NHS
Surrey Heartlands
Clinical Commissioning Group

SURREY HEARTLANDS CCG

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

Date	**Wednesday 9th December 2020**	**Time**	**2:30pm-4pm**
Venue	**Microsoft Teams Call**		

Attendees

Name	Title & Organisation
Rachael Graham (RG) (Chair)	Deputy Director of Contracts Non Acute and Primary Care, NHS Surrey Heartlands CCG
Lyn Reynolds (LR)	Interim Consultant, NHS Surrey Heartlands CCG
Janet Turrel (JT)	Administrator, Ambulance Contracts, NHS Heartlands CCG
Tatty Scott (TS)	Comms & Engagement Lead, NHS Surrey Heartlands CCG
Gemma Minter (GM)	Referral Support Service Manager, NHS West Sussex CCG (Sussex Commissioners)
Fiona McDowell (FMc)	Radiotherapy QA & Clinical Governance Manager, Royal Surrey NHS Foundation Trust
Steve Law (SL)	Occupational Therapist, Integrated Discharge Team, Royal Surrey NHS Foundation Trust
Paul Greenfield (PG)	Contracts Manager, NHS Surrey Heartlands CCG
Madeline Ludeman (ML)	Quality Manager, NHS Surrey Heartlands CCG

Apologies

Name	Title & Organisation
Becky Knight	Referral Management Lead, RSS Surrey Downs and Guildford & Waverley NHS Surrey Heartlands CCG
Filipe Alves	Clinical Site Nurse Practitioner Team Leader, Ashford and St Peter's Hospitals NHS Foundation Trust
Katy Neal	Associate Director Ambulance Commissioning, NHS Surrey Heartlands

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.

1.	**Welcome and Introductions**	

	RG welcomed everyone to the call and gained agreement for the call to be recorded from guest presentations for the purposes of the notes.. the recording will be destroyed thereafter.	
2.	**Purpose of the day**	
	RG outlined the purpose of the day: • To share the latest position of the Patient Transport Service • 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 • 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 step	
3.	**Brief Overview of Current Patient Transport Service**	
	RG presented the slide deck, which will be shared with participants and will also be published on the website in due course. The key salient points were presented on the planned activity versus actual activity undertaken for June 2020. The reduction in journeys was highlighted due to the pandemic. RG confirmed that the procurement is now paused due to the pandemic and provides us with three greater opportunities to: 1. Engage with key user groups, stakeholders and the market to redefine the service. 2. Analyse the activity shift seen recently, which will impact on forecasting future activity requirements. 3. Consider the outcomes of the NHSE national review for PTS and its outcomes/next steps, which is likely to form a national approach. A question was asked regarding the planning of journeys and how far in advance was this done? The journeys are based on an indicative activity/contract planning process, based on preceding years activity levels before the contract was let.	
4.	**Presentations/Experiences from user Groups**	
	GM initiated discussions and stated that she had not been given much brief about the requirements for today's session. RG confirmed that today was an invite to understand what are the most important issues from each participant's experience and what support is required to do things better. GM stated that the RSS team has limited interaction with the Patient Transport Service (PTS) booking teams, but understanding the process is the main issue for patients. For patients clarity of the process, guidelines on whether support is available, and information needs to be shared more widely. If patients are unable to use public transport then the RSS team tries to find a solution. When the users have gained access to the service there hasn't been much interaction on this with RSS but the feedback is positive, with nothing negative to raise. There have been no issues for	

	rebooking transport, but the RSS team only speak to a small cohort of planned care patients, who are often supported by family/carers. A question was asked whether RSS get involved in the booking of transport. If the patient is confused, then yes, but generally the queries are dealt with by the Medical Secretaries in the GP Practices who help to signpost the patient. A question was asked if GM thinks that RSS could have a role to play in the transport booking process. GM thought yes, but only if the information is made known to the team on the referral. TS outlined that within the first Round Table session with a GP, he suggested looking at the RSS process for which there are three who all work differently. GM outlined that her Team tries to contact each patient by phone, whereas other RSS teams have an automated letter sent by external contractor. There is nothing in the past or current referral script to ask the patient if transport is required or if they have ever used it in the past. Although this is not in place now, GM thought that this could be addressed/developed for the future. The wording for which, will need to be agreed to ensure correct eligibility is applied. The booking process is presenting as a key theme for reflection and improvement and in particular, how different parts/services can assist this process. The RSS team aim to lift stress from the practices and patients and assist where possible. FMc outlined that radiotherapy services are different in that the patient's cancer pathway and associated timescales are pre-determined. There are complicated pathways for treatment and these could include multiple trips and/or daily trips. The team tries not to prompt questioning patients whether they need transport, but they try to triage if they are asked. The booking if required, is done by the Radiotherapy admin team. Generally PTS works well. The complex nature of the RT treatment pathway and associated appointments can change and sometimes PTS is not informed of this, as a result, patients arrive at the wrong time, although the root cause for this is a mixture by both hospital and PTS staff. The biggest problem is timeliness; timings are not as they should be. When complications arise, or if the turnaround times are not as intended, then the re-booking of transport does not work well. The comms are not brilliant with PTS and the Radiotherapy team. The team do have the facility to take patients to the discharge lounge if needed. If a patient requires a 'on the day' return journey, the team tries to book these before 2:30pm to avoid return issues. In the past, some of these journey types have gone wrong (following an extended appointment/treatment or error in pickup time) and the patient has had to be admitted to wards as they are unable to get home. FMc outlined another issue for patients who require urgent radiotherapy treatment for metastatic spinal cord compression which should be delivered within 24hrs of decision to treat. This treatment is not deemed a medical emergency therefore doesn't need a blue light ambulance from another hospital. PTS when booked Mon-Fri is not too bad, but the department operate an on-call system at weekends, which is it can go badly wrong. Patients have probably concluded their treatment by 1.30pm, but this coincides with PTS shift handover, resulting in the patient not being collected until up to 5pm (on a Saturday). The hospital then incurs extended premium rates of pay for radiotherapy staff to stay with the patient until PTS arrives, without the facilities to care for them. FMc stated that	

	PTS doesn't seem to think outside the box, why can't a private provider be allocated to get the patients back in a more timely way? On average this happens once a month. Having an alternative service to call upon would be helpful. Treatment can take 3-4 hrs so a wait and return approach would not be appropriate as this takes up resource to wait with the patient. But there needs to be improvement in the speed of response. The current standards are not written to fit with the service requirements. The department features highly in users of PTS. The Hospital Ambulance Liaison Officer (HALO) has made a huge difference, but she finishes at 3.30-4pm, leaving no one on-site available thereafter. The individual is fabulous and when she is on holiday, the Department notice her missing. This role is key. The procurement team has had feedback from GP participants, outlining the cancer treatment timeline and targets, which have been compressed underlining that timeliness now is absolutely key. Some patient groups will start treatment within 14 days from referral. The Radiotherapy team works on bank holidays and some patients are brought in for treatment by their relatives but some will need PTS. There was an incident last week where a wait and return facility would have worked very well. The patient came from Frimley and had significant mental health issues. The delay in PTS resulted in their medication diminishing. This example/patient would have been an ideal candidate for a rapid return journey. Acknowledgement was given that this is not feasible for every patient. There needs to be an escalation or approval process required to discuss such individual needs for this type of response. TS asked in what way the comms is not good between the radiotherapy team and PTS for return journeys and whether FMc could give any examples or potential solutions. A live update would be helpful, the Radiotherapy team often feel that they are not being told the truth about arrival times for return vehicles and not informed of the full picture. Sometimes it takes so long to get through on phone, the comms needs to be more robust and transparent. The team uses the messaging system, online, and sometimes the phone. The Instant messaging is web based like Skype. The live system allows you to track vehicles and training/refresher courses can be offered to staff if needed. FMc stated that she is not sure there is a training issue. The volunteer drivers may not all be tracked; therefore no update on arrival/collection can be gained for them. ML asked if the HALO has helped with this issue. To which the response was yes, the team use the HALO as much as possible, but if she has left for the day/weekends, there is no on-site support. Utilising a Private Ambulance would be more cost effective than making staff stay late, which on average happens once a month. If radiotherapy is unable to use normal PTS provider eg for cord compression patients at weekends, the provider should be able to commission a private provider to cover. Would a HALO help at weekends, if working hours avoided shift change? It was acknowledged that the bulk of their workload is in the morning Mon-Fri and ideally, they need to be extended to 6pm. The HALO starts work at 7:30am currently. SL outlined that PTS is a hot topic and he echoed FMc's comments, the themes/issues encountered within his experience/team are the same.	

	There is a need to have greater insight into the clinical need for patients. The Emergency Department (ED) typically will need PTS for the presenting elderly/frail/wheelchair patients, responsiveness and flexibility is a key theme. The Outpatient Departments use PTS in bulk but when ED needs PTS, this needs to be responsive to clear ED quickly. Historically two years ago, patients were being admitted overnight. Funding was made available from Guildford and Waverley CCG for use of community transport ~~the Hopper~~ services ~~transport service~~ to assist. In the two week period the team were monitoring, there were 19 overnight admissions due to patients being unable to be collected by PTS. The Department would try to book and wait for hours. They need to move patients to maintain flow at the hospital. Frail patients who had presented following a clinical episode/fall are at risk of fatigue and high risk for admission. Patients would sit around waiting hours after their consultation with many then subsequently taking 2 hours total journey time to get home thereafter. SL stated that patients who have been brought in via 999 Ambulance staff, seem to have very different manual handling training compared to PTS staff. There have been two patients this month, brought in by 999 and when PTS was been booked by ED, they couldn't take them back and then had to re-book for a crew of 4-6. ED have used a Private Ambulance provider ~~- LSA Secure,~~ who also have a crew of two, so why was PTS unable to accommodate these journeys? Flexibility to change is an issue. Once when SL was working late with a palliative patient on a Friday at 6pm, he didn't even try to book PTS at this time and contacted a local community service ~~Hopper~~ instead. They discussed the priority of patients already booked, ~~; Hopper~~ listened and clinically prioritised their journeys accordingly to accommodate the request. The HALO in place makes a great difference, but she is not available for the full day and not able to help with clinical prioritisation. Flexibility and responsiveness are the main issues. PTS doesn't feel like it is designed around ED needs, the contract hasn't moved on. There is now quicker discharge processes, a frailty team in ED, but PTS is not supporting the discharge planning. The manual handling training needs to be the same as 999 and private ambulance staff. SL was unsure if this was a risk aversion approach or a training issue – probably both. Acknowledgement was given that 999 staff training is vastly different due to the presenting clinical need and PTS is different and not an easy fix, but the current approach is leading to unnecessary overnight admissions. The ED team book PTS directly. The system doesn't offer the greatest information and staff are often told to speak to the HALO or the PTS office directly. Staff often give up and use the local community ~~Hopper~~ service/alternatives. The HALO has upskilled the team using the online booking system and the incoming stack/live information works well. The largest part of patients' needs is to get back in a timely manner to meet their family/carer. The local community service ~~Hopper service~~ seems to respond to this request better.	
5.	**Round Table Discussion**	

	RG summarised the key themes arising from the presentations, some of which have been stated in other sessions:~~:~~ Flexibility Responsiveness Agility Specificity (tailored response) From a radiotherapy patient's experience, who are often an elderly cohort, greater consideration is required. The patient could be the main carer of an elderly spouse therefore, the service needs to be more responsive as the patient may have left someone at home whom they need to get back for. If they don't get home in a timely way, there could be a catalogue of issues as a result. Often these elderly carers are keeping people out of hospital. There is a perceived lack of autonomy of crews. They seem to work to a list and a logistics pattern. They are unable to listen to clinicians and prioritise patient needs. There is interface with the PTS crew, but there is no flexibility. The local community ~~Hopper~~ service crew has autonomy and they are in control of their workload. They are able to discuss priority with clinicians that makes the difference. RG stated that it would be interesting to know the total spend on all the additional private and community provisions by clinicians/hospitals, as there is currently a lot of layering. FMc outlined that her team offer treatments that are not available elsewhere in the South East of England. Once, when their specialist equipment was broken, the nearest available alternative treatment centre was Nottingham. Patients needing this type of treatment are not able to have surgery and are not able to drive, so they need to use patient transport to go out of area. When patients need to be seen out of area, including if they have to be transported to other nearby CCG areas, these authorities have different PTS providers. It isn't clear which transport service the radiotherapy team should use and the team doesn't have direct contacts in other CCGs. These patients need to be seen quickly. The team doesn't have the time or manpower to track down the correct person at the respective CCG within the timescales they work to. It's an issue for the Radiotherapy Dept and there isn't any joining up between the different CCGs in helping with the issue. Perhaps Surrey Heartland's PTS provider could take on the arrangements and reimbursements, not the clinical services providing the care~~-~~. Currently radiotherapy often pays from its own budget to resolve this. The scale of commissioned services could make a difference, but individual GP registration and the potential to better join services across our region in Kent, Surrey Sussex was noted. The eligibility criteria was discussed. This is a cause of concern for ED. An example was given of an alcoholic patient who needed to get home and a taxi nor would PTS accommodate the request. The local community ~~Hopper~~ service agreed to take him, avoiding senior staff and police involvement. The consideration of exceptional needs is required. Care	

	pathways are less rigid d now, it's so much more flexible now, but PTS is too silo-ed to fit with this change. Flexibility, reactiveness, timeliness is needed to protect patients to get the required speed of response. ED needs rapid discharge and re-occupancy of beds. Covid is also an issue on the patient's experience, sitting in full waiting areas due to PTS waits. This was less of an issue in the summer, but now the cold weather has added to this issue. There is a need for the ability to go outside of the eligibility criteria in exceptional circumstances. PG asked if the PTS Controllers who were previously available on site at the hospital worked better. SL confirmed that they worked really well, had the ability to take control and were the interface for decision making. This role would probably help with autonomy/extended working HALO role as mentioned previously. Someone/a PTS Controller on site to manage crews would help with bespoke requests and/or special circumstances. An open discussion regarding risk would be accommodated. FMc was unaware of the previous PTS Controller role. TS stated that when speaking to RSS colleagues and their attempt to book PTS, they had been informed that the patients had to book themselves. Had colleagues had any issues/requests to bring vulnerable patients to the phone to book PTS? FMc was not aware of these problems as they would have come into the respective Depts. via PTS. FMc stated that there had been occasional issues when teams haven't been aware that the patient is a bariatric patient. The hospital pathway is now being reviewed. If the referral is received via the phone, there is no way of knowing unless a weight question is asked. SL stated that he had not had problems/requests to bring bringing patients to the phone. TS shared previous discussions with SEEability and the Surrey Coalition of Disabled People regarding patients having a Care Passport. When patients arrive, their particular needs are clear and have the relevant information to share. Do colleagues have any experience of this? SL stated the he is familiar with the 'This is Me Care Passport' for learning difficulty patients which can be completed in hospital. It makes a difference, not particularly to PTS, but can confirm any issues. It was confirmed that the HALO has helped with any issues arising and all incidents are placed on Datix and reported to the provider. The contract is the main issue along with the KPIs. The system has moved on but the PTS has not. RG stated that there is an opportunity for the next contract to change the service spec associated KPIs and quality requirements. We have the ability to refresh the important elements and facilitate better experience for patients and stakeholders.	
6.	**Summary**	

	The key issues and themes are being collated from each session. Focus groups to discuss these in more detail will be developed in due course.	
7.	**Next Steps**	
	All Round Table notes, slide deck and subsequent FAQs will go up onto the website, the link for which will be shared by TS/CCG team. Further opportunities to engage in the future will be available and the CCG will keep participants appraised. Once the Round Table Engagement sessions have concluded, the themes coming from these will be reviewed and specific focus groups will be established in the new year. There is lots of opportunity to continue to talk, listen and shape future service. Participants were invited to continue to feedback through the website. RG thanked everyone for their valuable input.	