our last inspection but between July 2017 and September 2017, data was showing a downward trend and was currently 74.9%.

-Patients picked up within 4 hours of being 'booked ready' for collection. This had improved since our last inspection and was currently 84.2%.

- The service also had a target for pick-up of patients who were deemed end of life, within two hours of being 'booked ready' for collection. In Arriva's combined report September 2017 for this performance indicator, the service had not achieved the 85% target and was currently 69.2%.

- Information about people's outcomes was used and action was taken as a result to make improvements. On our previous inspection, we had found the service was not achieving KPIs, which had been set by one of the CCGs specifically in relation to dialysis patients.
- The service had six KPIs for dialysis patients. Data covering the 12 months up to September 2017 showed the service was achieving its KPI outcomes for;

-Patients travelling less than 10 miles not spending more than 60 minutes on the vehicle.

-Patients travelling more than 10 miles and less than 35 miles and not spending more than 90 minutes on the vehicle, however data was showing a downward trend for the three months prior to the report.

-Patients travelling more than 35 miles and less than 50 miles and not spending more than two hours on the vehicle.

-Patients picked up within 4 hours of being 'booked ready' for collection.

-Patients picked up within 1 hour of being 'booked ready' for collection.

- The service was not achieving its KPI outcome for;

-Patients dropped off between 45 minutes earlier than booked arrival time and 15 minutes later than booked arrival time.

- Managers told us they understood the need to apply the same KPIs to oncology patients as the frequency and nature of the treatments the patients received were time critical and important. The number of patients served was 18,059 which was significantly lower than the dialysis patient group. Data submitted up to September 2017 showed the service was achieving its KPIs for:

-Patients travelling less than 10 miles not spending more than 60 minutes.

-Patients travelling more than 10 miles and less than 35 miles and not spending more than 90 minutes on the vehicle.

-Patients travelling more than 35 miles and less than 50 miles and not spending more than two hours on the vehicle.

-Patients picked up within 4 hours of being 'booked ready' for collection.

- The service was not achieving its KPI for;

-Patients dropped off between 45 minutes earlier than booked arrival time and 15 minutes later than booked arrival time.

-Patients picked up within 1 hour of being 'booked ready' for collection.

- For on the day outward pick up times, the service demonstrated a varying ability to meet its 85% target of picking up patients within four hours of booking between October 2016 and September 2017. In eight out of 12 months, the service met its target, which was an improvement since our last inspection where it only met the target for three out of 12 months.
- On our previous inspection, we saw that the contract expected that less than 20% of bookings would be made by telephone. The service still consistently took over 50% of patient transport booking over the telephone between October 2016 and September 2017. On our previous inspection, we were told the service was working on a draft proposal requested by a commissioning group that could be used with other stakeholders to reduce telephone bookings. At the time of our inspection, compulsory online booking was being introduced in another area and its success was being monitored by Arriva and a CCG to provide evidence of its effectiveness to the southwest contract commissioners.
- On our previous inspection, locality managers for the service had been working with staff at the local hospitals on a 'train the trainer' scheme to increase the ability of hospital staff to use the online booking system. Staff had reported problems in monitoring access to the system where staff had left or a significant number of agency staff were used.
- Another key performance indicator used by the service was the number of calls answered within 30 seconds. Arriva had a target of answering 85% of all calls within 30 seconds. This was not being met and was inconsistent between October 2016 and July 2017, with percentages of calls answered within 30 seconds varying from 15.2% to 74.3%.The service hit the 85% target in July and August 2017, but had fallen below target again in September 2017. The percentages were displayed on a board in the control room so that staff could see how they were performing.
- Since our last inspection, the service had employed a call centre manager to oversee training to help improve call response times. However, call centre staff could not identify what had been done to help them achieve the KPI in July and August 2017, and the manager had since left the business. Some staff were also unsure what the KPI target was for call answering.
- Demand in excess of contract levels was managed through the use of subcontracted third party transport providers and volunteer car drivers. The company held 11 contracts with taxi companies and a number of contracts with other providers including independent ambulance providers to undertake work when demand outstretched Arriva's own capacity.

Competent staff

- All staff working for Arriva Transport Solutions Limited South West were required to have annual appraisals. At the time of our inspection appraisal rates were as follows: Gloucester operational staff: 47 (94%), Keynsham operational staff: 36 (100%), Lydney

operational staff: 21 (95%), Newport operational staff: 12 (85%), Swindon operational staff: 40 (97%), Salisbury operational staff: 15 (100%), Bristol staff: 15 (51%), HR staff: 5 (100%).

- All staff were required to have an annual personal development review or six-month review where training and development needs were identified. In October 2017, 72% of driving staff in the South region had received a PDR or six-month review within the previous six months.
- Staff were offered the necessary support during induction and training. We spoke with staff about the induction programme and training provided. They told us it had prepared them well for the realities of the job. Managers told us if a member of staff was not ready to undertake full duties by the end of their induction, they extended it and reviewed it on a weekly basis until the staff member was ready. Poor or variable staff performance was identified and managed by line managers through one to one meetings in the first instance.
- We spoke to one member of staff who was mentoring a new employee. Both told us they often came in early for their shift to go through appropriate vehicle checks to ensure they had time to discuss them and share learning.
- The provider carried out driving licence checks on all employees driving their vehicles. This check involved accessing the Driver and Vehicle Licensing Agency database to obtain up to date information on driver records and any endorsements. Licences were also checked manually during the induction process to ensure they were valid.
- Most staff were suitably trained and assessed to carry out driving duties safely. The provider reported in October 2017 81% of staff were up to date with their required annual driver training. In addition, 64% of staff had undergone an observed practice within the previous six months. However, this was still below the 85% company target.
- Staff competence of delivering patient care was assessed by managers or supervisors through observed practice. At the time of our inspection managers showed us detailed competency framework assessment documents, however no data was submitted to show us how many call takers or dispatchers had undergone these assessments in the 12 months leading up to the inspection.

Coordination with other providers

- Routine coordination with other providers of healthcare included attendance at site meetings, and occasional ward visits to discuss and problem solve transport issues. Sometimes meetings were cancelled by the service or by hospitals and clinics for a variety of reasons including staff availability. For example, when concerns were raised about renal KPIs, the provider arranged weekly meetings with the dialysis units to talk through and resolve the issues.
- The service worked with other organisations to coordinate improvements to care. Following the safeguarding investigation around renal KPIs, Arriva appointed a renal coordinator and established a renal working group with one main trust to trial and pilot new ways of working. At the time of our inspection the service had made the following changes :

-Created and distributed a dedicated service survey to renal patients..

-Created and shared a patient information poster with Healthwatch.

-Continued to work closely with ward clerks to provide early resolution to patient delays.

-Regularly reviewed dedicated vehicle routes to ensure best utilisation of resources.

-Reviewed patient mobility changes weekly to ensure correct transport was sent.

-Reminded all crews to contact patients ahead of collection to provide ETA's.

Multidisciplinary working

- The service worked with external organisations and providers to make sure that key information was shared. For example, we saw that when crews collected patients from hospitals, wards or clinics, they liaised with hospital staff to obtain copies of DNACPR information prior to transporting the patient. However, we were not assured the information was consistently provided when requested or made available. We saw one reported incident where a crew had asked the nurse looking after the patient if they had a DNACPR, and the nurse told the crew they did not know.

Access to information

- The information and record systems that supported the delivery of care were not always effective. Each vehicle had an allocated electronic tablet that was carried by the crew during each shift. The tablet enabled crews 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. However, staff did not always have all the information needed to deliver effective care and treatment. Special notes for patient journeys were recorded on booking forms which ambulance crews had access to on their electronic devices on each vehicle. However, we saw incidents and message logs that showed key information such as mobility and home access was often missing or not correct. Managers told us the information gained at the point of booking was often the reason for the missing information, however, no formal assessment of call centre staff had been done and at the time of our inspection, no call takers had undergone any observed practices to ensure all staff were actively asking for the same information when taking bookings.
- The new electronic system used by the service allowed text messages to be sent to and from crews. The system could send alerts to crews 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.
- Staff told us both hospital staff and control room staff made them aware of any special requirements. For example, they were alerted if a patient was living with dementia. We looked at the booking forms and saw information about dementia clearly recorded and flagged on the record.
- Policies were located in the staff area at the base and were easily accessible to staff. Policies included safeguarding, infection control, DNACPR, incident reporting and lone working. However, these polices could not be accessed remotely whilst the crews were on the road. Instead, a check box was kept on each vehicle, which contained up to date policies and information. We looked at six boxes and all polices were in date. Staff and managers told us if they needed guidance, they called the operational manager at the station who would look up the relevant policy or guidance for them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the importance of gaining patient consent. Examples included staff asking patients for their consent to be moved into a wheelchair or a stretcher. Staff also said they knew they could not expect a patient to do anything they did not want to and if patients refused to travel, they would try to understand why and support patients to change their minds if appropriate. Staff told us if renal patients refused transport, this was immediately escalated to the control room and renal unit.
- Staff we spoke with told us they had received training in the Mental Capacity Act 2005, and that the training had been informative. However, staff did not feel confident to make any assessments or judgments on a person's ability to give consent. Staff were unsure in what circumstances they might undertake a mental capacity assessment, and did not know if there was a lead person within Arriva they could contact for advice. However, staff did make visual and verbal assessments of patients on a daily basis and told us they incident reported any concerns.
- Staff told us if they had a patient who they suspected might be experiencing a mental health crisis, they would either call 999 in line with deteriorating patient guidance, or take the patient to a nearby hospital, however staff could not recall any situation where this had happened.

Are patient transport services caring?

Compassionate care

- Staff understood and respected the personal, cultural and social needs of patients and treated them with compassion and kindness. This was confirmed in the most recent Friends and Family test results, which showed that in September 2017, 88% of respondents were either likely or extremely likely to recommend the service. Only 6% said they would not recommend the service and the remaining respondents remaining either neutral or responding they did not know if they recommend the service or not.
- Friends and Family test data showed that in September 2017, of the 17,247 eligible patients who could have

responded to the survey, only 275 (1.59%) did. However, since April 2015, data submitted showed that the overall response rate had shown an upward trend, and the September 2017 response rate was the highest overall.

- Staff took the time to interact with people who used the services in a respectful and considerate way. We saw staff interact with patients and relatives in a positive, respectful and compassionate manner. They introduced themselves to the patients in line with the National Institute for Health and Care Excellence (NICE) QS15 (Statement 1, patient experience in adult NHS services).
- Staff showed sensitive and supportive attitudes towards patients and relatives. We saw staff greet patients in waiting areas and enquire after their health and wellbeing whilst escorting them to vehicles, clinics and patient homes.
- Staff told us they would raise concerns about disrespectful or abusive behaviour or attitudes displayed by other staff, and explained this would not be in line with the Arriva core values or objectives.
- When people needed physical or intimate care or treatment, staff made every effort to make sure people's privacy and dignity needs were understood and respected. Staff sought permission from patients to assist them or deliver intimate care and documented these conversations in the patients' records. For example, one patient vomited during transport, and the crew quickly took the patient to a private area and got them clean clothes and wipes.
- Staff ensured patients' dignity was maintained travelling to and from their vehicle. Crews explained clearly to patients what they were going to do and did not rush patients to get on and off the vehicles. Staff made sure patients were clothed and covered appropriately for their journeys.
- Staff responded in a compassionate way when people experienced physical pain, discomfort or emotional distress. Although staff could not administer any form of medication or pain relief, where patients were in discomfort, staff alerted clinical staff once the patients arrived at their destination.
- Staff told us they were aware that some patients, particularly older people, frail patients and patients with back problems sometimes found the journeys uncomfortable and bumpy. Where a driver knew a road well, we were told they tried to avoid potholes and speed bumps to minimise any discomfort. 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.
- 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.
- Staff showed respect and care towards relatives and carers that were travelling with patients and had provisions for escorts allowed for in the planning of their journeys. We were told that when children were transported to appointments, the service tried to accommodate families if more than one relative wanted to accompany the patient on the journey.

Understanding and involvement of patients and those close to them

- People who used services were involved 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. Staff told us this could sometimes be frustrating, as not all staff who contacted them about non-emergency patient transport understood the eligibility criteria.
- Patient's had their eligibility for the service assessed by call taking staff, the questions asked, helped to determine the most appropriate type of vehicle required for the individual, based on their age, mobility and individual needs.
- Staff were able to access translation services over the telephone for patients whose first language was not English.
- Staff communicated with people so that they understood their care. We spoke to a patient who said she enjoyed the ride because of the chats she would have with other patients and crewmembers. It was also clear that the friendly and fun way the crewmembers spoke to the patients brightened their day.
- Staff recognised when people needed additional support to help them understand and be involved in their care and treatment. We saw multiple examples of safeguarding referrals, which had been raised out of staffs concerns for patent social situations or lack of

understanding about their care or treatment. For example, one concern had been raised about the cleanliness of a patient's home and their apparent confusion about why hospital transport had come to collect them.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition could have on their wellbeing and on those close to them, both emotionally and socially. For example, staff were aware of the important role they played for patients who had to attend regular appointments. Staff we spoke with also told us they understood how this could have an effect on patients work, social life, hobbies and family.
- Patients 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 hospital. 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 they constantly reassured patients during the journey.

Supporting people to manage their own health

- Crews encouraged patients to be as independent as possible and provided support where required. We saw crewmembers 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. On our previous inspection, we had received feedback that patients had thought these organisations were able to book alternative transport. Feedback we received from Healthwatch confirmed this was still an issue and several healthcare professionals and patients had thought Healthwatch was an alternative transport provider or could arrange transport for them.
- Referrals to Healthwatch 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?

Service planning and delivery to meet the needs of local people

- Patient transport services planned to meet the needs of local people. The journey types and categories of patient journeys the service had been contracted to carry out included, outpatient appointments, hospital discharges admissions and transfers, renal, oncology, palliative care, intermediate care, mental health, paediatric, bariatric and transport of high dependency patients who had received minor cardiac treatment.
- Capacity was planned to meet the differing demands of services. For example, information about the needs of the local population was used to inform how renal transport services were planned and delivered. A service wide patient engagement exercise between March 2017 and July 2017 had shown several themes, which was feedback to the CCGs. An action plan was drawn up to address patient concerns, with clear actions and time frames for completion. Areas to addressed included;

-Issues with speed of some vehicles and overall journey experience.

-Recruitment problems and number of vehicles on road.

-Call centre complaints and communication to crews.

-Communication between hospitals and crews.

-Grouping of renal patients.

- At the time of our inspection, progress had been made against these actions and we were told they had all been completed and we saw evidence to support this.
- The services provided reflected the needs of the population but did not always ensure flexibility or continuity of care. 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 91 vehicles based in

the southwest, which were a mix of stretcher, seated and high dependency ambulances. The service also had vehicles and equipment for bariatric patients, however we were told and saw incidents recorded where crews had been dispatched to collect bariatric patients and had not had the appropriate equipment with them. Managers clarified that this was sometimes down to the quality of information they received when the booking was made. Call centre staff routinely asked if patients were bariatric but found the healthcare staff making the transport booking sometimes did not know.

- Where people's needs were not being met, this was identified and used to inform how services were planned and developed. The service had two Commissioning for Quality and Innovation (CQUIN) targets for 2017/18 agreed with the commissioners of the services.
- The aim of the first CQUIN was intended to improve communication between the service and patients. The service introduced a system to send a 'text ahead reminder' to the patient on the day before the appointments, and then a 'text' en-route when the vehicle was on its way. Patients were given information on how to cancel bookings if required. Both text-messaging services had started in December 2017 and its effectiveness was being monitored.
- The aim of the second CQUIN was to improve Arriva's performance against the key performance indicators. This would improve timeliness of service and contribute to a better patient experience. This target had been partially achieved in quarter one 2017 but was in part linked to the first CQUIN.
- Operational crews we spoke to sometimes felt journey time allocations were unrealistic and unachievable. Staff felt that control staff did not always understand the geography of the area they covered and the challenges the crews faced. Crews told us journeys were often based on the time it took to get from postcode to postcode and did not take account of traffic, or rurality of some pickups. To better help staff understand each other roles, the interim head of control was planning to bring each operational station manager into the control room to work shifts in planning and dispatching to help them understand the challenges those teams faced. It was hoped this would also help control staff to understand similar problems and issues for operational staff.
- Crews often felt they did not have enough time when picking up patients, and some of these due to factors were beyond their control. We saw examples where times given to crews to pick a patient or a number of patients up and drop them to their planned destinations were not achievable. Staff felt the times given to complete these journeys often did not take into account the mobility of the patient and the time that was needed for them to board the ambulance. We were told of an example where a patient was due to be picked up from an outpatient department, but when the crew arrived, they found the patient required a wheelchair and had to locate one from within the hospital which took additional time. We also saw a scheduled pick up where the patient had left the department from where the crew were assigned to pick them up. Instead the crew had to go looking for the patient. According to staff, it was common for crews to have to abort journeys if they could not find patients as they could not spare time looking for patients. Managers informed us that they documented and reported aborted journeys to the CCG on a monthly basis, and recorded reasons for aborting the journeys as they were often outside of Arriva's control.
- When there was not enough capacity within the service, the planners used volunteer drivers and local taxi companies in line with the commissioning contract. On our last inspection, the service was trying to reduce the use of taxis. However, in the 12 months to September 2017, taxi companies and other patient transport service providers carried out 35% of all Arriva work between October 2016 and September 2017, which is similar to what we found on the last inspection. One patient expressed concerns about the suitability of taxis for their transport and told us they did not feel safe as they had diabetes and had become unwell on one journey, and the taxi driver had not known what to do.

Meeting people's individual needs

- Services were planned delivered in a way that took account of the needs of different people. In Gloucester and Keynsham stations, staff showed us patient journeys were accompanied by booking details that highlighted any specific conditions such as dementia, learning disability, physical disability or whether a

patient had a resuscitation decision. Staff used this information to ensure the comfort of such patients. Mobility equipment was available for patients who had physical injuries and disabilities.

- Reasonable adjustments were made so that disabled people could access and use services on an equal basis to others. Call takers gained as much information as possible at the point of booking to ensure planners and dispatchers sent an appropriate vehicle and equipment to meet the patient's needs. Mobility codes were displayed on posters in the control room to ensure the correct mobility was captured at the point of booking. Although crews reported this sometimes changed when they actually went to collect the patient.
- The needs of some groups of patients were not always understood and we did not see any adaptions for patients who were blind or hard of hearing. On our previous inspection we found the needs of patients living with a learning disability, mental health illness, dementia or who were classed with bariatric needs were identified and supported by the equality and diversity policy and specialist equipment. We did not see any adaptations for visually impaired people and the service did not have any information in Braille. We also did not see any enhanced communication aids or 'easy read' guides. This was the same as on our last inspection. However, staff told us their training had covered learning disabilities and dementia and they felt confident transporting these patients.
- Provision was made for patients who did not speak English. Vehicles carried a sheet with common phrases in over twelve languages. A telephone translation service was also available for more complex translational needs.
- The control room attempted to plan journeys to take account of patients' hydration and toileting needs. Control staff tried to ensure that journeys were planned to account for comfort breaks and hydration if journeys were long. On our previous inspection, we saw evidence of complaints regarding journeys being too long and people missing meals. We found this also to be the case on this inspection and saw in a report from one of the CCGs, details of a diabetic patient who was taken to hospital. Concerns were raised by the patient's carer about not having any lunch for the patient (who was on a special diet). Crews reported that as they would be taking the patient to a hospital, any specialist treatment or food the patient might need whilst waiting for transport would be dealt with by the hospital. However, Arriva Transport Solutions Southwest pointed out that the hospital would not have access to that patient's medical record if they became unwell.

Access and flow

- People had timely access to transport services. The service could be accessed 24 hours a day seven days a week on the telephone as the control room was always staffed. Patients we spoke to told us the bookings line was easy to use and liked speaking to a person on the other end of the phone.
- Care and treatment was only cancelled or delayed when necessary, however, cancellations were not always explained to people, and people were not always supported to access alternative transport as soon as possible. We saw multiple complaints made to various Healthwatch organisations alleging that planned transport did not show up and patients were not informed why. In three complaints, patients had to use alternative methods of transport to get to appointments, which they had to fund themselves. In one case an operations manager had promised to get a taxi fare reimbursed, but had not done so promptly, causing the patient to complain again.
- Data submitted showed that between October 2016 and September 2017 August 2017 across all CCG contracts, Arriva aborted 14,183 (6.7%) journeys out of 209,758. Detailed monthly reports were produced documenting every reason for aborted and cancelled journeys and categorised them by hospital location, clinical commissioning area and type of patient.
- Between October 2016 and September 2017, Arriva reported 52,850 cancelled journeys out of which Arriva had cancelled 420 (>0.1%). The remaining journeys were cancelled by patients and healthcare providers. Cancelled journeys were monitored on a monthly basis and reported to the CCGs as part of the key performance indicators. We looked at the detailed data supplied for August 2017, and found 49 on the day cancellations classified as cancelled by control; however, the figure reported in the combined report to the CCGs was 34.
- We looked at the on the day cancellations for one CCG contract in August 2017. We saw cancellations were further divided into categories and found that there were 47 on the day cancellations that could be attributed to Arriva. Additional categories included; cancelled by control, appointment missed by Arriva,

picked up too late to travel, wrong day or time, Arriva arrived too late, patient ready too late to convey or incorrect booking. We asked the service to explain how they monitored and reported cancellations, and they acknowledged the large number of recordable reasons was confusing, and were planning to review them.

- Services did not always run on time, and people were not always kept informed about any disruptions. If crews were running late. they contacted either control or the clinic directly to inform them of the delay. We saw the dispatch team managing one of these calls by contacting the clinic to ensure they were aware of the delay so the clinic could alter the appointment time of the patient so that they did not miss it. On our previous inspection, crews stated that getting through to speak to staff at control or getting a response from a text message was challenging. The new en-route text message service was designed to keep patients informed of delays to their transport and also to let them know when to expect them. This system had just started at the time of our inspection.
- The service took action to ensure resources were where they needed to be at the time required. Vehicles were allocated by the service depending on which crews were free or were completing journeys close to the area where the service was required.

Learning from complaints and concerns

- People who used the service knew how to make a complaint or raise concerns, and they were encouraged to do so. For example, there were posters at the back of all vehicles with information on how to make a complaint. We spoke to two patients who had raised complaints in the past, and both said the system was easy to use. Complaints could be submitted in writing, email or over the phone.
- Complaints were handled effectively and complainants were updated of progress. We reviewed 10 complaints records and found there was evidence of monitoring of complaints. The service had a complaints policy that stated all complaints were recorded in a complaints log, which we saw. We could see in all 10 complaints we reviewed, all stages of the complaint process was recorded. In all but one of the 10 complaints, the service was timely in its response. The service had set a 25-day period to resolve all complaints. Where a complaint was complex a holding letter was sent out to inform the complainant of reasons for delays in resolving their complaint. Where fault lay with the service and a complaint upheld, we found the responses to be open and honest.
- Between September 2016 and August 2017, the service received 731 complaints. The most frequently complained about categories were missed inbound journeys (280 complaints, 38.3%), outbound journey (187 complaints, 25.5%) and late inbound journey (127 complaints, 17.3%).
- The next most frequently complained about category, was call answering and booking (29 complaints, 3.9%); however, staff showed us a call centre improvement plan which had improved the overall performance for call answering within 30 seconds. A call centre manager had been employed who had implemented a series of changes to help the call centre meet its quality standard in July and August 2017.
- Data submitted showed the service had consistency met its 95% target for all complaints to be acknowledged within three days of receipt for the 12 months to September 2017. However, in the same time period the service had only met its 95% target for a full response to be made within 25 days on four occasions for all four Clinical Commissioning Group contracts. The service was also not meeting its target for 100% of complaints to have had a full response within 40 days.
- Between September 2016 and August 2017, the service upheld 294 complaints, partially upheld 58 and did not uphold 33. As of the 10 October 2017, the service reported 53 open complaints with eight open past 25 days.
- Where learning from complaints was evident, we could see this recoded in the file on the complaint and were told this was shared through newsletters or bulletins which was confirmed by staff we spoke with.

Are patient transport services well-led?

Leadership of service

- Operational management for Arriva Transport Solutions Limited had been reviewed and restructured in June 2017. The restructure had been done to bring consistency to working practices across all the patient transport contracts. Further restructure in the planning, dispatch and control room management had also occurred in the week before the inspection. This was

because governance issues had been identified relating to management, appraisal and training of personnel and assurances of third party provider details such as Disclosure and Barring Service checks.

- The managing director had overall responsibility for the quality, safety and sustainability of the patient transport service. An operations director who maintained oversight of operations, and a finance and compliance director supported the managing director. The operations director had also applied to become the registered manager, as the current registered manager was on long-term sickness leave.
- Leaders and managers had the capacity, capability, and experience to lead services effectively. The head of quality and standards had been in post since 2014. Other senior managers had what they described as mainly 'fleet and logistics' experience. The managing director had been the registered manager from 17 October 2013 until this was transferred to a head of operations in 2016. The current registered manager was absent and the provider had notified CQC of this. The operations director had acknowledged the need to be more aware of the requirements of the registered manager post they had recently applied for during the inspection. However, they knew where they could access the knowledge required to carry out the role and were supported by other senior managers with health and social care experience within the service.
- The head of quality and standards was involved in board meetings and decision-making. They were considered by directors as an essential non-executive part of the board having oversight of incidents, complaints, safeguarding, risk management and acting as the main contact for CQC. A quality improvement and audit manager, and a quality, health, safety and environmental manager had recently come into post to support the development of quality and standards. The new staff acknowledged they were relying on the head of quality and standards at this early stage in their appointments. We did not see plans to review the head of quality and standards workload to ensure arrangements were sustainable.
- There was a national head of service development with several years' experience in patient transport who focussed on developing new ways to respond to challenges of non-emergency patient transport. They had been involved in developing the new renal dialysis transport following an investigation in to delays by local authorities, Clinical Commissioning Groups, renal dialysis units and Arriva.
- Management of organisational change was decisive. Recently following a review of the governance in the planning, control and dispatch team, senior managers had been redeployed to support staff. In April 2017, following a multi-agency investigation more vehicles and staff had been allocated to renal dialysis service, which had improved patients' overall experience. Also following an inspection in another part of the patient transport business, new training had been implemented as the training was identified by CQC as being below the requirement of national guidelines.
- Leaders understood the challenges to good quality care. Issues included, the restructure of the control room, recruitment challenges, developing and sustaining commissioning relationships and accurate outcome measurement. The managing director described these issues in a presentation during the inspection and we heard these spoken about across the organisation.
- Staff spoke highly of the base operations managers and supervisors. They used words such as ''very fair", "fantastic", and "very approachable". Not all operational road staff felt they saw their manager enough but there was a process in place to ensure they were able to see their manager once a day but this was a basic 'check in'. Some staff we spoke with told us they saw senior staff on occasion in the bases but were not very approachable. Some staff did not know who the senior managers were when they saw them.
- Operations managers were accessible and approachable by all crews at bases and contactable any time by telephone. Not all staff we spoke with could identify the different leads and managers and their roles and their responsibilities within the business. Some of this was due to a recent reorganisation as well as the area some managers had to cover within a national operation.
- Leaders we spoke with said they encouraged appreciative, supportive relationships among staff and most staff we spoke with supported this. Senior managers had carried out 'tours' of stations to discuss issues face to face.

Vision and strategy for this this core service

- Arriva Transport Solutions South West had a vision, strategy, and set of values which supported the overall company view. The vision was to be the mobility partner of choice. Their strategy was to 'delight customers', to 'cut waste and transform the efficiency of the operation', to 'be an amazing place to work' and 'to achieve a successful, sustainable business'.
- The provider's vision, values and strategy had been developed by the managing director and the senior leadership team. Senior managers told us staff had wanted the phrase 'to be an amazing place to work' as part of the vision. However, staff we spoke with could not recall how they had been involved in the development of the vision. one member of staff was able to show us a booklet issued to them, which clearly explained the objectives for 2017 and how all staff were expected to contribute to deliver the vision and strategy but it was not clear how this had been done.
- Senior managers had a realistic strategy for achieving their vision and priorities in order to deliver good quality care. Progress against delivering the vision and strategy was monitored and reviewed at several meetings including the monthly 'trading review' as well as station team meetings run by operational managers.
- Staff at all levels understood what the pressures, risks, key drivers and action plans were for providing safe patient transport services. For example they knew that accurate data reporting to clinical commissioning groups, visible leaders, a safe fleet of vehicles and trained staff were central to providing safe and quality outcomes for patients. Some recently redeployed managers were not personally aware of all the key performance indicators or important operational knowledge. However, we saw they had other experienced staff allocated to support them and the changes needed.

Governance, risk management and quality measurement

- There were arrangements for identifying, recording and managing risks, which included governance meetings and risk registers. The service had a corporate risk register and we saw how risks were identified and how control measures were put in place to mitigate them. We saw risks were regularly reviewed by the senior leadership team and managers told us their 'worry lists' were reflected on the register.
- The governance framework and management systems had recently been reviewed and improved however, we saw that not all of it was working effectively. There was poor management of third party providers, which included taxi drivers. We were told a lapse in governance had led to not all third party providers providing evidence for Disclosure and Barring Service (DBS) checks, vehicle MOT testing, motor insurance or driving licences. However, for other third party providers such as volunteer car drivers these documents were in up to date. The manager we spoke with planned to utilise the framework used to check the volunteer car drivers for all third party providers. We saw one incident where a subcontracted taxi company had further subcontracted work out to a company without Arriva's knowledge. This had been investigated but the report was incomplete for all actions needed to ensure adequate governance. When we pointed this out to the quality and safety lead they responded to ensure governance was adequate for the drivers they used.
- As part of the HSCA 2008 (regulated activities) Regulations 2014, providers are required to demonstrate how individuals who hold eligible roles are of good character to hold that role. We saw DBS checks for all director level roles, except the financial director and some control room staff who were no longer checked from January 2017. Senior managers told us they had used the NHS employer's handbook to assess the roles. They decided that as the roles did not involve direct physical contact with patients, the post holder was not eligible for a DBS check. We asked to see the written assessment for the roles, which was not supplied, so we were not assured the service had taken all reasonable steps to gain all available assurances.
- All Arriva operational staff were subject to a Disclosure and Barring Service (DBS) checks as part of the service's recruitment process. We found that DBS checks were in place or had been applied for in relation to all operational staff. New staff that were waiting for DBS checks for eligible roles to come through continued with induction but had no physical patient contact.
- Prior to 2017, all control room staff were subject to a DBS check, however in January 2017; this had stopped for new starters as the third party company who processed DBS applications for Arriva had said the DBS service had rejected the applications because the roles were not patient facing. The service used the NHS

Employers handbook to assess whether each role was eligible for a DBS check, however we did not see individual assessments for these roles supporting this decision.

- There was a programme of clinical and internal audit being carried out. We were shown an 'audit overview' from the quality and standards team which showed regular audits were undertaken at the bases we inspected including infection prevention control and vehicle safety. Information from the audits completed was monitored by middle and senior management and used to improve performance. We saw plans to expand on the audit programme based on the overview that was to be used to effectively monitor quality and systems and to identify where action should be taken.
- Nearly all senior managers we spoke with were clear about their roles and understood what they were accountable for. We saw that some managers and staff had been recently re-deployed to oversee one area of the business. It had been identified that the senior manager did not have all the necessary skills and experience for the role, so other staff had been brought in to support them and fill in any gaps in operational knowledge.
- There were comprehensive assurance and service performance measures, which were monitored and reported on. Action was taken to improve performance where resources allowed. For example the provision of dedicated vehicles for dialysis transport in April 2017. We saw where data about movement of crews had been tested when identified as inaccurate and actions taken to ensure accuracy. However, we noticed that some data related to cancelled journeys was not accurate and so were not assured that all information used to monitor and manage quality and performance was being used and reported. The quality and safety lead checked the data we queried and acknowledged that the multiple reasons available for staff to choose when recording a cancelled journey was confusing and was under review.

Culture within the service

- Most staff we spoke with felt respected and valued and felt that managers demonstrated openness and honesty. Organisational change was handled openly, for example the need for recent management changes had been discussed in online groups. Operational staff we spoke with described the service as a friendly and open environment with some staff describing it as "a big family".
- Some staff did not feel all managers and teams had worked collaboratively to resolve conflict quickly and constructively. Crews spoke of the inability to get breaks and some felt resources were not always allocated effectively. Some crews expressed frustrations that the information given to patients about the reasons for delays in their transport was inaccurate. Following the recent reorganisation in the business there were plans for operational managers and supervisors to spend time in other areas of the business to better help them understand day to day challenges and resolve issues in the future.
- We saw that the leadership culture encouraged candour, openness and honesty. This was also seen in other aspects of the business from operational road staff to control, planning and dispatch. We saw that action was taken to address behaviour and performance that was inconsistent with the vision and values of the organisation, regardless of seniority. Staff and teams had not always worked collaboratively but we saw examples of conflict being resolved quickly and constructively in control and planning with a shared responsibility to deliver good quality care.
- The language of the vision, strategy and values was clear. We spoke with and observed staff and reviewed the staff handbook and saw that the business culture centred on the direct needs and experiences of people who used the services. This culture was particularly noticeable in projects such as the reconfigured 'dialysis transport' service as well as some day-to-day operations. Staff actions were clearly focussed on patient care. To embed the values operation managers in both Gloucester and Keynsham had employee of the month awards. Staff nominated co-workers for standards of work that reflected the services vision and values.
- There was a clear drive to improve patient transport services overall. Senior managers had visited patients where distress and anxiety had been caused for patients and those close to them. They had offered apologies and taken action to improve the service. Operational staff sometimes were able to 'go the extra mile' to

ensure that patients were not just transported but had an opportunity to see places that were important to them. Staff remained conscious of the impact this had on other patient's journey times.

Public and staff engagement

- Leaders tried to ensure that people who used services, those close to them and their representatives were actively engaged and involved in decision-making and improving the quality of services. This included a patient survey, although the response rates were low. When issues had been raised for timings of transport for dialysis patients had been spoken with to ensure where possible that they had convenient transport times and treatment times.
- The service had clear eligibility criteria about who could and could not use services and explained them to members of the public who contacted them. This criteria had been set by the clinical commissioning groups as part of the commissioning contact. Staff were also clear in referring patients elsewhere if the transport service was not appropriate for their needs or why they were not eligible.
- Most staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. The service engaged with staff and volunteers, including those working from remote locations by ensuring that email notices were shared. The service had recently re-launched its social media group for all Arriva employees. The group set out strict expectations of the members, and if these were broken, members were asked to leave. We saw examples of where staff had raised concerns and had responses from senior managers. Staff raised concerns about the upcoming adverse weather, and senior managers had responded to clarify the policy about reporting to work. Staff told us they liked the group, as they knew the senior management team read posts and responded, so they felt they were being heard. It was clear that both leaders and staff understood the value of raising concerns to improve patient care. We saw that appropriate action was taken as a result of the concerns raised.

Innovation, improvement and sustainability

- The managing director had presented at a national conference by the Community Transport Association (CTA) for patient transport services in November 2017. The CTA provides leadership by promoting community transport and influencing the development of better strategy, policy, regulations and investment at all levels of government. The report looked at the provision of non-emergency patient transport and considered how innovations could improve the quality and reliability of services.
- The service engaged with four different clinical commissioning group (CCG) leads in the southwest and managers had suggested a trial of the model of engagement used by them elsewhere. The service felt that it improved communication and efficiency when one clinical commissioning group or CCG lead was able to speak on behalf of other CCGs for the patient transport service contracts, although this was not being considered by the CCGs at the time of our inspection. The service regularly provided the CCG with monthly performance reports and dashboards and quarterly quality and CQUIN reports so that CCGs could assess the timeliness and quality of the service.
- All staff we spoke with were focused on continually improving the quality of care. When leaders considered developments to services or efficiency changes they used both quantitative data and patient experience to inform the change. They shared data every three months or as and when required in special cases with CCGs. They met with CCG representatives and listened to patient experience to assess and monitor the impact on quality and sustainability in order to improve.
- Leaders told us there were examples, especially in renal dialysis, where the pressure of demand on resource had compromised care. They felt that some delays were due to internal issues. However, managers also identified the structure of the contract (now five years old) and the financing of that contract had not kept pace with the increase in demand for patient transport. The increasing geographic spread of patients was also a factor.
- A renal dialysis co-ordinator had provided dedicated support to a dialysis unit when significant problems with delay had been experienced by patients. There were plans to expand their responsibilities to support renal dialysis patients and units across the region following improvements in patient experience.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the hospital MUST take to improve

- Take action to ensure the systems in place to protect children and vulnerable adults from avoidable harm are robust and effective.
- Take action to ensure all staff are up to date with their mandatory training which is of good quality and relevant to their roles.
- Take action to ensure staff have access to information and equipment for the safe transportation of all patients.
- Take action to ensure patients' DNACPR decisions are consistently recorded.
- Take action to ensure all call centre staff have undergone observed practices.
- Take action to ensure all staff have had an appraisal or professional development review.
- Take action to ensure staff working remotely or in isolation have appropriate welfare and safety checks.
- Take action to ensure all staff have had the appropriate disclosure and barring checks for all eligible roles.
- Take action to ensure contracts with third party patient transport providers are up to date and contain all necessary assurances of safety.
- Take action to ensure all incidents are captured and acted upon, and all staff are aware of associated processes.

Action the hospital SHOULD take to improve

- Ensure all relevant staff have undergone an appropriate driving assessment and observed practice.
- Ensure action continues to improve overall KPI performance for all patient groups.
- Ensure action is taken to address ongoing vacancy and turnover rates for operational staff.
- Ensure staff and patients are involved in the development and delivery of the service's vison and values.
- Ensure communication is effective between managers and staff in regard of organisational changes.
- Ensure staff who work remotely have access to all information and equipment they need to do their jobs.
- Ensure there is oversight of incidents reported to third party providers who carry out work for or on behalf of Arriva Transport Solutions South West.
- Ensure staff who transport patients with mental health needs or who are detained voluntarily, have access to policies and guidance relevant to their role.
- Ensure risk assessments are carried out when planning the mixed journeys of children and adults.
- Use best practice guidance to write and review policies and procedures.
- Ensure all managers are aware of all the key performance indicators or relevant operational knowledge for their roles..
- Ensure that all data provided about the quality, safety and timeliness of the service is accurate.
- Ensure that the person who is registered manager has an understanding and recall of relevant aspects of the guidance/knowledge for the role.
- Ensure infection risks to staff and patients are escalated an acted upon.
- Ensure electronic tablets for remote use have adequate battery life and make sure charging devices are readily available.
- Ensure patients who are detained voluntarily under the Mental Health Act have undergone a risk assessment prior to transportation.
- Ensure staff have had sufficient training to complete Mental Capacity Assessments.

Outstanding practice and areas for improvement

- **Ensure information is available in formats which allow patients with disabilities to access services on an equal basis to others.**
- **Ensure patients are kept updated of delays and cancellations to services.**

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (a)** assessing the risk to the health and safety of service users of receiving care and treatment; The processes and systems in place were not sufficient to monitor the use of wheelchair seatbelts. Staff were unsure of company policy and did not have access to all necessary safety equipment. The processes and systems in place were not sufficient to consistently obtain DNACPR for every patient, as this was not a mandatory field on the booking computer system.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (2)** Systems and processes must be established and operated effectively to prevent abuse of service users. The processes and systems in place to report safeguarding concerns did not always correctly categorise concerns. We saw multiple potential safeguarding concerns incorrectly categorised as part of the overall incident log and not all had subsequently been identified.

This section is primarily information for the provider

Requirement notices

The systems and processes in place to give staff the knowledge and skills to deal with safeguarding concerns were not sufficient. Only 23% of staff had received updated level two safeguarding training.

Regulation 13 (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

The processes and systems in place to monitor incidents and possible safeguarding concerns were not robust and we saw multiple incidents where safeguarding concerns had not been raised or followed up.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a)** assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The systems and processes in place were not sufficient to gain assurances that third party subcontracted patient transport providers were providing safe services. The service did not hold up to date records on key information such as insurance certificates and driving licences. **Regulation 17(2)(b**) assess, monitor and mitigate the risks to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

The systems and processes in place to give assurances that third party subcontracted provider were providing safe services, had not been reviewed or updated for several years.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2)(a)** persons employed by the service provider in the provision of regulated activity must receive appropriate support, training, professional development, supervision and appraisal as is necessary to carry out the duties they are employed to perform. Training compliance for mandatory training for control room and call taking staff was significantly below company targets. This posed a risk as staff did not have up to date training necessary to carry out their role The processes and systems in place were not sufficient to monitor the quality of calls handled by the control centre. There was no structured approach to regularly monitor the call takers competence with call handling and patient assessments. The processes and systems in place to ensure all staff had access to an annual appraisal were not sufficient, and we saw a significant number of staff in the control room had not had appraisals.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

Regulation 19 (1) (a) Persons employed for the purposes of carrying on a regulated activity must be of good character.

The systems and processes in place were not sufficient or robust and did not make use of all available information to give assurances that persons employed who had verbal contact with patients and had access to patient information, were of good character, and non-eligibility for the roles had not been formally assessed.