

**SURREY HEARTLANDS CCG**

**SURREY PATIENT TRANSPORT SERVICES (PTS) ROUND TABLE ENGAGEMENT SESSION**

**NOTES**

<b>Date</b>	<b>Tuesday 24<sup>th</sup> November 2020</b>	<b>Time</b>	<b>9am-10:30am</b>
<b>Venue</b>	<b>Microsoft Teams Call</b>		

**Attendees**

<b>Name</b>	<b>Title &amp; Organisation</b>
Rachael Graham (RG) (Chair)	Deputy Director of Contracts: Non Acute and Primary Care, NHS Surrey Heartlands CCG
Katy Neal (KN)	Associate Director, Commissioning, NHS Surrey Heartlands CCG
Lyn Reynolds (LR)	Interim Consultant, NHS Surrey Heartlands CCG
Paul Greenfield (PG)	Contracts Manager, NHS Surrey Heartlands CCG
Veenu Sood (VS)	Finance Lead, NHS Surrey Heartlands CCG
Tatty Scott (TS)	Comms & Engagement Lead, NHS Surrey Heartlands CCG
Dorah May Hancock (DMH)	Chief Officer, Age Concern Epsom and Ewell
Dr Alex Norman (AN)	Surrey Downs Clinical Cancer Lead, and Surrey and Sussex Cancer Alliance Macmillan Clinical Lead
Nick Markwick (NM)	Co-Chair, Surrey Coalition for Disabled People, and Transport Lead

**Freedom of Information:** Those present at the meeting should be aware that their name will be listed in the agenda and action notes of this meeting, which may be released to members of the public on request under Freedom of Information requirements.

<b>1.</b>	<b>Welcome and Introductions</b>	
	RG welcomed everyone to the call.	
<b>2.</b>	<b>Purpose of the day</b>	
	<ul style="list-style-type: none"> <li>To share the latest position of the Patient Transport Service</li> <li>To listen and learn from our invited guests and hear, from a range of different perspectives, about real experiences of using and accessing the current Patient Transport Service</li> </ul>	

	<ul style="list-style-type: none"> <li>• Invite attendees to participate in a Round Table discussion that will support the identification of key themes and issues, strengths and opportunities and potential solutions and next steps.</li> </ul>	
<b>3.</b>	<b>Brief Overview of Current Patient Transport Service</b>	
	<p>RG presented the slide deck, and advised that this would I be shared with participants and published on the website in due course. The key salient points were presented detailing planned activity versus actual activity undertaken during June 2020. The reduction in journeys due to the pandemic was highlighted.</p> <p>RG confirmed that the option of enacting the permissible extension upon the contract is being negotiated and consequently, the procurement programme timeline has been extended with the extended timeline gives us greater opportunities to:</p> <ol style="list-style-type: none"> <li>1. Engage with key user groups, stakeholders and the market to redefine the service.</li> <li>2. Analyse the activity shift seen recently, which will impact on forecasting future activity requirements.</li> <li>3. Consider the outcomes of the NHSE national review for PTS and its outcomes/next steps, which is likely to form a more consistent national approach.</li> </ol> <p>RG reviewed the extended procurement timeline with participants each phase of requirements. The new service contract is due to go live April 2023, affording sufficient time to listen, learn and redesign.</p>	
<b>4.</b>	<b>Presentations/Experiences from user Groups</b>	
	<p>DMH reflected on the very personal transport service Age Concern offer/facilitate. It is a 1:1 service run by volunteers, has an easy to access booking process over the phone. For some clients, the volunteer is the only person they talk to. They like having that personal touch. Drivers take clients to their appointment/place/room and often stay with them for up to 2 hours in order to take them home again. The local PTS service is not so personalised. Clients find it long-winded; they are often picked up a long time before their appointment, wait for their appointment and then wait again to be collected. An internet based booking process for transport appointments is difficult for elderly clients and this is a current barrier. Clients can use Uber taxis easier and prefer to do this sometimes rather than use the main PTS service. The current Age Concern volunteer service however does not accommodate wheelchairs. Further patient engagement will provide more detail and DMH offered to help with the engagement programme.</p> <p>AN reported that whilst he has little insight into the local PTS service, he has asked colleagues, who have said that it can be a mine-field. Cancer services are moving towards a 28 day faster diagnosis process. Literally from seeing your GP the referral will go that day and you can expect a</p>	

phone call that day or within 24 hours. Hospital investigations are undertaken within a few days. Hospitals have said that patient transport service cannot cope with this rapid turnaround. Having arranged tests, the transport can't get the patients to the hospital in time. The response time is so important. The main feedback has been the long waits. Patients have reported that they do not want to use PTS as they are picked up too early, have long periods of waiting, cold, no advocate available to support them and experience the same when trying to get home, some of which has been as late as 10pm on occasion. PTS not turning up/reliability is another issue because chemo and radiotherapy patients have multiple appointments and these need to be regular. These also require multiple trips which could be planned in advance for the month ahead, removing the need to keep ringing/booking. Surrey has a large number of learning disability patients, care homes and complex patients needing lots of advocacy. These patients have a vulnerability needing additional support and the current PTS service is not suitable. Feedback includes some patients coming home at 2am. Most GPs are unlikely to know the current criteria to access PTS. The GPs job is to diagnose the issue as early as possible and signpost patients to access the support/treatment they need. GPs only have 10-minute consultation time per patient. Booking transport within this timeframe would be very difficult, particularly when delivering sensitive news that further diagnostic/treatment is required. GPs may also not have the information required for hospitals' patient transport booking forms. AN pleaded with commissioners not to revert the booking for PTS back to GPs. They are best placed to signpost. Whilst the current online transport booking process was welcomed, it is not everyone's preferred approach. Commissioners should make sure that there is not just a hot line number available, but other support is available too. The voluntary sector transport service is more personable, but patients usually have no idea that about the range of services that exist or how to access them. Covid has improved the awareness of services available, but there is still more to do. The main priority/focus is to get patients in quickly for cancer treatment and improve the reliability to reduce waits.

LR stated that commissioners had heard differing views about the level of GP involvement and that hospital colleagues have reported that they would like them to be more involved. AN advised that Covid has impacted the primary care workload significantly and the appointment time does not really allow for extended support. Appreciation that the GP is seen as an advocate but perhaps an administrative function could be at PCN level to provide wider support. A named GP is not necessarily relevant any more and someone with more time/dedicated role would be better to assist with access. It would be useful to engage with more GPs on this issue.

NM reported that the main issue for clients is timeliness. Timeliness of collection initially and then the wait to come home is what most people find distressing or annoying. Often hear of long waits of 4-5 hours, which is most distressing and one the reasons why people do not use PTS when they are entitled to do so. The separateness of the service delivered in the Surrey Downs area is the main issue. Due to being London facing, drivers often do not know the local area well. There is definitely a need to bring the system together into one contract. The social aspect is also a very important factor for patients, who are often isolated, having the same drivers would be beneficial. Taking a carer with patients is often pushed

down in importance. It is important for clients to have someone supporting them, although the cost of this, along with seating capacity is appreciated. The mobility status is very confusing, wrong vehicles are often sent. Volunteer car drivers are often older, some of which are now shielding, limiting their availability. This pool of people has made a huge difference but their availability has dropped dramatically. Nearly all recent GP/hospital appointments are via telephone/video. In the future, we could require a smaller cohort of ambulance type transport, have we assessed this? Within Surrey County Council (SCC) there are likely large transport costs, taking people to school and day centres etc. It is felt that we must be able to interact with this cohort/commissioner more closely. There are few community transport providers, availability of which also seems to have reduced recently. When clients phone to make a PTS appointment, they hang on for ages waiting for the provider pick up, which implies that the call centre is not working efficiently. The website app is also not very friendly, whilst more people that are elderly are using technology, it needs a simpler app. Patients requiring PTS have their eligibility re-assessed every few weeks - is this necessary? When clients have a condition or situation that will not change, why do they have to keep repeating themselves and their request? Obtaining PTS seems to be based on how assertive you are to get over the eligibility criteria threshold. Why would clients use PTS unnecessarily when they are subjected to long waits etc.? The quality of the PTS service when you are actually using it has, by and large, been very good. The drivers / team have been very nice, chatting to clients. However, poor quality has also been witnessed – shouting at people with dementia, but this was acknowledged as having been a long time ago. Quality is an important issue.

RG confirmed that commissioners are exploring wider economies of scale e.g. inclusion of Surrey Downs area, SCC etc. The contract extension period allows us an opportunity to explore these options. A question was asked if Surrey Downs still has the option to procure elsewhere. It was confirmed that Surrey Downs is no longer a CCG, and now comes within Surrey Heartlands CCG. Surrey Downs is an Integrated Care Partnership (ICP). ICPs are not a legal entity. Surrey Heartlands is looking to commission as a CCG and inclusion of potential other partners is to be determined. It is an aim to include renal in the future service. The geography and volume will need further exploration, particularly if remote appointments continue. The level of PTS needed requires more investigation/development. The extension period provides us with a stabilisation period to understand the activity and future demand and access to services.

An example was given during lockdown of a hospital consultation with Stoke Mandeville Hospital being held remotely by video, which would have been a huge cost if PTS was used.

AN re-affirmed the very good point made regarding the Surrey Downs issue. Particularly for cancer patients and patient choice. The ERS referral system books patients into hospital that is nearest / first choice / shortest waiting list. A GP might not know where the patient is going, so would not know what transport to use or how to access it. It was felt that the

	<p>assertiveness issue is getting worse, patients feel like you have to fight for everything, getting pushed back and feel like PTS don't want to take you. The Key Performance Indicator (KPI) should not be a reduction of conveyances. It was acknowledged that the Surrey Downs area is unique as it doesn't have a single acute to which the majority of its patient group leans, it looks to many different Trusts.</p>	
<p><b>5.</b></p>	<p><b>Round Table Discussion</b></p>	
	<p>TS asked what the best way to share information was. We heard from yesterday's round table engagement session participants that patients with learning disabilities are not plugged in to support networks, there is confusion about accessing PTS, so how do we best get information to them, particularly those who do not have good literacy skills. Is it best to utilise GPs, community centres, Community Prescribers? How do we get basic info to patients regarding available transport? DMH stated that they do not widely advertise their available volunteer transport service due to capacity. However, information can be found within their brochure and on their website.</p> <p>It was asked if any of the members use standard PTS, but only the local volunteer transport scheme information is shared directly with Age Concern members. The Information Advice Officer would be able to give more detail. Points of information sharing suggested were; GP practices, hospitals and social services.</p> <p>The Surrey Coalition of Disabled People probably share information on the website, but are more likely to do so via focus groups. The issues for patients with impairments was discussed and how they access services. NHS 111 has made some progress with texts, but the PTS website is not particularly user friendly, small text (which could be enlarged) and not easy to navigate. It is felt that the whole system is not transparent, GPs do not know who fits the eligibility criteria, and everyone needs to know the system. Often carer/family member is the first point of contact, patients with visual or hearing impairments will result in others booking on their behalf, but this does not eradicate the need to have fully accessible information for all.</p> <p>It was stated that there is 'no silver bullet' for sharing the required information. Websites and mandatory training for GP receptionists could be utilised to make the information more visible. There is a high turn-over of staff in primary care and Practice Managers could assist in a staff training package. The use of AccuRX – a text messaging facility stored in patient notes works really well and could be explored to see if this could be adopted for PTS. Transport needs appears on the front page of pan-London referral forms. It was felt that Social Prescribers could be used more. For patients' first referral and those not knowing system, there is a need to get the process right. Commissioning colleagues to check with RSS if a referral letter for hospital appointments is still sent. The vast majority of cancer referrals are processed very quickly, so this may not be the case for this patient cohort. This could be a touch point to improve the</p>	

	<p>process and information (e.g. provide a web link for a video etc.) The number of face to face hospital appointments may drop off, but cancer numbers are still rising and we are living longer etc., so more people will need diagnostics. We may remove/reduce seeing a hospital Consultant, but diagnostics will increase needing rapid transport.</p> <p>A letter is usually sent for routine hospital appointments. An example was given for an appointment at Dorking Hospital containing 5 pages of information, but nothing was included regarding getting to the appointment itself. The timeliness and appropriateness of paperwork needs reviewing. It was also reported that the PTS patient zone was not working – PG will investigate this.</p>	<b>PG</b>
<b>6.</b>	<b>Summary</b>	
	<p>The key points summarised were:</p> <ul style="list-style-type: none"> <li>• Importance of how you book, differing means of booking, sensory or access needs to be improved</li> <li>• Timeliness - waiting before and after appointments and all discomforts associated with these waits.</li> <li>• Social needs – recognition that for many, the service offers a means of social interaction</li> <li>• Quality – drivers and escorts, patient/user experience</li> <li>• Need for a rapid response – requirement for next/same day booking will increase.</li> <li>• Reliability – ability to make pre-bookings and confidence that once booking has been made the journey will take place</li> <li>• Tailoring of support to the service depending on patients’ needs</li> <li>• Central booking service – ability to get in contact with service, check times of arrival</li> <li>• Use of the voluntary sector and how we could network that to the contract/s awarded</li> <li>• Importance of carers and ability to accompany patients</li> <li>• Re-assessment – sometimes this is unnecessary, how do we best tailor the use of eligibility criteria and reassessment required.</li> <li>• Reduce anxiety – coming home late and carer has finished and anxiety of missing appointment when arriving late.</li> <li>• Make provision as local as possible to ensure timeliness.</li> <li>• Continuity of drivers might apply in certain circumstances.</li> <li>• Renal/Surrey Downs/SCC/Integration of system.</li> </ul>	
<b>7.</b>	<b>Next Steps</b>	
	<p>The next Round Table Engagement session is planned for 3<sup>rd</sup> Dec. These sessions are an opportunity for key users/groups/representatives to come together and share their views which will be collated into key themes and issues. The notes and slides will be on our website and an FAQ will be developed. Commissioners will review all feedback and devise future focus groups. Commissioners then plan to open up the learning from focus</p>	

	<p>groups to wider stakeholders, market engagement, testing models etc. The round table process is a conceptual start to the programme at this moment.</p> <p>The website will be kept up to date. A direct email address has also been established and will be shared with participants.</p> <p>Surrey Community Action supports the voluntary sector with transport schemes and could become involved in the wider stakeholder engagement in due course as they could be a potential provider. There will be a range of different engagement opportunities, but commissioners need to keep the commerciality elements separate and treat the market equally.</p> <p>RG thanked everyone for their valuable input.</p>	<p><b>TS</b></p>
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