NHS
Bath and North East Somerset
Clinical Commissioning Group

Report on Arriva Transport Solutions Ltd Non-Emergency Patient Services for The Wellbeing Policy Development & Scrutiny Panel

Friday 21st March 2014

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Executive Summary
In February 2012 the former Primary Care Trusts (PCTs) for BaNES and Wiltshire approved a review of existing non-emergency patient transport services (NEPTS). This was on the basis the provision across the two areas was split over at least 20 different providers with very limited contractual coverage and financial or clinical governance processes in place.

While some acute providers operated a central transport booking facility within their own Trust, there was no central booking facility at a PCT level, nor was there any mechanism for capturing and recording all patient journey activity. This made it extremely difficult, almost impossible, to measure NEPTS service performance, understand the volume of patient journeys, monitor standards, patient quality, safety and experience and understand costs of the service.

Subsequently Swindon and Gloucestershire PCTs engaged with the review on the basis of the same issues and concerns. In 2011/12 over £8.2 million was spent on NEPTS across BaNES, Gloucestershire, Swindon and Wiltshire (BGSW). This was split over at least 30 different providers. The four PCTs also faced increasing charges from the NEPTS providers and were incurring significant expenditure outside the scope of the contracts.

Following the review, the four PCT's approved a single joint procurement process in May 2012. This included a competitive dialogue process to provide the PCTs with the opportunity to openly develop a service specification, discuss service issues and experiences in detail with providers. It was also agreed four contracts would be awarded to a single accountable provider to manage the service more effectively, capturing journey information in a single database providing service intelligence that the PCTs had never had.

The procurement process commenced on 17th July 2012, and was concluded with contract award in June 2013 and contract signature in August 2013. Overlaying this was 18 months of stakeholder engagement and consultation. All stages were assessed by a panel of representatives from acute providers, commissioners and patient representatives.

Service Launch
The new NEPTS contract with Arriva went live on 1st December 2013, replacing a multitude of contract and ad-hoc arrangements. Initial weeks were characterised by:

- an extremely high volume of calls
- problems arising from the incomplete or inaccurate nature of bookings information inherited from the previous providers
- a journey volume that exceeded the expected level
- a significant variation to the expected journey mix (different patient mobility and vehicle types required)
- early winter pressures being experienced within the acute trusts
- some significant issues regarding arrangements for the movement of out-of-area patients to/from acute trusts within the contract area
- the need for acute trusts to revise their internal processes in a much more significant way than had been appreciated

Despite a comprehensive mobilisation process, the combination of these issues meant that there was considerable concern at the outset of the contract. Much of this was based on

information, which though in part unsubstantiated, has been challenging to refute, given that at the same time, there have also been some examples of poor performance as a result of the impact of the factors described (typically excessively long waits, sometimes resulting in overnight re-admissions or potentially detrimental impact on patients). Within this context, the following summarises some of the improvements that have taken place during the first three months of the contract.

Booking Centre – Call Taking

- Initial call-taking capacity was increased by 60%, including experienced Arriva staff from other NEPTS call centres, to cope with the anticipated volume of calls, and to reduce call wait times.
- Call volume has reduced from 5,500 per week to 3,500 per week (1st Dec to 14th Feb).
- Call abandonment rate has reduced from >30% to <10% (1st Dec to 14th Feb).
- Average call wait time has reduced from >3 minutes to <2 minutes (1st Dec to 14th Feb).
- Maximum call wait time has reduced from >25 minutes to <5 minutes (1st Dec to 14th Feb).
- Improved internal call handler training and individual performance management now taking place.

Online Booking

- Arriva trainers have attended acute trust sites to train up hospital staff and to train internal trainers on using the on-line booking system, Cleric.
- Ad-hoc issues with using online booking have been addressed and resolved.
- The proportion of bookings, amendments, cancellations and "make ready" actions made online has increased steadily and is now >30% (14th Feb 2014). This reduces the burden on the call centre, meaning faster call answering; and also provides real-time visibility of bookings, for hospital staff.
- The benefits of the online system are becoming progressively clearer for hospital staff, including the ability to review lists of booked journeys, and to take ad-hoc snapshots of outstanding patient journeys including those not booked ready.

Journey Timings

- Journey time and patient drop-off/collection performance has improved. Across the four CCGs, time on vehicle performance exceeds KPI level for all journeys over 10 miles, and is 1% below target for journeys under 10 miles (BaNES specific values are shown in appendix 2).
- On-time drop-off (in-bound) has consistently improved but is still below KPI target.
- On-day collection (within four hours) out-bound exceeds KPI target.
- Planned out-bound collection (within 60 minutes) has improved but is still below KPI target.

Capacity & Resources

- Total patient carrying capacity has been increased by 15% since day one.
- Front-line staffing is planned to increase by 15% with five new staff already in post.
- Accredited sub-contractors are now receiving their work through an innovative online tool.
- Significant re-profiling of Arriva vehicle shift patterns is resulting in increased capacity at critical times of the day, mainly weekday afternoons.

Dialysis

- A renal hotline has been implemented to provide direct renal-dedicated assistance.
- Two planners have been assigned on a dedicated basis.
- Progress has been made to move to dedicated drivers for renal dialysis patients.
- Ambulances fulfilling dialysis journeys now have in-built buffer (catch-up) time in their schedules to increase reliability and on-time performance.
- A “renal champion” operational support manager has been appointed and is now in post to address the various issues impacting renal dialysis patients, and to manage the implementation of Arriva service for Wiltshire patients attending SFT for dialysis; and to manage the relocation of the dialysis unit within Southmead for GBSW patients.

Acute Trust Action Plans

- Diagnostic visits conducted by Arriva and joint action plans produced by Arriva, in conjunction with the acute Trusts. These identify the main issues and concerns experienced within each Trust, and a series of actions that will resolve those issues. These plans are reviewed and updated weekly.
- Joint performance information is now provided weekly to acute Trusts, to further assist in embedding new processes and help build confidence in the new service.
- Where fixed time slots are required eg for home visits, or regular reliable clinic timings, these are now booked on a throughput time, to reduce delays.
- Arriva checks all open bookings daily with the acute trusts, between 3-4pm, to confirm if the journeys are still required / ready to proceed / are to be cancelled, to reduce late afternoon/early evening delays.
- Where phone numbers are provided, patients are being called in advance to ensure they are more likely to be ready when their transport arrives.

Communications & Engagement

- A communications pack including points of contact, FAQs, escalation arrangements, guidance on booking requirements, etc. has been distributed widely to healthcare professionals, including acute trusts, community providers, and GP practices.
- A monthly bulletin has begun to be distributed.

Complaints

- A full-time patient experience manager joined Arriva on 3rd March 2014 and has a clear mandate to review and refine the complaints handling process across the entire organisation.
- Arriva is also appointing a local complaints administrator by the end of March 2014.

1. Context & Background

1.1 In February 2012 the former Primary Care Trusts for BaNES and Wiltshire approved a review of existing non-emergency patient transport services (NEPTS). This was on the basis the provision across BaNES and Wiltshire was split over at least 20 different providers with very limited contractual coverage and financial or clinical governance processes in place.

1.2 While some acute providers operated a central transport booking facility within their own Trust, there was no central booking facility at a PCT level, nor was there any mechanism for capturing and recording all patient journey activity. This made it extremely difficult, almost impossible, to measure NEPTS service performance, understand the volume of patient journeys, monitor standards, patient quality, safety and experience and understand costs of the service.

1.3 In BaNES at the time patients were receiving transport from various providers. The RUH held a direct contract with a non-NHS provider (E-zec) for RUH related journeys only (new & follow up out-patients, discharges and transfers from the RUH). They also used other non-NHS providers for ad-hoc transport requirements. The PCT held a contract with Bristol Ambulance Emergency Medical Service (Bristol Ambulance EMS) for the provision of Sirona's PTS activity as well as out of area activity, ie patient choice or transport to specialist units. The booking function for this activity was provided by the RUH transport booking office.

1.4 Transport to and from renal dialysis units and renal outpatient clinics was also provided by Bristol Ambulance EMS and CTS taxis provided the transport for the non-complex renal patients. Great Western Ambulance Service (now South West Ambulance NHS Foundation Trust) provided the transport for the patients discharged and transferred from the Bristol Acute Trusts as well as follow up out-patient activity.

1.5 Subsequently, Swindon and Gloucestershire PCTs engaged with the review on the basis of the same issues and concerns. In 2011/12 over £8.2 million was spent on NEPTS across BaNES, Gloucestershire, Swindon and Wiltshire (BGSW). This was split over at least 30 different providers. Each of the acute hospitals across BGSW had booking facilities that linked in with their current NEPTS Providers; these may have made a positive impact at a local level but all had different manual processes and systems that required significant investment and integration with provider solutions, if they were to offer a central booking solution for the region. The four PCTs also faced increasing charges from the NEPTS providers and were incurring significant expenditure outside the scope of the contracts.

2. Non-Emergency Patient Transport Definition

2.1 Non-emergency patient transport services are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from premises providing NHS health care and between NHS health care providers. It encompasses a wide range of vehicle types and levels of care consistent with the patients' medical needs.

2.2 In 2007, the Department of Health published revised national eligibility criteria (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373

) to ensure that NEPTS is available to those who have a genuine need for transport and whose medical condition prevents them from travelling to or from their appointment/s by any other means. Patients are eligible for transport when:

- The medical condition of the patient is such that they require the skills or support of NEPTS staff during the journey and where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
- The patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare or it would be detrimental to the patient's condition or recovery to travel by other means.

2.3 NEPTS can also be provided to a patient's escort or carer where their particular skills or support is needed during the journey. For example, this might be appropriate for those accompanying a person with physical or mental incapacity, vulnerable adults or to act as a translator during the journey. Only one escort should travel with a patient under such circumstances. Such discretionary provision would need to be agreed in advance, when transport is booked. The eligibility criteria for PTS have not been extended to include visitors. All children under the age of 18 are required to have an escort for their journey.

2.4 The distance to be travelled and frequency of travel should also be taken into account, as the medical need for NEPTS may be affected by these factors.

2.5 Financial or social grounds are not reasons for granting NEPTS. When assessing patients for NEPTS they should be routinely asked about their normal means of travel. If a patient can normally get around without support and assistance they should not be offered transport.

2.6 A patient's eligibility for NEPTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:

- Clinically supervised and/or working within locally agreed protocols or guidelines, and
- Employed by the NHS or working under contract for the NHS.

2.1 Other Health Related Transport that is not NEPTS

2.1.1 There are a number of other health related transport arrangements that are often confused with NEPTS they are:

- The Healthcare Travel Costs Scheme is for individuals who are on a low income and have made an additional journey to receive NHS care following a referral.
- Emergency and urgent ambulance services.
- Various types of community transport such as:
    - Dial-a-ride
    - Mini bus schemes
    - Voluntary care schemes

3. BGSW Non-Emergency Patient Transport Service Review

3.1 The review identified several cross-cutting issues and concerns as follows:

- Inconsistent provision of NEPTS across the BGSW area.
- Concerns around the clinical governance of the current arrangements.
- Relatively high levels of enquiries to patient advice & liaison services regarding NEPTS services.
- The application of the Department of Health eligibility criteria was not consistently adhered to by requesting staff and providers were not required to assess patient eligibility, consequently some patients received NEPTS when they should have found another mode of transport, for example private or community transport.
- A number of NEPTS providers were not performance managed due to the lack of information.
- There was a significant lack of clarity regarding the levels of activity delivered through the multiple commissioning arrangements.
- Different booking and authorising arrangements required dependent upon time of day, distance, patient needs e.g. out-of-hours, out-of-area, bariatric.
- The cost of NEPTS services were increasing with several providers requesting increased funding in 2012/13 without a clear rationale for the uplift.
- Increased demand for NEPTS as a result of an ageing population, the number of bariatric patients and NHS services provided in the community.
- Ad-hoc patient transport requests which were not under contract.
- NHS Gloucestershire commissioned and funded a separate call handling and booking service for journeys outside the Ambulance Trust block contract – a temporary arrangement with additional cost.

3.2 As part of this review a number of off-site and on-site informal meetings with existing and potential suppliers were undertaken to understand the NEPTS market. This culminated in a NEPTS supplier day with a number of providers presenting their approaches to the commissioning teams and addressing a number of pertinent questions around operational approaches. This also identified NEPTS providers who were managing their services well and considering innovative models for the future. An options appraisal with a preferred option for the service model was then set out to provide:

- a single point of contact offering patient transport advice;
- assessment of eligibility for NHS funded transport based on medical need following Department of Health guidance;
- a 365 day 24/7 service;
- patient transport booking facilities;
- sign posting for non-eligible patients;
- a minimum 10% of activity to be sub-contracted with third party providers to support capacity and the development of the market and;
- the continued use of volunteer car drivers.

4. The Procurement Process

4.1 Following the service review, the four PCT's approved a single joint procurement process in May 2012. This included a competitive dialogue process to provide the PCTs with the opportunity to openly develop a service specification, discuss service issues and experiences in detail with providers. It was also agreed four contracts would be awarded to a single accountable provider to manage the service more effectively, capturing journey information in a single database providing service intelligence that the PCTs had never had.

4.2 The key objectives of the procurement were to secure:

- **Quality** – patient-centred services delivered in a safe, friendly and effective manner by trained staff in clean, comfortable vehicles. This included keeping journey times low and ensuring promptness of arrival and pick-up.
- **Flexible & Responsive** – flexibility to respond to changing needs, e.g. new healthcare locations, on-the-day requests, flexible times for pick-up and delivery including evenings and weekends.
- **Communication & Performance Information** – high-quality communication with commissioners to discuss flexible and innovative approaches. Clear and complete information must be provided regularly on activity, finance and quality of service provision.
- **Value for Money** – affordable and provide value for money.
- **Green** – take action to reduce the carbon footprint of patient journeys wherever possible.
- **Innovation & Use of Information Technology** – innovative service approach using best practice to respond to future needs. It needed to make the most effective use of technology for the scheduling of journeys.

4.3 The procurement process commenced on 17th July 2012, and was concluded with contract award in June 2013 and contract signature in August 2013. Overlaying this was 18 months of stakeholder engagement and consultation. All stages were assessed by a panel of representatives from acute providers, commissioners and patient representatives.

5. Contract Summary

5.1 Arriva Transport Solutions Ltd (Arriva) was awarded the contract in summer 2013 and the service went live on 1st December 2013. Go-live was preceded by six months of planning and mobilisation work between the four CCGs and Arriva to:

- transfer 176 staff from incumbent providers;
- recruit and train new staff;
- procure and equip ambulances;
- establish ambulance base stations and a control centre;
- establish on-line booking systems and processes for transferring existing journeys and;
- engage with the acute Trusts and community providers across BGSW to provide information about changes in the booking processes, etc.

5.2 Arriva's contract covers NEPTS for patients travelling to and from out-patient appointments, day case in-patient admissions, discharges, inter-hospital (including time critical), A&E/Minor Injury home returners, end of life patients, renal dialysis patients and on-site interdepartmental hospital transfer.

5.3 It is primarily for patients (and escorts where appropriate) who are GP-registered in the area covered by the CCG areas of BGSW. These patients must also meet the agreed eligibility criteria for PTS, as laid out by the Department of Health. It also includes some patients from other health communities where discharge or transfers are required. There may be a requirement for transport to anywhere within England,

Scotland or Wales and to specialist centres outside the specified area anywhere within the country.

5.4 Arriva are responsible for the safe, timely and comfortable transport of patients between their place of residence and the healthcare facility, between healthcare facilities and from the healthcare facility to their place of residence. They also maintain a comprehensive directory of service, detailing alternative providers of transport for those patients ineligible for NEPTS.

5.5 All staff are easily identifiable as working in NEPTS, and are qualified and/or trained in accordance with NHS guidelines for national job profiles in vehicle management, health, safety, safeguarding of patients, risk and incident management, security, equality and diversity, confidentiality and complaints procedures.

5.6 An appropriately-graded crew, operating dedicated vehicles equipped with internal equipment appropriate for the task, and detailed in the contracts, (serviced in accordance with manufacturers' specifications and fulfilling legal requirements) are available at all times. The vehicle type and crew available are required to meet the needs of the patients including, for example, general aids, safety and specialist equipment.

5.7 The contract includes a requirement for Arriva to sub-contract a minimum of 10% of journeys with third party providers across each contract. Arriva are also maintaining volunteer car drivers who are required to meet minimum standards and sign up to the volunteer car driver handbook.

5.8 Relevant data and progress reports are presented at intervals (e.g. weekly, monthly, quarterly) as specified by the CCGs, supported by quarterly user surveys and annual staff surveys. An official incidents and complaints procedure is in place within the Arriva structure and includes the CCGs within the escalation process for complaints that cannot be dealt with locally.

5.9 Key performance indicators (KPIs) are as follows:

PTS01 – Patients travelling less than 10 miles should not spend more than 60 minutes on any one journey;
PTS02 – Patients travelling between 10 and 35 miles should not spend more than 90 minutes on any one journey;
PTS03 – Patients travelling between 35 and 50 miles should not spend more than 120 minutes on any one journey;
PTS04 – Arrival within 45 minutes before or within 15 minutes after scheduled appointment time;
PTS05 – Patients should not wait more than 60 minutes for their outbound journey (where booked at least a day in advance) from the point of booked ready by the HCP;
PTS06 – Patients will be collected within four hours where booked on the day (within two hours for end of life);
PTS07 – Percentage of journeys cancelled by Arriva to be below an agreed %;
PTS08 – Percentage of journey collections missed (aborted journeys) to be below an agreed %;

PTS09 – Percentage of in-bound calls to Arriva call centre answered within 30 seconds to be above an agreed %;
PTS10 – Application of eligibility criteria;
PTS11 – Percentage of complaints acknowledged within one working day;
PTS12 – Compliance with agreed complaints procedure (full response within 25 days);
PTS16 – Availability of on-line booking system; and
PTS17 – Availability of telephone booking system.

5.10 An agreed KPI penalty regime commences from 1st April 2014 and performance will be reviewed monthly. This has not been applied for the first four months of the contract, to ensure that Arriva was afforded the opportunity to align the multiple incumbent resources and allow time for staff to settle into their new roles. Equally, there is quality incentive uplift earnable across the year one period against KPIs PTS01, 04, 06, 09 and 10.

5.11 Penalties and incentives will be imposed/rewarded on a quarterly basis and will be calculated as a percentage of the block contract value.

6. Service Model

6.1 The service has been commissioned to operate 24 hours a day, 7 days a week, 365 days of the year including all statutory and discretionary bank holidays. It includes a single point of contact which has a dedicated phone number for the receipt of all patient transport requests, to manage and apply the eligibility criteria and process, arrange appropriate transport and provide advice and support for patients who are ineligible for patient transport but still need help in getting to and from their relevant healthcare facilities.

6.2 Bookings for transport can also be made on-line and a key objective of the contract is to encourage health care professionals to book on-line wherever possible as the process is simple, accurate and quick. The on-line system, called Cleric, is available 24 hours a day, as is the call centre, so that bookings can be made at any time.

6.3 To ensure a timely and efficient service, all bookings, whether made by telephone or on-line should be made before 15:00 hours on the working day prior to the day of travel. Bookings may still be made after this time, but there is a time limit on the total number that can be accepted and different response times will be applied.

6.4 If journeys have to be booked at short notice on the day, then this should be done at least four hours before the time the transport is required. Any bookings made on the day of travel will be subject to a four hour response window (two hours for end of life patients).

6.5 Before Arriva started the service, return journeys from hospitals, etc, were booked in advance based upon the time that the patient was expected to have completed their appointment. The new contract has introduced a ‘book when ready’ service which requires staff to book the return journey when the patient is ready to go home. Once a patient is ‘booked ready’, Arriva aim to pick them up within an hour. In this way patients do not have to wait for long periods because their appointment finished sooner than anticipated and ambulance trips are not wasted if the patient is not ready to go when the ambulance arrives.

6.6 Patients can be 'booked ready' either on-line or by telephone. Telephone bookings are confirmed with a booking number during the call; on-line bookings automatically generate a booking number. This aids health care professional staff and Arriva's staff to easily identify the patient and their journey details should they need to be changed or cancelled.

6.7 In order to assess eligibility, health care professionals and patents will be asked four main questions:

- Pre-screening questions to assess if the patient is registered with a GP practice in the BGSW area;
- Exemption questions – exempt patients are those travelling for renal dialysis treatment, oncology patients receiving a course or programme of chemotherapy or radiotherapy treatment; and patients who must lie down for at least part of the journey;
- Mobility questions to determine the type of transport required; and
- Medical questions to identify the level of care required during the journey.

6.8 For those patients who are ineligible for NEPTS, they will be signposted to other suitable transport providers within the community. They may also be able to access the Healthcare Travel Costs Scheme.

6.9 The transport and mobility guidance is set out in the table below:

Code Used When Booking	**Description**
C1	For patients who can travel in a car without the assistance of anyone
C1A	For patients who will require assistance of one person to and from the vehicle
C2	For patients who require the assistance of two crew members
W1	For patients who must travel in their own wheelchair for the journey with the assistance of one person
W2	For patients who must travel in their own wheelchair for the journey with the assistance of two people
Stretcher	For patients who must lie down for at least part of the journey
Bariatric Vehicle	For patients who are 25 stone & over
NB Oxygen Therapy	Patients requiring oxygen must travel on a vehicle with two crew members.

7. Governance

7.1 An evolving series of governance arrangements have been used, tailored to the precise needs at the time, from the initial procurement phase through to post go-live and routine contract management as follows:

- Following contract award, a mobilisation group with representatives for the four CCGs, plus Arriva, plus South Central Commissioning Support Unit (and predecessor organisations which led and co-ordinated the procurement work on

behalf of the PCTs/CCGs) met weekly, to agree the Arriva mobilisation plan and to review progress, address issues, and manage risk.

- The PTS Procurement Board transitioned into a Mobilisation Board with CCG Governing Body level representation, which met monthly. Key risks and issues were escalated as appropriate.
- Each CCG took the lead for coordination and engagement with one of the four acute trusts, to help provide focus to acute trust concerns.
- For the first month following go-live, daily conference calls were carried out between commissioners and Arriva to review progress and address issues.
- Mobilisation meetings of Arriva and commissioners continued to be held weekly until the end of January and are now held twice monthly.
- Mobilisation Boards continue monthly.
- Lead commissioners have engaged directly with respective acute trusts to help address issues.
- Arriva locality managers are based at and work closely with each hospital trust to address issues and an Arriva escalation process enables healthcare staff to escalate issues as required
- From March, routine contract performance monitoring and quality review meetings will replace the mobilisation meetings (NB majority of the existing attendees will be unchanged; CCG quality leads will in future meet bi-monthly to review relevant issues), coordinated by South Central Commissioning Support Unit.
- Performance and activity data is provided by Arriva monthly and weekly, by CCG, and specific acute trust level dashboards are also now in place.

8. Service Launch

8.1 The new NEPTS contract with Arriva went live on 1st December 2013, replacing a multitude of contract and ad hoc arrangements. Initial weeks were characterised by:

- an extremely high volume of calls;
- problems arising from the incomplete or inaccurate nature of bookings information inherited from the previous providers;
- a journey volume that exceeded the expected level;
- a significant variation to the expected journey mix (different patient mobility and vehicle types required);
- early winter pressures being experienced within the acute trusts;
- some significant issues regarding arrangements for the movement of out-of-area patients to/from acute trusts within the contract area and;
- the need for acute trusts to revise their internal processes in a much more significant way than had been appreciated.

8.2 Despite a comprehensive mobilisation process, the combination of these issues meant that there was considerable concern at the outset of the contract. Much of this was based on information, which though in part unsubstantiated, has been challenging to refute, given that at the same time, there have also been some examples of poor performance as a result of the impact of the factors described (typically excessively long waits, sometimes resulting in overnight re-admissions or potentially detrimental impact on patients).

8.1 Support to Acute Hospitals

8.1.1 As a result of the issues identified in the early weeks of the contract, Arriva have completed reviews at all the acute Trust sites in BGSW and developed action plans in response to the findings of these reviews. These action plans are jointly owned between Arriva and the acute Trust. The RUH action plan was created at the end of December 2013 and agreed with the Trust prior to the Christmas break. Good progress has been made against the actions delivered.

8.1.2 The Trust management has engaged in supporting staff to use the booking system and the local Arriva management team have been proactive in supporting the Trust staff. A weekly acute Trust dashboard has also been developed which helps the Trusts understand its role in helping to deliver improvements in the service.

8.2 Support to Renal Dialysis Units

8.2.1 BaNES and Wiltshire renal dialysis patients can receive their treatment either at the Richard Bright Renal Unit at Southmead Hospital which is part of North Bristol NHS Trust (NBT) or at one of NBT's satellite units at the RUH, Weston-super-Mare, Southmead, South Bristol, Taunton, Frome and Kingswood.

8.2.2 Arriva are carrying out approximately 1,400 regular weekly dialysis patient journeys across BGSW. 1,200 of these are automatically planned to a combination of taxi providers and volunteer car drivers. The remainder are patients with higher mobility needs and are generally transported by Arriva vehicles.

8.2.3 Given the issues experienced by renal dialysis patients and the staff of the units, particularly at the beginning of the contract, Arriva implemented two full-time planners from 3rd February 2014 to provide dedicated planning of dialysis journeys. A dedicated renal hotline was set up in December and continues to provide a direct, dedicated route to the dispatch desk for the units across the BGSW area.

8.2.4 To provide further support for this group of patients, a full-time operational support manager joined the Arriva team on 24th February 2014 with a remit to provide central support for planners and the locality managers in oversight and quality assurance of all renal dialysis NEPTS activity. Key tasks will include daily reconciliation of planned journeys against actual activity, pro-active engagement with renal unit staff, and on-going refinements of auto and manual planning arrangements in conjunction with the planners.

8.2.5 The CCGs and Arriva also met with NBT's service manager for the renal and transplant directorate and the clinical matron at the beginning of February to discuss their issues and concerns. A further meeting has been arranged in April to review progress as well as discuss the impending move of the Richard Bright Dialysis Unit into the new NBT hospital building.

9. Activity

9.1 Activity has been recorded by Arriva since the start of the contract. Having a single provider has meant that for the first time, a comprehensive view of total NEPTS activity can be achieved. This in turn helps to inform decisions about the provision of service by location, by mobility category, and by journey type and distance. It also helps to inform the position in terms of how well KPIs are achieved.

9.2 Detailed charts are provided at appendix 1 which shows the total BaNES NEPTS activity between 1st December 2013 and 28th February 2014. These are NEPTS journeys, conducted by Arriva, for patients registered to a GP practice within BaNES CCG. The journeys are a combination of actual journeys completed, plus aborted journeys, but excluding cancelled journeys.

9.3 Aborted journeys are chargeable, since they are journeys where NEPTS resource has been committed to the task, but the task was not completed. This can be for one of a multitude of reasons (e.g. patient not ready / patient too ill to travel / patient no longer requires transport / appointment cancelled but transport was not / patient too ill to travel / patient used own transport / patient had been admitted but transport not cancelled / etc.)

9.4 Cancelled journeys are those for which a booking was made but, are cancelled prior to the start of the journey, by the person/organisation that made the booking. Cancellations are not chargeable.

9.5 Total activity including aborted journeys, is typically slightly above the expected level, per week (excluding the bank holiday Christmas and New Year weeks). However patient mobility is also a function of activity, as is average mileage per journey.

9.6 The average mileage per journey is below that which was identified during the tender process. However, in the other CCG areas this is not the case which has an impact on resourcing, since longer journeys last longer and therefore require a higher level of resource than expected in order to complete the same number of journeys.

9.7 The tender process also described the existing activity in terms of patient mobility (and therefore the numbers of each type of NEPTS resource required). The reality seen since 1st December 2013 is that the actual mix per type of NEPTS resource required, reflecting patient mobility, is in some regards significantly different:

Definition	**Average Weekly Baseline (bid) Activity**	**Average Weekly Actual Activity**	**Percentage of Expected Volume**
Car, one crew	319	269	84%
Car, two crew	53	171	323%
Wheelchair, one crew	21	112	533%
Wheelchair, two crew	140	37	378%
Stretcher	48	51	106%

9.8 Arriva were resourced to provide the service according to the expected mix of patient mobility. The Arriva resourcing was also established based on the expected mobility mix of all four CCGs who have contracted their service. Thus variances in the volume, mileage and mobility mix of other CCGs' activity also have a bearing. These variances mean that Arriva began the contract with a level and type of resource, across the area that did not fully match the requirement.

10. Performance

10.1 Performance is being reported within the context of the total activity, average journey distance, and mobility mix compared to that which was expected, for BaNES CCG and other CCGs, as described above.

10.2 Detailed key performance indicator (KPI) charts are shown at appendix 2 showing performance for:

- all BaNES CCG patients transported by Arriva
- all BaNES CCG dialysis patients transported by Arriva
- all BaNES patients attending the RUH to which the majority of BaNES patients attend, transported by Arriva.

10.3 The main key performance indicator (KPI) measures shown look at three aspects of patient experience:

- time spent on vehicle
- on-time in-bound journeys
- on-time collection for out-bound journeys

10.4 Time on vehicle – overall, performance is being achieved in line with KPIs for time on vehicle. The dips in performance for the longer distance journeys generally reflect a small or very small number of journeys in these categories (graphs 1 to 3).

10.5 In-bound on time – is an area where performance is improving but requires continuing improvement to get to KPI level (graph 4).

10.6 Out-bound on time (for on-day bookings) – is generally being achieved or exceeded (graph 6). The response timeframe for these journeys is four hours from the time the patient is "made ready." The area requiring greatest improvement is on-time collection for pre-booked outbound journeys (graph 5). The response timeframe for these is one hour from the time the patient is "made ready."

10.7 Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys and the knowledge that transport is critical for this group of patients.

10.8 There are a range of other KPI measures, and these include average and maximum telephone waiting time for booking requests made by phone. Although patients are able to make telephone bookings direct with Arriva, it is not possible to break out BaNES only calls, or patient-only calls, from the total, for KPI reporting purposes. Therefore telephone responsiveness figures are not included; although it is understood that in BaNES the volume of patient-generated telephone bookings is low. Nonetheless, average call wait time has reduced from over 3 minutes to less than 2 minutes; and the maximum daily call wait time across the areas served by Arriva has reduced from >25 minutes to <5 minutes.

10.9 KPI performance reflects some of the issues that have been found since the start of the contract, and which Arriva, Commissioners, and acute Trusts, are continuing to work to address. The main issues with service delivery that have led to complaints from patients and problems for acute trusts have been:

- Periods, particularly early in the contract, but still the case currently, when on-time pick-ups for out-bound journeys was significantly below KPI, meaning many

patients had long or very long waits. This arose from a combination of many factors, these include: incomplete journey data inherited from the outgoing incumbent providers; lack of familiarity in the acute trusts with the "make ready" process; inherited bookings being of an incorrect mobility, meaning on the spot reallocation of appropriate resources, which inevitably take longer to become available; wrong vehicle mix for the overall total actual activity identified, meaning insufficient resource for certain categories of patients. Although performance is improving, there is more to be done on this.

- Delays for in-bound journeys, typically those later in the day where a knock-on effect from late out-bound journeys earlier in the day, as described above. Again, although performance is improving, there is more to be done on this.

- Difficulty and long waits to get through when healthcare staff calling the booking centre. Initially this was a result of low levels of uptake of the on-line booking tool among healthcare staff; as well as an extremely high call volume due to the need to chase up "missing" or incorrect inherited journey bookings as described above; and lack of confidence in and familiarity with the new NEPTS arrangements; but is now much improved.

- Problems with incorrect mobility with healthcare staff getting used to the mobility categories used by Arriva this is now much improved.

10.10 All of these and a range of other operational issues are being addressed, and progress is being made. A patient satisfaction survey will be undertaken in quarter two of 2014/15. The content and sample size is currently being agreed between the four CCGs and Arriva.

11. Complaints

11.1 Complaints received by Arriva are handled by a central complaints team and are acknowledged within one day of receipt. Each complaint is graded according to its severity and impact. Thereafter, each complaint is directed to the appropriate Locality Manager, Area Manage or the Head of Service according to the locality to which the complaint relates and the severity rating. Every complaint should receive a full written response within 25 days.

11.2 For all CCGs, the highest volume of complaints relates to long waiting times. Since the commencement of the contract, and in the context of high volumes of activity, there is a reducing trend in all categories of complaint. Total complaints since the launch of the contract for BaNES are as follows:

Month	**Number of Complaints**
December	31
January	26
February	20

12. Improvements Made Since Service Launch

12.1 Booking Centre – Call Taking

- Initial call-taking capacity was increased by 60%, including experienced Arriva staff from other NEPTS call centres, to cope with the anticipated volume of calls, and to reduce call wait times.
- Call volume has reduced from 5,500 per week to 3,500 per week (1st Dec to 14th Feb).
- Call abandonment rate has reduced from >30% to <10% (1st Dec to 14th Feb).
- Average call wait time has reduced from >3 minutes to <2 minutes (1st Dec to 14th Feb).
- Maximum call wait time has reduced from >25 minutes to <5 minutes (1st Dec to 14th Feb).
- Improved internal call handler training and individual performance management now taking place.

12.2 Online Booking

- Arriva trainers have attended acute Trust sites to train up hospital staff and to train internal trainers.
- Ad-hoc issues with using online booking have been addressed and resolved.
- The proportion of bookings, amendments, cancellations and "make ready" actions made online has increased steadily and is now >30% (14th Feb 2014). This reduces the burden on the call centre, meaning faster call answering; and also provides real-time visibility of bookings, for hospital staff.
- The benefits of the online system are becoming progressively clearer for hospital staff, including the ability to review lists of booked journeys, and to take ad-hoc snapshots of outstanding patient journeys including those not booked ready.

12.3 Journey Timings

- Journey time and patient drop-off/collection performance has improved. Across the four CCGs, time on vehicle performance exceeds KPI level for all journeys over 10 miles, and is 1% below target for journeys under 10 miles.
- On-time drop-off (in-bound) has consistently improved but is still below KPI target.
- On-day collection (within four hours) out-bound exceeds KPI target.
- Planned out-bound collection (within 60 minutes) has improved but is still below KPI target.

12.4 Capacity & Resources

- Total patient carrying capacity has been increased by 15% since day one.
- Front-line staffing is planned to increase by 15% with five new staff already in post.
- Accredited sub-contractors are now receiving their work through an innovative online tool.
- Significant re-profiling of Arriva vehicle shift patterns is resulting in increased capacity at critical times of the day, mainly weekday afternoons.

12.5 Dialysis

- A renal hotline has been implemented to provide direct renal-dedicated assistance.
- Two planners have been assigned on a dedicated basis.
- Progress has been made to move to dedicated drivers for renal dialysis patients.
- Ambulances fulfilling dialysis journeys now have in-built buffer (catch-up) time in their schedules to increase reliability and on-time performance.

- A “renal champion” operational support manager has been appointed and is now in post to address the various issues impacting renal dialysis patients, and to manage the implementation of Arriva service for Wiltshire patients attending SFT for dialysis; and to manage the relocation of the dialysis unit within Southmead for GBSW patients.

12.6 Acute Trust Action Plans

- Diagnostic visits conducted by Arriva and joint action plans produced by Arriva, developed jointly with the acute Trusts. These identify the main issues and concerns experienced within each Trust, and a series of actions that will resolve those issues. These plans are reviewed and updated weekly.
- Joint performance information is now provided weekly to acute Trusts, to further assist in embedding new processes and help build confidence in the new service.
- Where fixed time slots are required eg for home visits, or regular reliable clinic timings, these are now booked on a throughput time, to reduce delays.
- Arriva checks all open bookings daily with the acute Trusts, between 3-4pm, to confirm if the journeys are still required/ ready to proceed / are to be cancelled, to reduce late afternoon/early evening delays.
- Where phone numbers are provided, patients are being called in advance to ensure they are more likely to be ready when their transport arrives.

12.7 Communications & Engagement

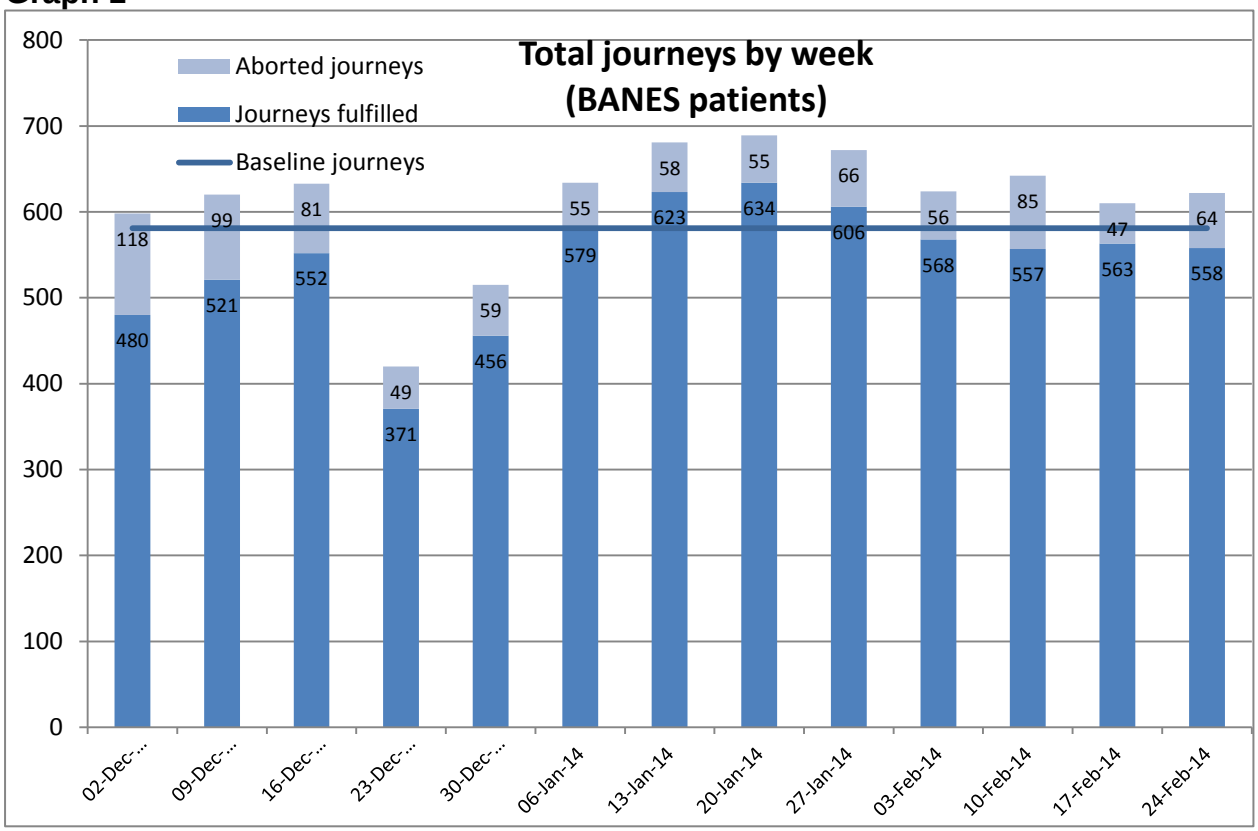
- A communications pack including points of contact, FAQs, escalation arrangements, guidance on booking requirements, etc. has been distributed widely to healthcare professionals, including acute trusts, community providers, and GP practices.
- A monthly bulletin has begun to be distributed.

12.8 Complaints

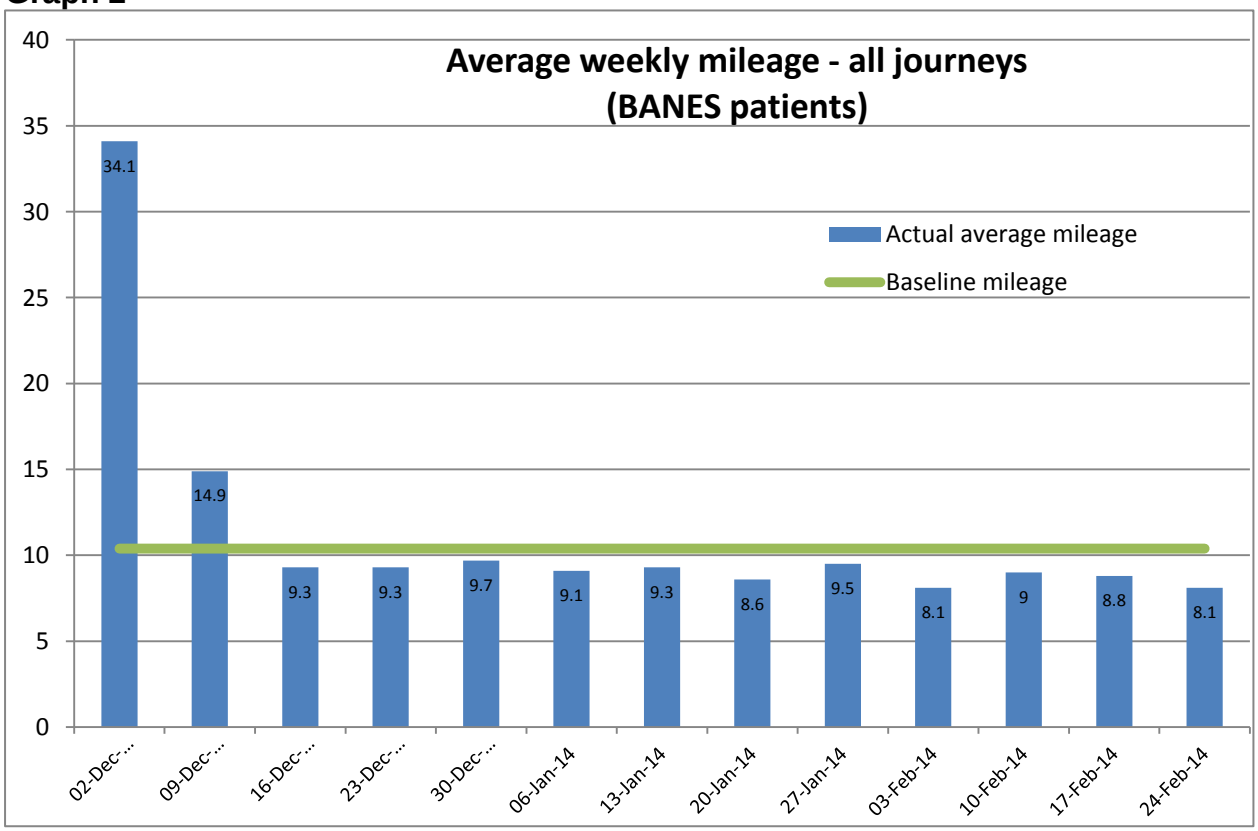
- A full-time patient experience manager joined Arriva on 3rd March 2014 and has a clear mandate to review and refine the complaints handling process across the entire organisation.
- Arriva is also appointing a local complaints administrator by the end of March 2014.

Appendix 1 - Activity

Graph 1

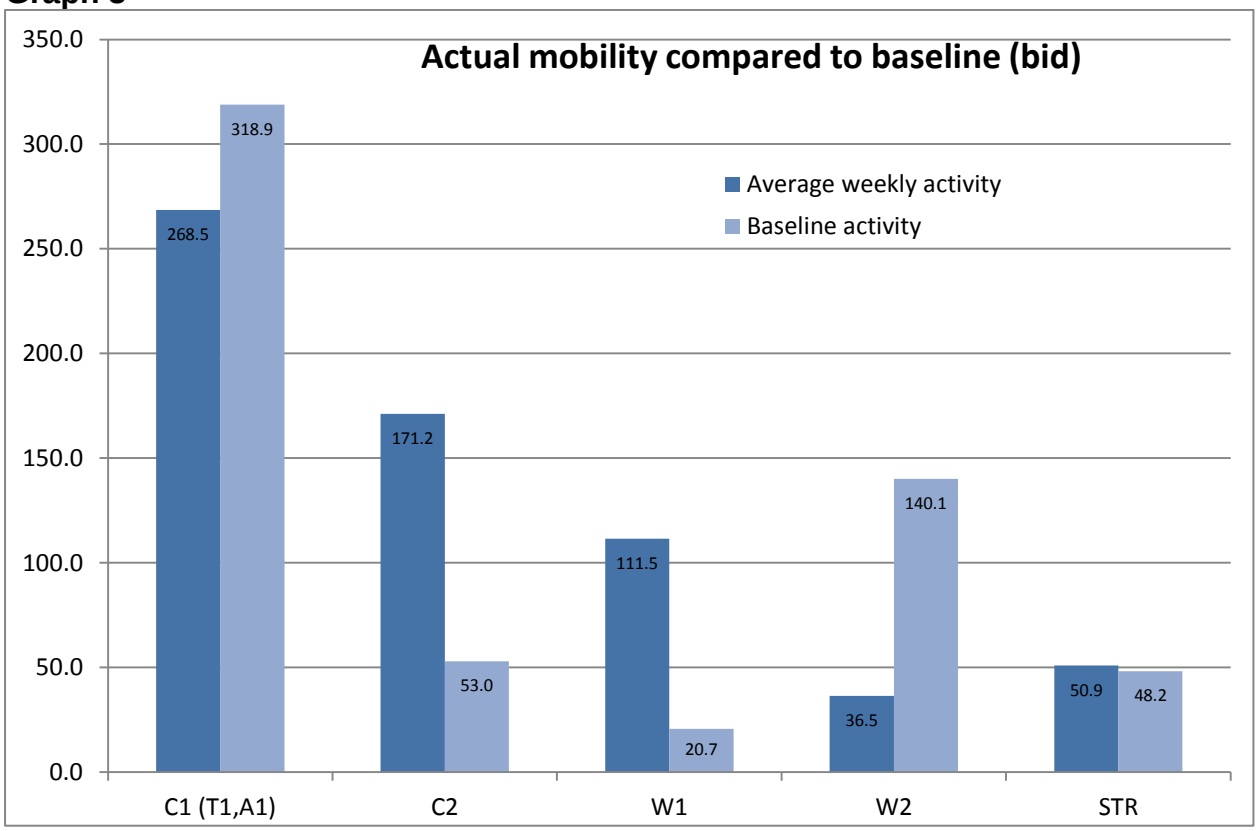


Graph 2



Data represents average weekly mileage for all chargeable journeys. Data is based on "planned mileage," an assumption made by Cleric software which represents the shortest viable route by road.

Graph 3



Data represents average weekly activity by mobility category using 11 weeks of data (02/12/13 to 02/03/14 excluding 23/12/13 to 05/01/14 inclusive). All mobility codes relating to walking patients (including A1, T1) are shown in the C1 category.

Mobility definitions

C1 - able to walk unaccompanied or with assistance of one person. Generally suitable for travel by taxi or car.

C2 - able to walk but with assistance of two people; or requires a wheelchair to be provided for transport purposes. Generally will travel by ambulance.

W1 - wheelchair user who is generally suitable for travel in a wheelchair-adapted car.

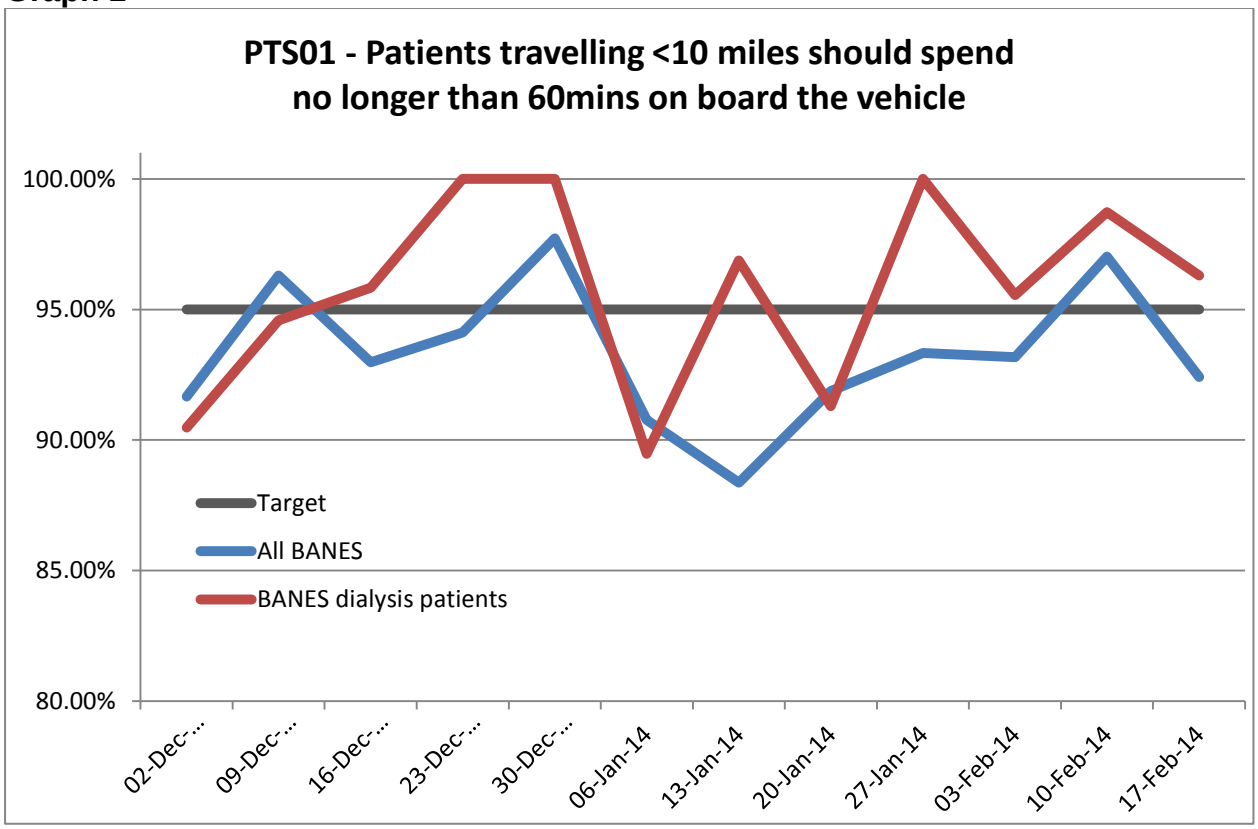
W2 - wheelchair user who is generally suitable for travel by ambulance; requires assistance of two people.

STR - only able to travel on a stretcher. Ambulance patient.

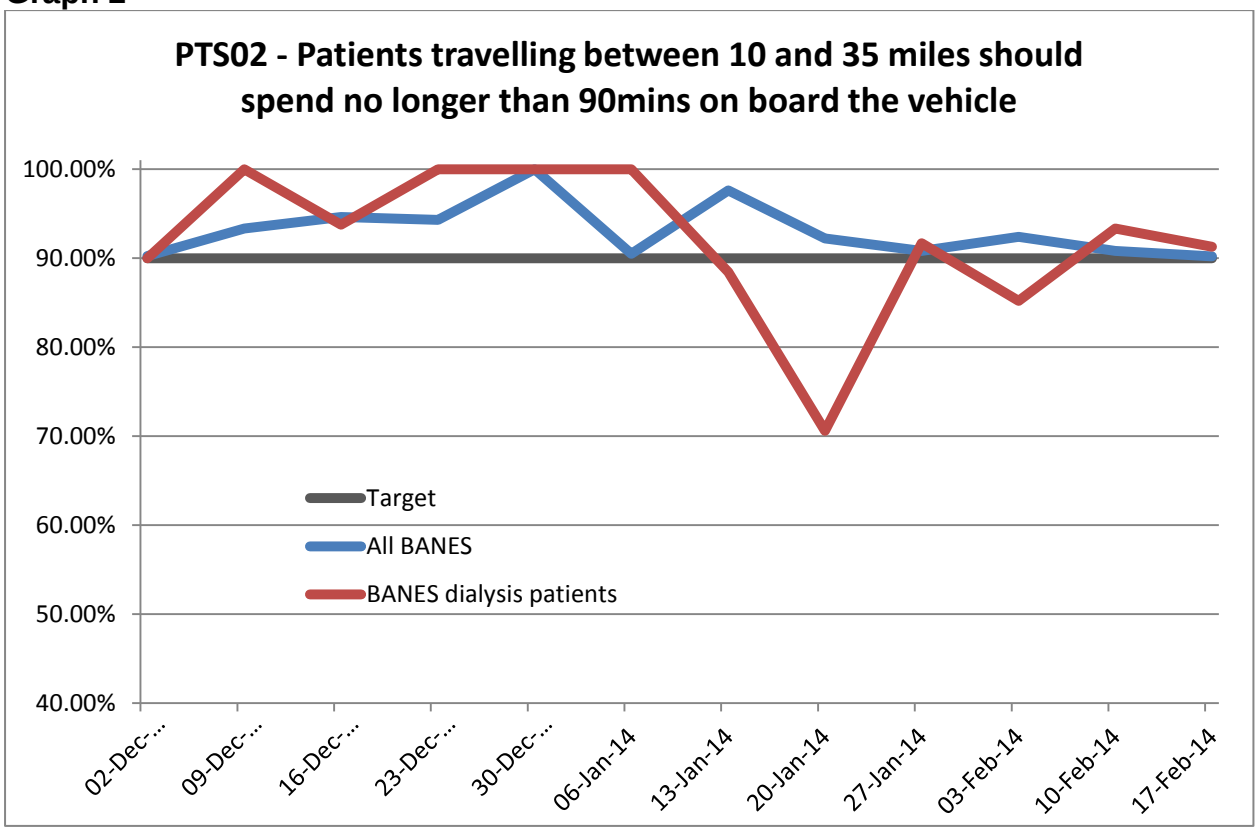
Appendix 2 – Performance

The data provided in the following graphs, is based on journeys for which complete journey time information is known.

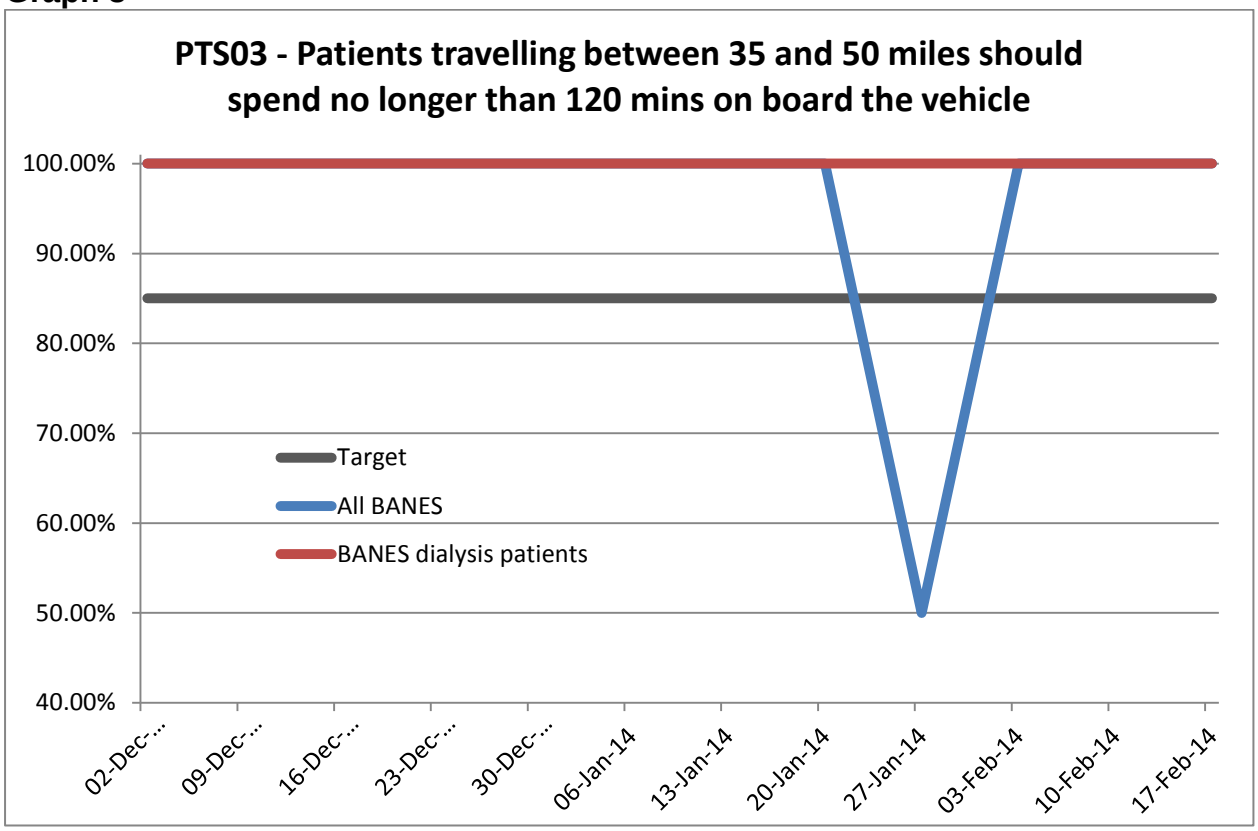
Graph 1



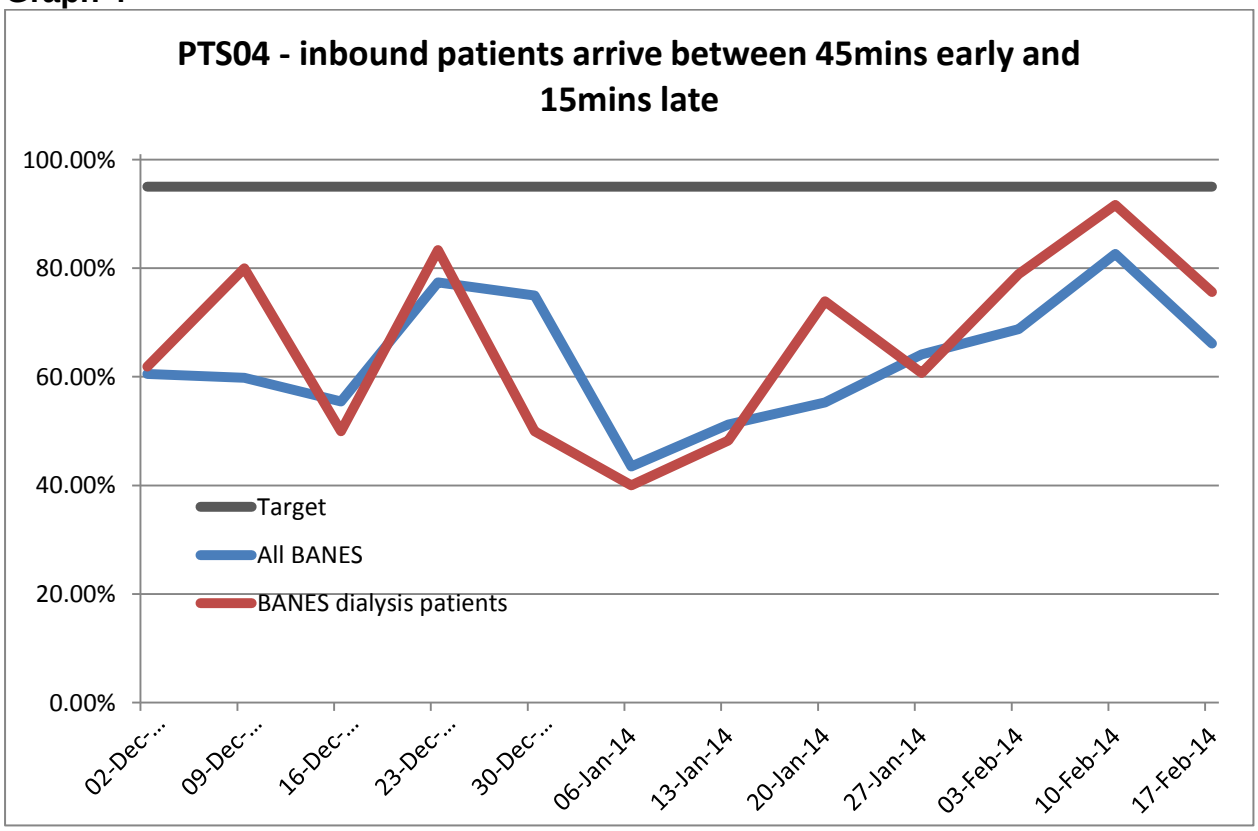
Graph 2



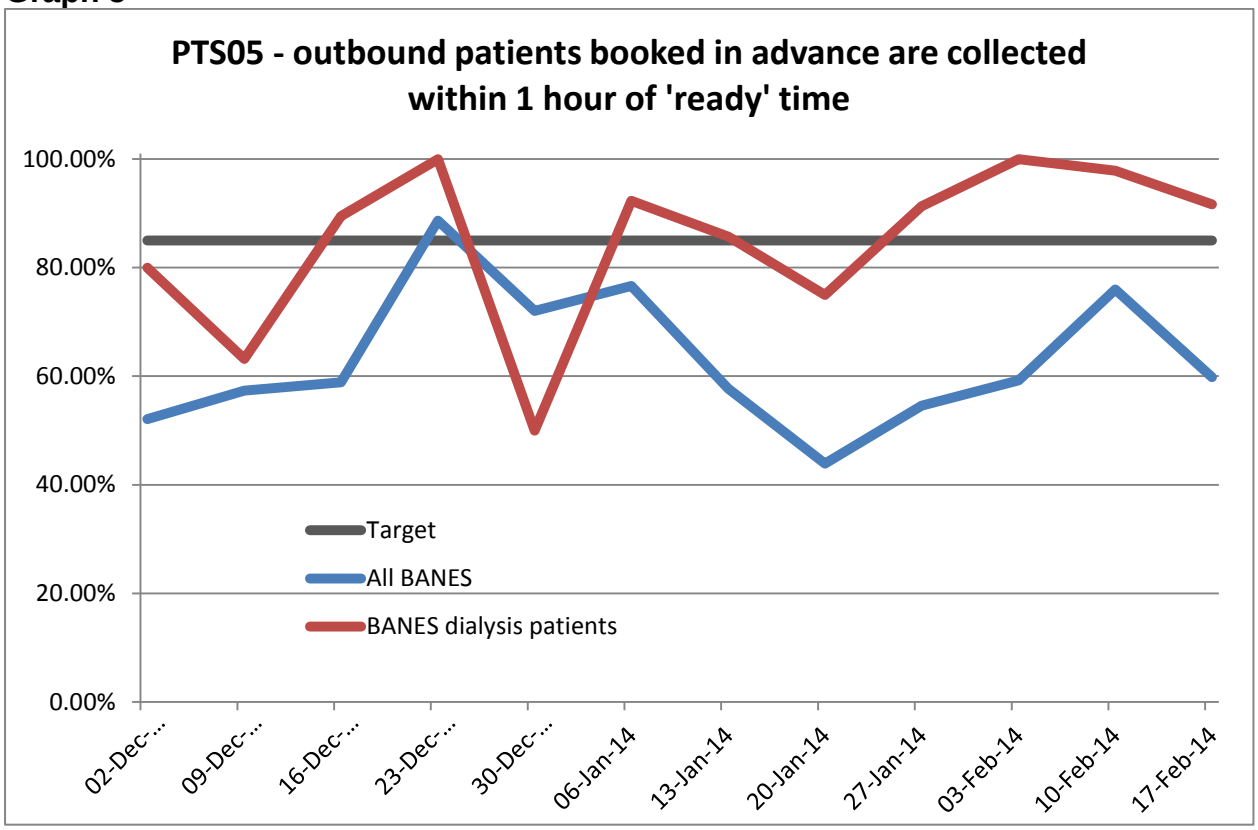
Graph 3



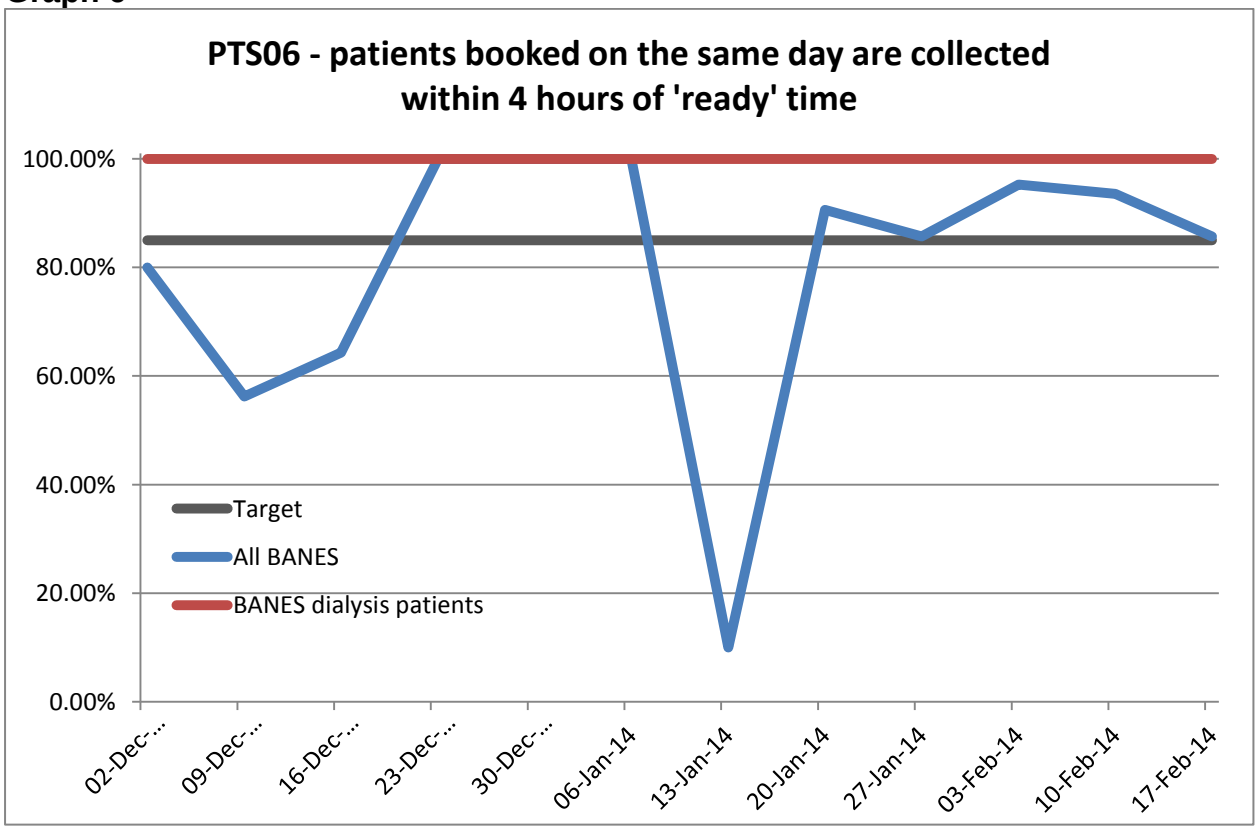
Graph 4



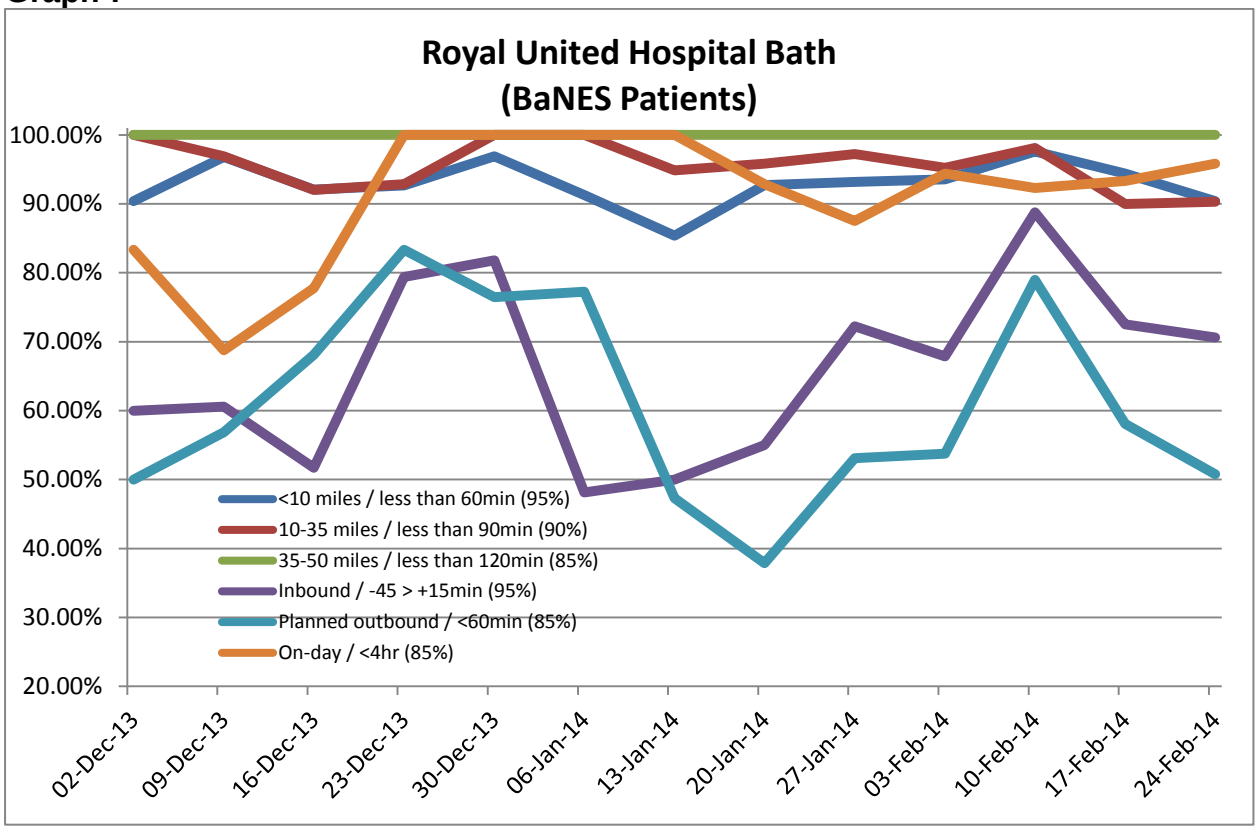
Graph 5



Graph 6



Graph 7


Royal United Hospital Bath
(BaNES Patients)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
02-Dec-13
09-Dec-13
16-Dec-13
23-Dec-13
30-Dec-13
06-Jan-14
13-Jan-14
20-Jan-14
27-Jan-14
03-Feb-14
10-Feb-14
17-Feb-14
24-Feb-14