NHS
Surrey Heartlands
Clinical Commissioning Group

SURREY HEARTLANDS CCG

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

Date	**Thursday 10th December 2020**	**Time**	**1pm-2:30pm**
Venue	**Microsoft Teams Call**		

Attendees

Name	Title & Organisation
Katy Neal (KN) (Chair)	Associate Director Ambulance Commissioning, NHS Surrey Heartlands CCG
Rachael Graham (RG)	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
Dr Lucy Jane Abbott (LJA)	Consultant Geriatrician, Consultant Geriatrician, Chief of Service for Community Services and Older Peoples Medicine, Frimley Park Hospital
Sara Reeve (SR)	Logistics Co-ordinator, Surrey and Sussex Healthcare NHS Trust
Virginia Porter (VP)	Discharge Liaison Administrator, Surrey and Sussex Healthcare NHS Trust
Joanna Smith (JS)	Outpatient Booking Office Manager, Surrey and Sussex Healthcare NHS Trust
Paul Greenfield (PG)	Contracts Manager, NHS Surrey Heartlands CCG

Apologies

Name	Title & Organisation
Charlotte Broughton	Head of Patient Experience and Involvement, Ashford and St Peter's Hospitals NHS Foundation Trust

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**	
	KN 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 deleted thereafter. Each participant introduced themselves and outlined their respective role.	
2.	**Purpose of the day**	
	KN 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**	
	KN 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. SR expressed surprise that the outlined proposed one year extension of the current PTS contract to 2023 had not been communicated to Managers at Trust level. KN explained that the decision had moved at pace in light of the reported incident Level 4 due to Covid. Commissioners have only just began dialogue with the Provider regarding the potential opportunities around a possible extension and this is not yet formally agreed. Once a formal position is available, then appropriate comms will be issued. SR outlined that the Surrey and Sussex Healthcare NHS Trust (SASH) serves two main PTS contracts (Surrey and Sussex), for which there are a few differences in the contracts. Concern was raised that if Surrey goes ahead with its intentions, it will not dovetail with Sussex and creating risk of differences between the two contracts, some of the current recommendations being made in the Sussex spec may affect Surrey, resulting in split patient experience. Horley was given as an example of this,	

	which straddles both counties. This was acknowledged and KN confirmed that the Surrey commissioners are in regular contact with the Sussex commissioners. Despite the differing procurement timeframe pathways, both commissioning teams are committed to align process, KPIs and patient experience as far as possible.	
4.	**Presentations/Experiences from user Groups**	
	SR outlined the main issues for her hospital is HALO cover. At the beginning of the contracts both Surrey and Sussex had a Hospital Ambulance Liaison Officer (HALO), but then one moved, which left only one for Sussex. When the Provider was challenged regarding this decision, it was stated that there only has to be one for each major Trust and that being on site was not in the spec. PTS has since then been managed by the Sussex HALO, which has been very detrimental. If the Sussex contract changes in 2022, this may further impact the Trust and Surrey commissioners. Commissioners need to make sure that there is robust wording and clarity of working arrangements and hours for the HALO. The PTS contracts needs to change/move with the changing times. Packages of care, Rehabilitation, End of Life patients were not relevant in the past, so the service needs to build in robustness for these. The contracts are currently predominantly based on the need to pre book, but PTS requirements are more 'on the day' now, not pre-booked. When the patient is ready, they need to go. A plea was made to try and resolve this going forward. There are now increased numbers of complex and bariatric inpatients, requiring more resources for rapid discharge arrangements. Recently, one vehicle has been out of service, affecting discharging/transporting patients appropriately. There is no facility for a stretcher wait and return process in the contract. Whilst appreciation was given that restriction of clinic rooms and their availability was not a PTS issue, the Trust has worked hard to get patients seen immediately and returned home asap. This is an issue for Trusts. More emphasis is required for Surrey sectioned mental health patients, who require a stretcher. The Provider, who is usually assigned, do not have stretcher facility. The Hospital then usually has to deploy its own private Trust vehicle with the patient under sedation. SR has agreed with the Provider to include a facility within the booking process to highlight a package of care timeline so that Palliative/End of Life patients can be prioritised. There is also an issue with risk assessments being completed for patients going home on a stretcher for the first time. Acknowledgement was given that this process is useful to stop aborted journeys / problems. A clear process/SOP is required so that the request is logged and is trackable from when the ward rings up to book the risk assessment until it is carried out. These requests are currently getting lost in the system which is causing problems.	

SR asked for the continuation of the joint Surrey/Sussex contract meetings, which have previously worked well; but for these to be extended with the consortium of hospitals/wider system partners.

LR asked PG to check the spec and bid response regarding the on-site HALO issue raised.
Action: PG

KN asked SR how the risk assessment process has worked elsewhere. It seems to be a local Provider issue. A minimum of 24 hours' notice is required, so if requesting a risk assessment on a Thursday, the patient can wait until Tuesday to get collected as risk assessment can't happen until Friday/Monday. The comms/process to book a risk assessment needs addressing. Clerks and Nursing staff on different shifts can make duplicate bookings as the requests often gets lost in translation. There needs to be a confirmed booking process for risk assessments to address this.

LJA joined the call.

JS shared a slide of PTS common issues and themes from the agents receiving calls at SASH:

1. Unable to get through to the Transport line. Two separate phone numbers for Surrey and Sussex with only 1 digit difference at the end, resulting in patients calling the wrong number as well as struggling to get through. Patient's NHS number is also required which they don't always have.
2. Declined PTS, but they have a disability
3. PTS not arrived
4. PTS stating they collected but patient is still waiting with no contact made.
5. Appointment time is near or past and PTS is en-route, so a call has to be made to the outpatient dept to check if they can still be seen as they will be late.
6. Patient not informed if PTS is late, no courtesy call. A central email address is needed, as there is no one to speak to.
7. Special requirements/larger team/hoist/stretcher/bariatric comms is broken down. Incorrect PTS vehicle is sent, appointment then missed
8. Patient taken to the wrong hospital.

The booking team are not familiar with the current eligibility criteria.
Action: PG to send eligibility criteria to JS. ***Post meeting note – action completed***

KN asked what happens when the wrong vehicle arrives to convey patient to their appointment. The patient then calls the hospital, the vehicle leaves, so the patient is not seen, recorded as a DNA unless comms made in suitable time. This is not meeting the Referral To Treatment target, as the Consultant may need to see them. There is a constant issue for hoist and stretcher patients arriving late and with clinic time constraints, the Consultant often will not be able to see them,

	LR asked if Sussex PTS is experiencing the same issues for telephone pick up. It was concluded there were challenges across both areas. Sussex are not on the virtual platform, which is why there is a different number. JS reported no access to the Provider's online booking service. PG to organise training / progress access to the online system. **Action: PG** SR reported that there is an online screen in the outpatient office. SR will contact HALO to liaise with JS. The system provides up to date ETA and instant messaging. PG to mention this on the Friday catch up call with the Provider. The Provider contract meetings take place monthly; JS will be invited to the January meeting. **Action: SR** VP stated that the HALO impacts on her team when he/she is not available. There is a good connection with the discharge unit, who are finding increasing PTS issues are going to her team not to the HALO due to lack of availability/visibility. VP's team have had mixed experiences using the instant messenger facility. After the HALO has left for the day, they used to be able to ring the Provider but now the Health Care Professional facility has been taken away and could this be explained. PG stated that the Provider requested a change of approach as a pilot for December to help with managing patient and system demand in light of the impact of Covid and to help support the call centre currently experiencing high sickness levels. The escalation process can be found in the ward folders including details for the on call manager. VP outlined that the on-call manager was contacted the other night but the call went to voicemail. The call was time critical, as the patient was sitting in the discharge lounge most of the afternoon. Patients are not arriving back at their Care home by the agreed cut off time. SASH colleagues then have to inform Social Care etc. The repercussions of these late care home patients have a ripple effect. VP used instant messenger, but gained no reply/unable to assist; a real time solution is required. The on-call Manager is part of the control room team and Operational team. PG will mention to the Provider regarding the instant messenger issue. PG stated that the pilot may change in January. A request has been made for the HALO to be on site asap to cover both Surrey and Sussex. An enquiry was made regarding the booking system and whether this is an 'off the shelf' product unable to make changes. PG outlined that it is part of a Cleric system and that changes should be able to be made. A recent deep dive outlined over 45 reasons why discharges do not happen on the day. These included: • PTS - mobility matching with journey. This is totally reliant on the Ward Clerk choosing the correct mobility. SASH are working with the Provider on this. PTS not arriving in agreed timeframe – SASH have built the 2 hour KPI window into their booking process. (e.g. the care package commences at 4pm, so the booking is entered on the system at 2pm, with encouragement to collect the patient asap) • TTOs - ready on time/juggle to avoid cancelled/aborted journeys.	

	• Booking system - Keen to look at system to have mistake proofing in booking process to assist. • The Pick-up time - has no mandatory field for required delivery time. Daily phone calls occur for packages of care in the community setting as patients are not being picked up in time. Stretcher patients in particular, taking over 2 hours and the service providers/families are then disrupted. There are also multiple care homes with different rules regarding delivery deadlines. PG will discuss the above with the Provider. Notes can be added into the system when booking, but it only allows for two lines of journey notes, which are reliant on the user to add and is not mandatory. KN acknowledged these issues for future spec consideration. Discharges are much lower over the weekend. The hours of HALO coverage are not aligned to the discharge team which operates 8-6pm and weekend coverage. Cultural learning is needed, SASH colleagues are keen to increase morning discharge and will be approaching the Provider for the data/split of journeys to adjust discharge process accordingly where possible. SR gave an example where the virtual platform was not working to its optimum. Late one Monday evening, a Sussex patient was left at Royal Brompton Hospital after an outpatient appointment. After trying the Provider's desk for Sussex, she went through to the Provider's desk for Surrey, to be eventually put through to the Hampshire Provider's desk, where she spoke to a rude staff member. She was informed that ETAs are not given to Health Care Professionals, but was eventually given the information begrudgingly by the Provider's staff member. LJA outlined her PTS experiences as a Geriatrician with a clinical perspective. She resonated with previous discussions, which are the same at Frimley Hospital. LJA works across acute and community hospitals with frail patients. Her team are promoting the use of step up beds in community hospitals and the main issue is PTS - booking transport and arrival take too long. No medical staff are available in the community hospital overnight. so patients have to arrive by 5pm latest. If PTS/the patient is delayed, then there is no Dr to book them in, resulting in a transport to Frimley A&E. This is not a good experience for patients who are already frail/suffering with dementia. The night time transport from ED is invariably required at 4/5pm. This is a huge issue. Patients are being admitted overnight due to no transport. An example was given when this group of patients are coming from a community setting, who require a CT scan/assessment via ED, there is no transport to get them back to their community hospital bed. Delays in discharge occur when home access/bariatric assessment is required before transport can be booked. The assessment process seems lengthy. Many of these patients are in/out of hospital on a regular basis, so why are their details not kept on the system for stairs/crew required etc., to speed up the process?	

5.	**Round Table Discussion**	
	KN summarised the key themes arising from the presentations, some of which have been stated in other sessions: SASH HALOs discrepancy in responsibility for Sussex and Surrey if procured separately. A better understanding on the accessibility for hours available is required. Comms between partners in system managing messages – come together as a consortium to share circumstances, share issues, availability and accessibly to contact PTS to understand patient delay issues. Wait and return to support the Outpatient Department, step up beds/swift return to a community bed may help support a timely and responsive service . Challenges for patients with mental health issues and having the appropriate transport across 999/primary/ad hoc. This was recognised by commissioners and part of ongoing discussions with the current Providers. The quality of care to the patient is paramount. Palliative care patients and journey delays are prevented and facilitated. Risk assessment delays. Information for the patient – streamline the process so there is no need to repeat. If patients have a long-term condition, ensure this is captured on the booking system, so it does not have to be repeated. TS asked if participants had any experience of PTS bookings only being accepted if the patient speaks to the Provider directly. This could be more relevant for outpatient appointments because if they are an inpatient, the booking is made by the Ward Clerk/Nursing staff. Sometimes the Provider will ask for more information.	
6.	**Summary**	
	The themes from a clinical perspective resonates with the operational challenges. It has been valuable to have found some immediate actions. **Action: PG to support with instant messenger/access and look at requirements for HALO recognising disconnect with Surrey and Sussex.** **Action: SR to send Joanna's email details to PG** The session was useful to understand from an on the ground experience. Concerning to hear about wrong transport being sent and the impact of that.	

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. The Sussex discussion will continue and commissioners will align where possible. SR enquired about the Surrey Downs PTS and renal contracts. These are part of the options beings reviewed. If an extension is agreed, there will be no change until the new service in 2023. Renal is also being considered in the National PTS Review. KN thanked everyone for their valuable input.	