NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Clinical Commissioning Group Update for Wiltshire Council Health Select Committee:

Provision of NHS-funded Non-Emergency Patient Transport Service by Arriva Transport Services Ltd

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Report Produced by

Andy Jennings
Commissioning Manager
Wiltshire CCG

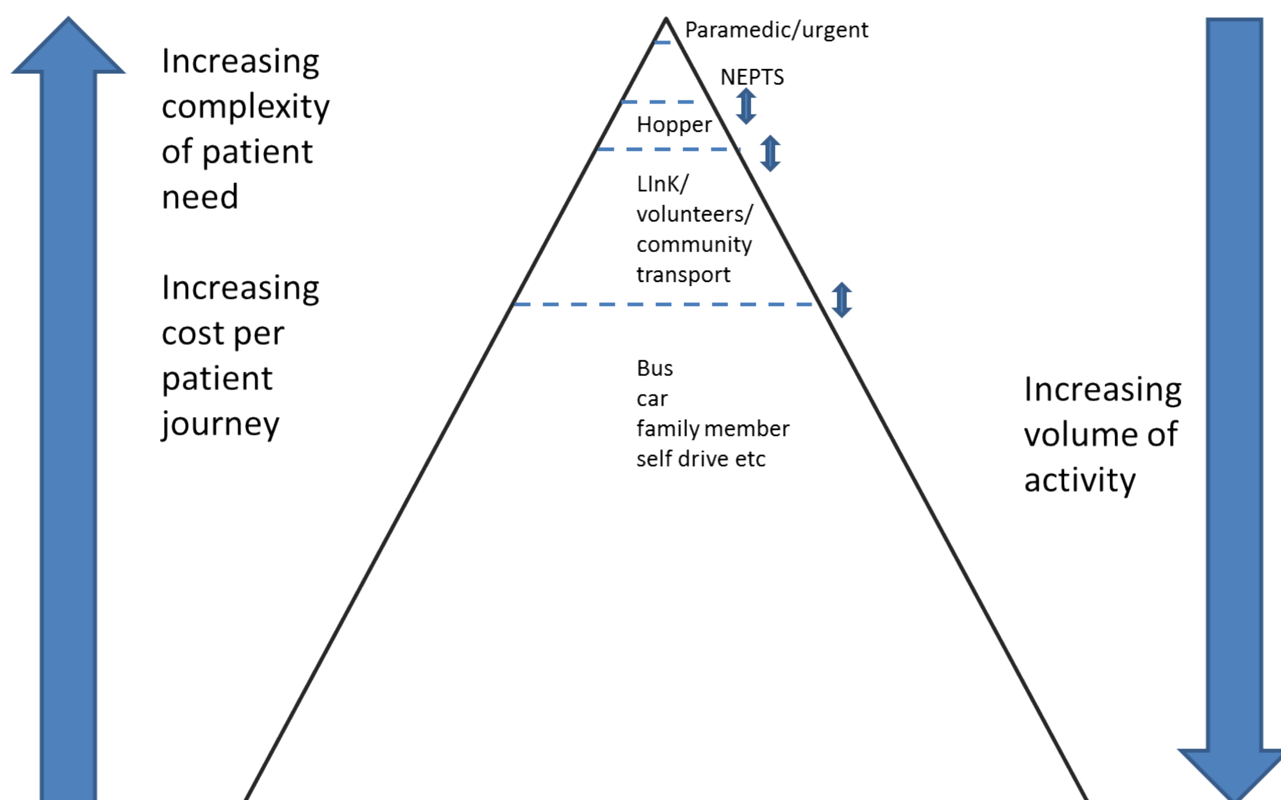
1 INTRODUCTION

This report builds on those provided to the Committee in February, September and November 2014, and February 2015.

2 BACKGROUND

The NHS-funded Non-Emergency Patient Transport Service (NEPTS) is for those who, due to their mobility or medical needs, cannot travel safely by any other means. The Arriva contract replaced a plethora of previous arrangements operating to a disparate set of quality, performance and operational arrangements. In a hierarchy describing the needs of the patient, and the complexity of support provided by the transport operator, NEPTS sits near the top of the pyramid; below only paramedic crew/emergency ambulance services; and above arrangements such as Hopper bus; LINK groups; community transport services; volunteers; and normal bus, car, and other self-help transport options:

Hierarchy of patient transport



Within the NEPTS service there is a further hierarchy of need/complexity, ranging from the lowest (patient can walk, can travel by car, and requires the support of only one member of PTS staff), through patients who can walk and require the support of two members of staff, patients who are in or need to travel by wheelchair, to patients who need to travel by stretcher.

In the period since the last report, Wiltshire CCG and Arriva Transport Solutions Ltd (ATSL) have completed a contractual rebasing of the contract, this was based on known actual activity seen in the first 12 months of operation of the Arriva contract. A number of further service improvements have been made and continue to be made, to bring Key Performance indicator (KPI) performance up to the required level. Some of these are described in further detail below.

3 ACTIVITY & PERFORMANCE

Number of journeys (Wiltshire CCG patients)

Activity per month typically varies between 5,000 and 6,000 journeys. There are typically more outbound journeys, this is due to discharges and transfers to home/care home/community hospital etc. Within Wiltshire, 40-45% is outpatient appointments, 35-40% of activity is dialysis, 9-11% is discharges, 5-7% is oncology, 2-3% is transfers, up to 5% is "other".

Contract year 1

Direction	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	YTD
Inward	2108	2254	2042	2187	2489	2561	2424	2692	2366	2442	2368	2191	28124
Outward	2696	3061	2762	2756	3209	3289	3046	3337	2946	3068	2986	2749	35905
Total	**4804**	**5315**	**4804**	**4943**	**5698**	**5850**	**5470**	**6029**	**5312**	**5510**	**5354**	**4940**	**64029**

Contract year 2 to date

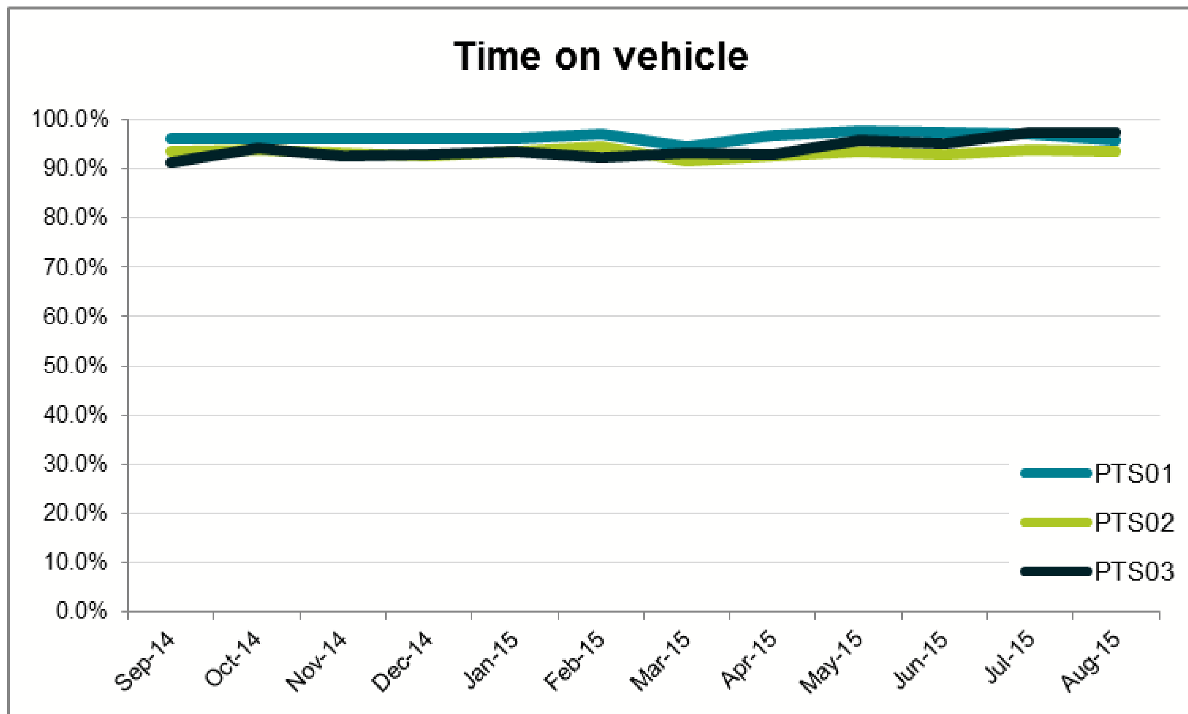
Direction	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	YTD
Inward	2292	2360	2054	2354	2464	2468	2689	2732	19413
Outward	2878	2941	2542	2806	3088	2985	3363	3356	23959
Total	**5170**	**5301**	**4596**	**5160**	**5552**	**5453**	**6052**	**6088**	**43372**

Key Performance Indicators (KPIs) - by Month

The main focus for KPIs is timeliness of service delivery, since this has the most significant impact on patient experience, and is the area that has been most challenging.

		Target	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
<10 miles < 60 minutes on vehicle	PTS01	**95%**	96%	96%	97%	95%	97%	98%	97%	97%	96%
10 - 35 miles < 90 mins on vehicle	PTS02	**90%**	92%	94%	94%	92%	94%	93%	93%	94%	93%
35 - 50 miles < 120 mins on vehicle	PTS03	**85%**	92%	94%	91%	93%	94%	96%	95%	98%	97%
On time arrival -45 > + 15 mins	PTS04	**95%**	80%	84%	84%	83%	86%	86%	84%	87%	86%
60 minute pick up (planned)	PTS05	**85%**	78%	79%	74%	76%	78%	81%	80%	79%	82%
4 hour pick up (on the day)	PTS06	**85%**	83%	84%	83%	80%	79%	79%	73%	73%	84%

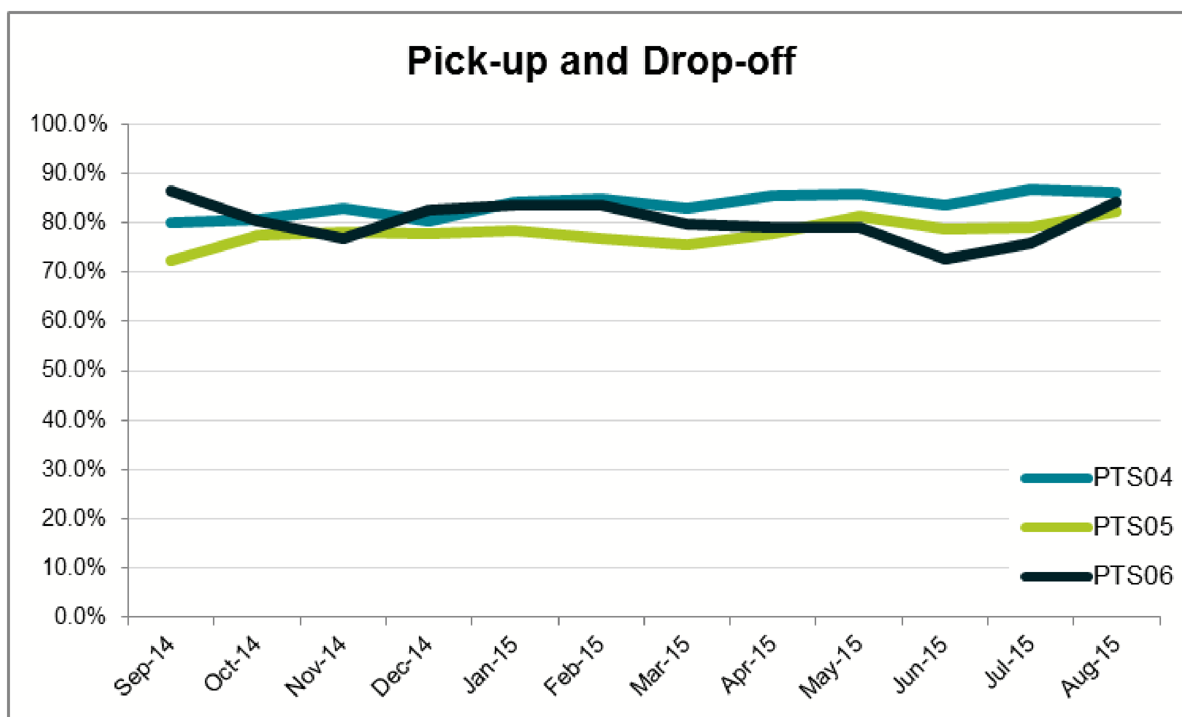
KPI 1,2,3 (time on vehicle) performance continues to exceed the KPI target level, consistently.



KPI 4 (timeliness of inbound drop-off) continues to show slow but consistent improvement

KPI 5 (timeliness of outbound pick-up, pre-booked journeys) has consistently been 5-6% below KPI target; with a small improvement in the last month..

KPI 6 (timeliness of outbound pick-up, booked on day of travel) has shown a significant improvement this month, after a period of slow decline, and is now on the cusp of achieving the KPI target. This improvement is attributed primarily to the revised scheduling processes, described later.



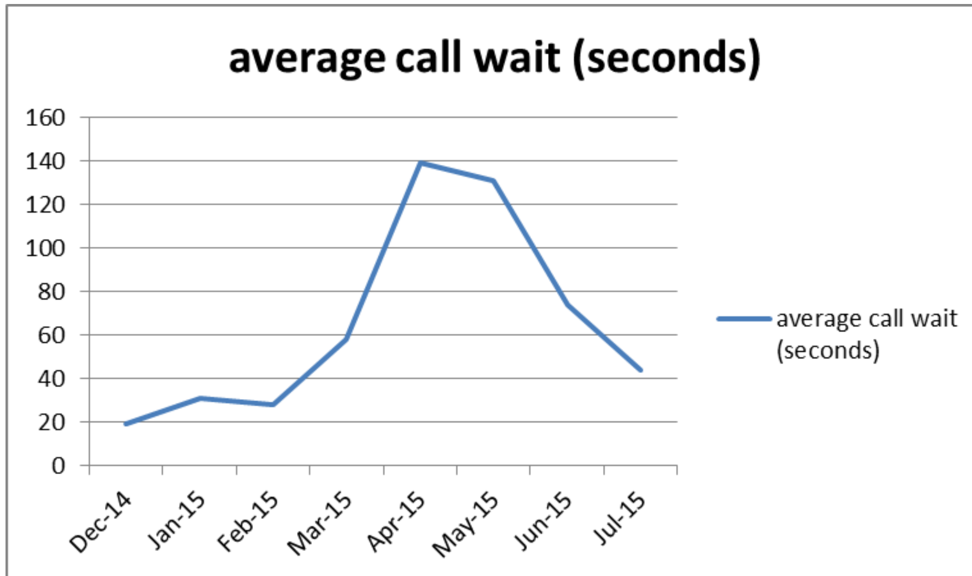
These scores represent an improvement on the performance in contract year 1 but in several cases remain below target.

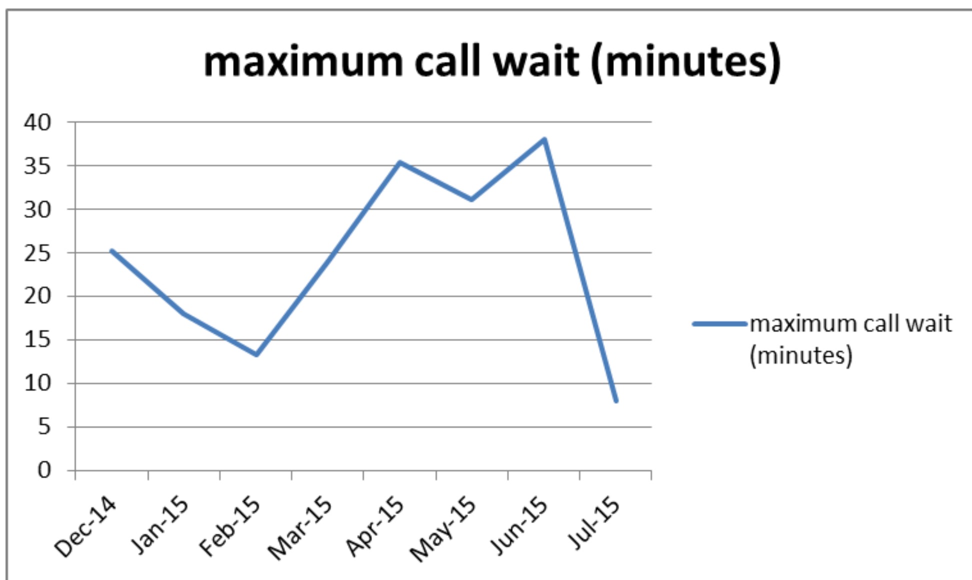
Call Centre Performance

Most bookings are made by acute trust staff. Bookings can be made either over the phone or electronically. Some bookings are made by patients. These can only be made over the phone. As a result, there is a KPI for speed of telephone answering within the Bristol-based control centre: 85% of calls to be answered within 30 seconds of the end of the welcome message. Arriva has struggled to achieve this target during 2015.

In part, the performance in the second half of 2014 and into the early months of 2015 was such that acute trust staff often chose to use the phone rather than the online system. This put pressure on the call handling staff, resulting in the longer waits shown below. In turn, the longer waits have helped support the case for wider use of the online system (although there are various other reasons which mean that it is not as useful in some departments and clinics as it is for others). A continuing programme of training for acute trust staff is carried out by Arriva to improve the understanding, confidence in, and use of, the online system. In urn this is now helping to reduce call wait times for patients, and for those acute trust staff for whom the online booking method is more of a challenge. It is also of note that call volumes increase when performance decreases.

	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
average call wait	19 seconds	31s	28s	58s	2m 19s	2m 11s	1m 14s	44s
maximum call wait	25min 15s	18m 4s	13m 19s	24m 5s	35m 21s	31m 7s	38m	8m 1s





After 3-4 months of deterioration, performance is now returning to an improved position, which is very much welcomed.

4 COMPLAINTS

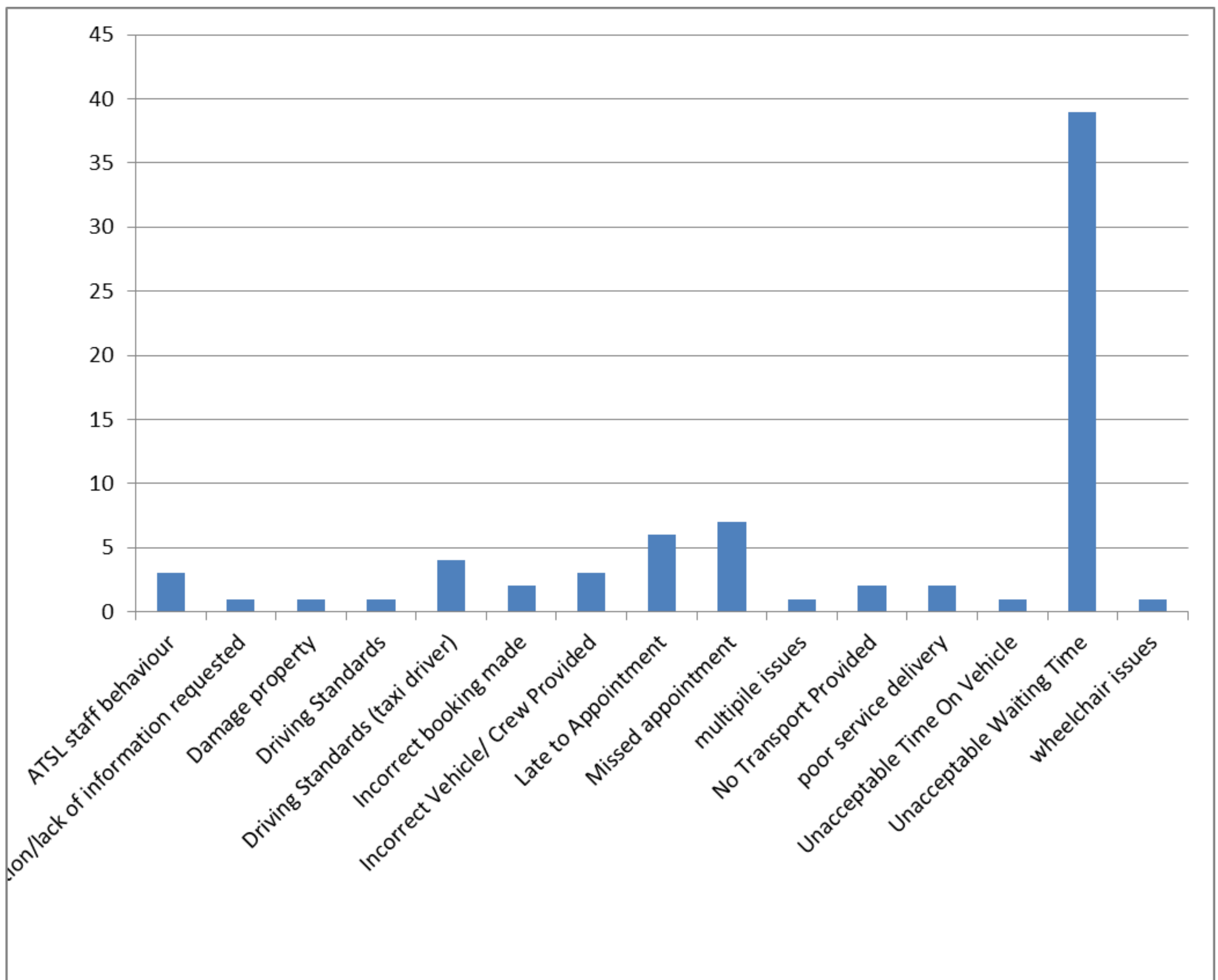
Arriva implemented a new complaints process during 2015 and created a new in-house complaints team. This team is dedicated to the Arriva patient transport business, rather than being part of a central Arriva complaints team; allowing a faster service and more comprehensive responses.

Contact breakdown by type, Jan-Aug 2015

Contacts	78
Complaints	74
Commendations	2
Comments/feedback	2

There are also a multitude of “Service to service” issues i.e. issues raised on a daily basis between acute trusts, community hospitals etc, and Arriva, as part of the operational management of normal daily business.

Complaint trend analysis by cause January to August 2015 (inclusive)

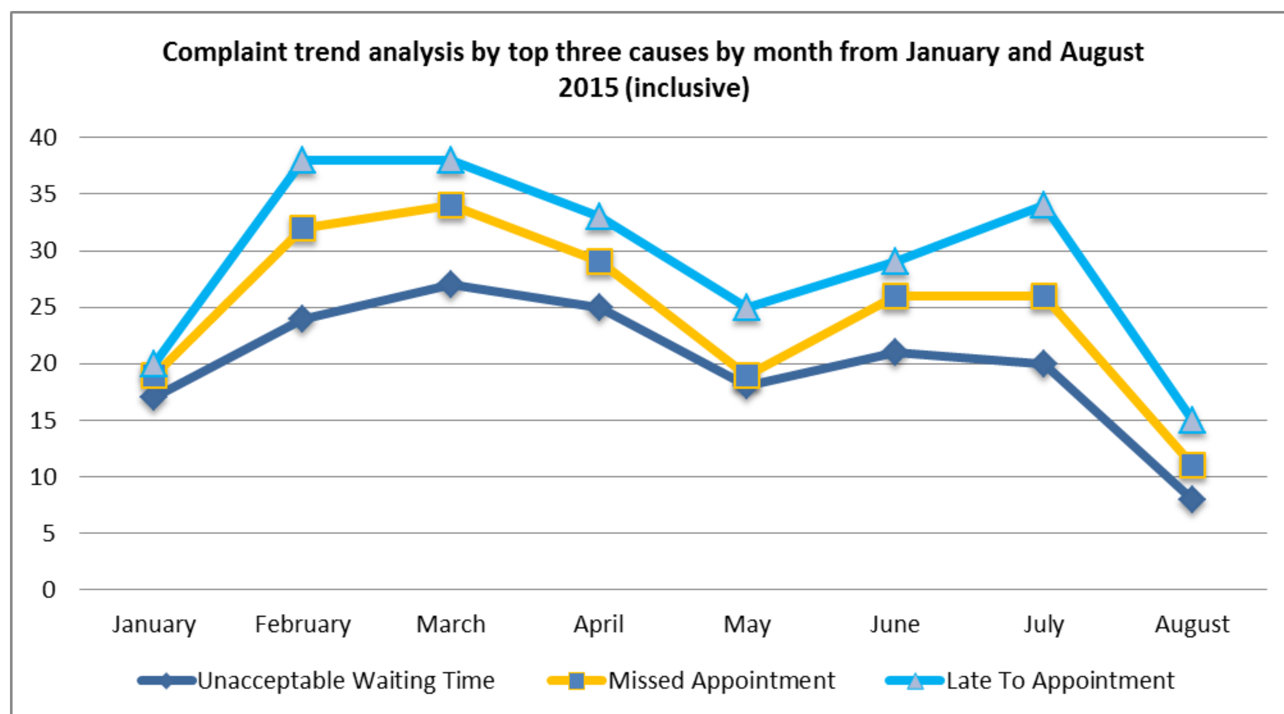


Whilst relatively low numbers can often create misleading trends, it is clear that timeliness is the biggest issue for complainants. Most of these relate to outbound journeys.

The number of complaints is typically 5-10- per month in total, with June the highest month during the period. This represents one complaint per 516 journeys; or a complaint rate of 0.2%.

Each CCG served by Arriva in the South West has a volume of complaints per month that is broadly proportionally consistent with the numbers of journeys conducted, i.e. CCGs with fewer journeys result in fewer complaints. The rate of complaints is not significantly dissimilar between CCGs.

The following shows the top three complaint reasons, and numbers, across the 4 CCGs in the South West served by Arriva.



To improve the quality of service provision, and to address the key performance and complaints issue of "timeliness" in its various guises, Arriva has recently made a series of process changes. These include wholesale changes to the staffing rosters across the South West area; revision to call-centre configuration, and new developments to enable better use of the Cleric software. These developments are covered in more detail later.

Feedback from Healthwatch Wiltshire

In 2014, Healthwatch Wiltshire indicated that it was receiving a number of calls of complaint regarding NEPTS. At joint CCG/Healthwatch/Arriva meetings in 2015, and more recent feedback, Healthwatch Wiltshire has indicated that the volume of calls received regarding NEPTS is now much reduced. Of the calls that are now being received, the majority are seeking advice on alternative transport options, rather than making complaints about the service.

5 FUNDING

The committee has requested details regarding how funding has been allocated and spent within the NEPTS service.

The contractual arrangement between the CCG and the provider consists of a block payment for the majority of the expected monthly demand. The remainder is a variable amount, at marginal cost rates, it is understood that this is similar to a number of existing WCC transport contract arrangements. This ensures that the provider has a minimum guaranteed income and above this, the CCG only pays for the activity that is actually conducted. This arrangement allows for fluctuation above and below the expected annual / monthly volume of activity, per mobility category.

The cost of each journey is determined by the patient's mobility, which will fit under one of 6 categories. (The number of mobility categories is currently being reviewed and revised to a greater number of categories; however these will all map back to the original six, and be a cost-neutral change). The mobility category then maps to the vehicle type, equipment required (wheelchair/stretcher/bariatric equipment), and number of crew required to safely move the patient. The more complex the patient's needs, the greater the resource required, and the higher the journey cost. An additional payment is made for any long distance journeys (over 65 miles one-way) above the baseline year total number of long-distance journeys.

CCG funding is intended to enable the provider to meet all their costs and overheads including staffing, vehicle depreciation, basing, fuel, other consumables, etc. Additional payments are made when and if Arriva achieve certain "stretch targets", known as CQUINs. In 2015/16 these can be earned by: exceeding KPI 5 and 6 (outbound journey) performance; improving communication with patients; working with acute trusts to reduce the volume of on-day activity they generate. Conversely, there are contract fines for underperformance against KPI 4 (inbound journeys); and for the longest delayed outbound journeys (when the patient is picked up more than 2 hours beyond the end of the KPI window).

6 CONTRACTUAL DEVELOPMENTS

Contract rebasing negotiations were completed earlier in 2015 and the contract amended accordingly. This has resulted in an enduring revised funding position, reflecting the known actual demand as seen during the first year of the contract, to enable the core service to better match known demand. This has also enabled the cessation of non-recurrent monthly top-up funding, previously used to purchase additional third party resource. It also enables commissioners' sole focus to now be on performance and service quality.

7 OTHER DEVELOPMENTS

Commissioners continue to seek the achievement of KPIs. In support of this, Arriva have and continue to put in place a series of continuous improvement measures intended to result in improved performance and improved patient experience. The principal examples are described below.

Longest wait analysis

A significant time waiting for transport has a significant impact on patients. A contract fine now applies to the longest waits. Arriva is carrying out detailed analysis, with the aim of improving the experience for patients. Their Locality teams receive daily reports to show patients who:

1. Are booked as pre-planned journeys and wait longer than 180 minutes (120 mins over KPI)

2. Are booked on the day of transport and wait longer than 360 minutes (120 mins over KPI)

Locality managers are then tasked with reviewing daily and following up any extreme waits to analysis the root cause, follow up with patients directly, as well as taking any appropriate action and sharing any learning.

Introduction of Dispatch Manager role

In March 2015 a new Dispatch Manager position was created to:

- Develop consistent practice across the team of dispatchers
- Oversee decision-making and intervene as appropriate
- Reduce delays and act appropriately to mitigate potential service failure
- Act as the first point of escalation

The role became permanent from 1 June 2015.

Review of capacity and rosters

Revised rosters were introduced at all South West bases from 1 June 2015. The key changes were:

- Extra capacity in the early and middle evening
- Extra weekend capacity
- Reduced overnight coverage (midnight to 06.00)
- Reduction capacity on Thursday
- Conversion of a small number of stretcher vehicles to seated ambulances
- Overall increase in the total number of planned ambulance hours (from c.4,200 to c.4,950 per week), partly through growth and partly through a change from double to single manning on some vehicles

Pre-planning more of the outbound journeys

Following a review of “booked time” versus actual “ready time” it has been possible to identify those clinics and departments where the patient is most likely to actually be ready, at the time the clinic initially expected them to be ready. For these clinics and departments it has now been possible to introduce a process of pre-planned outbound pick-ups. This in turn means less on-the-day planning for these patients and greater ability to make efficient use of available resources. Outbound journeys for over 300 clinics and departments across the four SW CCG contracts are now managed in this way. Inevitably the introduction of this significant process change had a detrimental impact on performance while it bedded in during June and July, as it also completely changed the way in which on-day bookings had to be managed. The benefits are now beginning to be seen.

Assisted Planning

In late July 2015 ATSL introduced Assisted Planning (AP) to the Bristol control room (which supports the SW contracts, including Wiltshire). This is a feature of ATSL’s Cleric (operational management, data recording and communications) system which allows the system itself to make planning decisions based on a range of rules, restrictions and other configuration settings put in place by Arriva staff. These settings, or business rules, include details of things such as:

- KPI requirements
- Mobility categories and associated minimum crew requirements
- Vehicle configurations to reflect all possible occupancy permutations
- Prioritisation of certain work according to contract requirements or local exceptions
- The time it takes to load and unload patients from vehicles based on individual mobility and location of appointment within the hospital

The Assisted Planning functionality creates a daily plan that is then reviewed and as necessary amended for any subsequent changes to booked activity; and to address any journeys that Assisted Planning identifies as “unachievable”. The functionality has already been rolled out across some 400 sub-locations across the SW contract areas, covering 87% of total daily activity. Where Arriva has implemented this approach elsewhere it has delivered a 3-4% immediate improvement in KPI performance.

Assisted Dispatch

Once the Assisted Planning function is fully implemented and stabilised, the next phase will be the introduction of Assisted Dispatch (AD). Like AP, this function introduces computer-aided decision making to the dispatch and real-time control process, and like AP, it is intended to support control room staff rather than replace them.

Through live GPS tracking, it makes suggestions about the allocation of journeys to vehicles as those journeys become ‘ready’. It also supports Dispatchers in processing and re-allocating journeys which had previously been planned but are subsequently amended. The strength of AD is in being able to handle thousands of scenarios every time an allocation decision is required, evaluating every possible seat and vehicle flow to deliver the strongest patient experience.

AD is a less well-developed function within the Cleric application and a significant amount of back-end work is required before implementation can take place.

With the complexities of the winter period being well understood, ATSL does not intend to activate AD in the live environment any later than Monday 16 November 2015. If that launch date cannot be achieved, the implementation will be delayed until an appropriate date in 2016 to be agreed with commissioners.

Managing the risk of failure

As well as their role in allocating patients to vehicles and managing enquiries from ATSL staff, the Dispatch team also manage escalation and the effective resolution of journeys which either may or will fail to achieve KPI.

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In July 2015 a new process for the standardised management and prioritisation of “at risk” journeys was introduced.

Courtesy calls

Every ATSL vehicle is supplied with a tablet device which also functions as a mobile phone. The concept of staff calling ahead at the start of a journey is not new, but ATSL will continue to further embed this practice and make it as meaningful as possible. The benefits of consistent, routine courtesy calls include:

- Personal interaction with the staff who will fulfil the journey
- Reassurance that transport provided by a named individual is on the way
- The opportunity to confirm a patient’s individual needs
- Any potential delay can be communicated more credibly
- The risk of an aborted journey is reduced

8 EXTERNAL CHALLENGES

The effectiveness of the service delivered by Arriva is only partly under Arriva’s direct control. There are a number of key external actions and influences which impact on the effective delivery of a high quality timely service to all patients. Some of these, and steps being taken to ensure they are appropriately managed, are summarised below.

Accurate booking information

ATSL depends on accurate information at the point of booking. Inaccurate mobility information can result in an aborted journey, delay for the patient, inconvenience for the acute trust staff and a waste of PTS resource. A review of mobility re-grading trends across all treatment locations, highlighting those locations and sub-locations where there are disproportionate cases of mobility codes undergoing either an upgrade or downgrade, has been carried out. This shows those occasions where the original mobility disposition was incorrect.
This analysis is being introduced into the routine Transport Working Group (TWG1) meeting reports shared with acute trust staff, so that appropriate action can be taken, i.e. to improve the extent to which the right mobility is booked, first time.

Moving location within hospital

As part of the monthly TWG reports, ATSL will highlight any areas within the hospital where there are high numbers of aborted journeys resulting from moving between locations. ATSL understands the negative impact this can have on the patient, the hospital and its own capacity. In real time ATSL Locality Managers will identify individual case studies, challenging where appropriate, and sharing findings and themes at TWG meetings.

Ready on time

Patients not being ready when ambulance staff arrive, is a daily challenge. The reasons vary, however the underlying principal that patients must be completely ready to leave the hospital is not yet fully embedded. ATSL continue to identify via the TWG those areas where journeys are aborted for this reason.

9 NEXT STEPS

A further series of developments are in train or are planned.

Demand forecasting and capacity planning

An improved internal process for capacity planning and demand forecasting is being implemented during September/October 2015. This will deliver:

- Greater flexibility to adapt to changing patterns of demand
- Better input into health system planning activities
- A better ‘early warning system’ for instances of potential risk
- Improved ability to match capacity to demand

All of which will improve patient experience and attainment of KPIs.

New mobility categories

The current set of mobility codes are very broad and may not cater to the complexities of all patients. As a result a new mobility classification system is being introduced. This separates patients into four core groups, each of which has a series of subcategories giving a total of 21 mobility codes versus the current six. These categories are used internally, so acute trust staff and others making bookings are not required to become experts in the details of 21 different mobility options.

The change will help ATSL determine the type of vehicle to send, the number of staff required, and gain information about any specialist equipment needed. Crucially, as far as online booking is concerned, this will also help ATSL identify bookings which require a further assessment of mobility or risk before the journey is undertaken (which might include

[1] Transport Working Group – monthly meeting between Arriva and Acute Trust sataff, also attended by Commissioner rep, to discuss operational issues, performance, behaviours, and actions needed to improve overall service delivery

a home visit). This will aid a reduction in aborted journeys; an increase in vehicle capacity utilisation, and crucially, an increase in positive patient experience.

Demand management

During 2015/16 ATSL will develop a new mechanism to articulate to the wider health community any known demand or capacity pressures. This will be aligned to existing, established health community demand management arrangements. ATSL will use a range of levers including known and assumed demand, known capacity, planned events and factors influencing service delivery in real time, in order to provide a snapshot of operating state (using a RAG rating) for internal and external consumption. The aim is for Arriva to provide reliable information about their operational resilience to the wider health community, so that other providers understand the potential impact on their own services, and can offer support where possible.

Service specification review

Acute trust colleagues have formally notified the CCG that the current service specification – although developed with their input – may no longer fully reflect the needs of the acute care setting, particularly with regard to the time delay for the on-day element of service (even though in the pre-Arriva scenario, the CCG did not fund any same-day service). A further piece of work is to be carried out to identify how better to meet acute trusts' needs while remaining within the limits of affordability.

National Study Day

Wiltshire and Gloucestershire CCG commissioning leads have designed and will lead a national PTS study day for CCG commissioners, in November. This is in response to the local experience and the knowledge that similar problems and issues are faced by many CCGs across England. The aim of the study day is to identify and share best practice against a number of contentious common issues of interest, with the ultimate aim of helping all to get a better service within affordability constraints. In particular it is hoped to be able to introduce locally any appropriate elements of best practice, to further improve and develop the local NEPTS service.

Total Transport Pilots

The aim of the Total Transport pilots are to see how all of the different ways of meeting transport need can be co-ordinated together so that the total transport needs of residents can be met by a Total Transport network. Although Wiltshire County Council did not bid for Total Transport pilot funding, the CCG's commissioner lead has, with a colleague from Gloucestershire CCG, been invited to attend and speak at a Total Transport seminar being held in October. The aim will be to discuss what such an approach could mean for NHS-funded PTS services. It is anticipated that there may be learning that can be brought back and applied locally.