healthwatch
Brighton and Hove

Users' perspectives on the Patient Transport Service April - September 2016

Perspectives of Renal Outpatient Department patients at the Royal Sussex County Hospital, Brighton

Contents

1. Introduction

Early in September 2016, Healthwatch Brighton and Hove was approached by a patient who was attending the Renal Outpatient Department at the Royal Sussex County Hospital (RSCH). The patient voiced serious concerns about the Patient Transport Service (PTS) operated by Coperforma. As a result of that encounter, Healthwatch decided to undertake a review of the PTS by interviewing patients at the Renal Outpatient Department who used the service.

The Chair and Chief Executive Officer (CEO) of Healthwatch witnessed at first hand the personal distress of people waiting for two to three hours for PTS after a four hour treatment. We talked to Mrs S, a woman in her mid-70s and an amputee using a wheelchair, whose transport had been two hours late that morning. She had missed her treatment slot and had to wait for the afternoon session. When we met her after 6pm, her treatment had finished and she had already been waiting nearly three hours for transport home. No one was able to give Mrs S a time when she would be picked up. Staff commented that a driver, who had just been to the ward and taken other patients, had not taken her with him. What surprised Healthwatch was that no one - patients or staff - thought this was an unusual event: this was 'business as unusual', a daily occurrence.

Prior to September 2016 Healthwatch had already raised serious concerns about the performance of Coperforma. Earlier in the summer we had carried out an extensive service review in eight Outpatient Department (OPD) clinics at the RSCH that included the Cancer Centre and other clinics where people required patient transport. The primary purpose of that OPD review was to assist the RSCH quality improvement programme, and it had been undertaken at the request of the hospital and with the support of Brighton and Hove Clinical Commissioning Group. The OPD review involved Healthwatch interviewing 118 patients. During that review we heard stories of transport not arriving to take patients to radiotherapy, patients being unable to make contact with the Coperforma control centre to check arrangements, and people with complex needs, e.g. requiring a bariatric ambulance, having appointments repeatedly cancelled.[1] Healthwatch raised these issues at a number of forums including Brighton and Hove City Council's Health Overview and Scrutiny Committee and the Health and Wellbeing Board.

[1] Patients' Perspectives of the Royal Sussex County Hospital Outpatients' Departments, July 2016 Overview Report.For individual reports see: http://www.healthwatchbrightonandhove.co.uk/what-weve-done/healthwatch-reports/

Healthwatch is also currently committed to reviewing patient experiences of PTS across a wide range of outpatient settings as part of a cross-Sussex programme. That work has been negotiated by Healthwatch East Sussex on behalf of Healthwatch West Sussex and Healthwatch Brighton and Hove with the High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG).

The request of patients at the RSCH Renal Outpatient Department for Healthwatch to step in and listen to their concerns was compelling. We decided to use our 'Enter and View' statutory powers to gather patient experiences at the Renal Outpatient Department. We have agreed with HWLH CCG that our results and report will be part of their Patient Safety and Quality Review processes. The fieldwork and interviews took place within two weeks of the initial meeting with a patient in mid-September, with the full cooperation of senior management and ward staff at the RSCH. We extend our thanks to staff at the RSCH for supporting the project.

2. Background

Healthwatch Brighton and Hove was made aware of the initial failure of the Patient Transport Service (PTS) when it was transferred from South East Coast Ambulance Service NHS Foundation Trust (SECAmb) to Coperforma in April 2016. In the period from April to September 2016 Healthwatch did the following:

- Gathered patient experiences of PTS through the Healthwatch Information Line.
- Helped people make complaints and provided advocacy through the Healthwatch Brighton and Hove Independent Health Complaints Advocacy Service (IHCAS).
- Shared our concerns with the Care Quality Commission (CQC), Healthwatch England and our local Brighton and Hove Clinical Commissioning Group (B&H CCG).
- Healthwatch Sussex-wide – East and West Sussex Healthwatch organisations and Healthwatch Brighton and Hove - shared concerns about the PTS with the High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG), who acted as lead commissioner for Sussex-wide PTS services.
- Healthwatch Sussex-wide offered to gather patient experiences and report those systematically to HWLH CCG.

On 8th August 2016 an independent Internal Audit Agency (TIAA) review, commissioned by HWLH CCG, was published ("Adequacy of the mobilisation arrangements for the new Patient Transport Service contract"). The comprehensive failure of the PTS in Sussex during April and early May 2016 was highlighted in this

report, and we shall not rehearse the same material again, other than to echo findings in the report that we also heard directly from patients (TIAA Executive summary section 2):

- The new service was markedly different from what had been provided before – clearly a different model of service delivery
- There seem to be underlying problems with the service beyond those of handover and set up of a new service
- There was a serious failure to have contingency plans or a clear pathway for corrective action when things went very badly wrong.

The summer of 2016 in Brighton and Hove was a challenging time for the health and social care services. Brighton and Sussex University Hospitals NHS Trust (BSUH) had an adverse CQC report and Healthwatch had provided evidence to that inspection. The Trust was subsequently placed in 'Special Measures' by the CQC. SECAmb also received a critical CQC report and was later placed in 'Special Measures'. Some GP practices were also placed in special measures, one GP practice had been closed by the CQC, and B&H CCG was rated 'Inadequate' by NHS England.[2]

Through the summer Healthwatch, Brighton and Hove City Council's Health and Wellbeing Board and local people had repeatedly received assurances from Coperforma and HWLH CCG that the PTS was recovering from the poor early start to the contract, and that performance was improving and near to target levels. The claims of improvement did not reflect continuing patient reports of poor performance:

- Individual complaints, comments and requests for advocacy support to Healthwatch continued. We also received reports of deficits in the PTS from research undertaken at the Royal Sussex County Hospital Outpatient Departments.
- The Coperforma business model seemed at risk of collapse, with sub-contractors going out of business, claims and counter claims around bills not being paid, and staff left without wages.
- Healthwatch heard numerous contradictory stories, but our own evidence from our Outpatient Department work in August had demonstrated that many patients were still being let down by Coperforma.

[2] For information about the CQC rating system see: http://www.cqc.org.uk/content/ratings

- In the light of the TIAA report, the assurances Coperforma had provided to HWLH CCG before starting the contract proved to be unreliable:
    a. Management of risks and robust contingency planning (TIAA sections 26.9-26.18, 26.21-26.23)
    b. Mobilisation readiness (TIAA 26.24-26.27)
    c. Handover readiness and mitigation actions (TIAA 27.1-27.7)

3. Methodology

Patients at the Renal Outpatient Department, Royal Sussex County Hospital, who had used the Patient Transport Service (PTS) were interviewed in September using a structured questionnaire. Patients were asked a series of questions evaluating the quality of the service across three different time periods:

- before April 2016 (pre-Coperforma)
- April to July (Coperforma)
- August and September (Coperforma)

Patients were also invited to share their personal experiences of the service.

Questions included two quantitative questions, a five point satisfaction question, and the NHS 'Friends and Family Test' (FFT) question. Other questions asked for qualitative feedback on various aspects of the service including timeliness of pickup, quality of transport provided, customer relations, communication with central office, problem resolution, handling of complaints and knowledge of staff. Patients were encouraged to talk freely about their experiences.

50 patient interviews were completed and Healthwatch Brighton and Hove's authorised Enter and View volunteers also observed patients in the waiting areas and informally discussed the PTS with patients, visitors, hospital staff and drivers.

4. Findings

Note that 50 questionnaires were completed but not all respondents answered all questions. For each question, we have indicated the number of responses received.

4.1 Overview

Patients interviewed reported that the Patient Transport Service (PTS) performed extremely poorly in the initial months (April-July 2016) when Coperforma took over the contract. Nearly all patients who used the service in this period reported

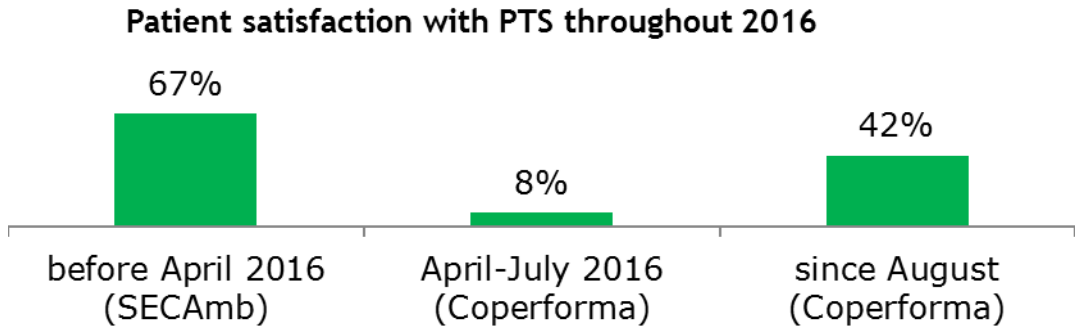
pickup failures, long delays and a poor quality service. A number of patients described the situation in this period as “chaotic”.

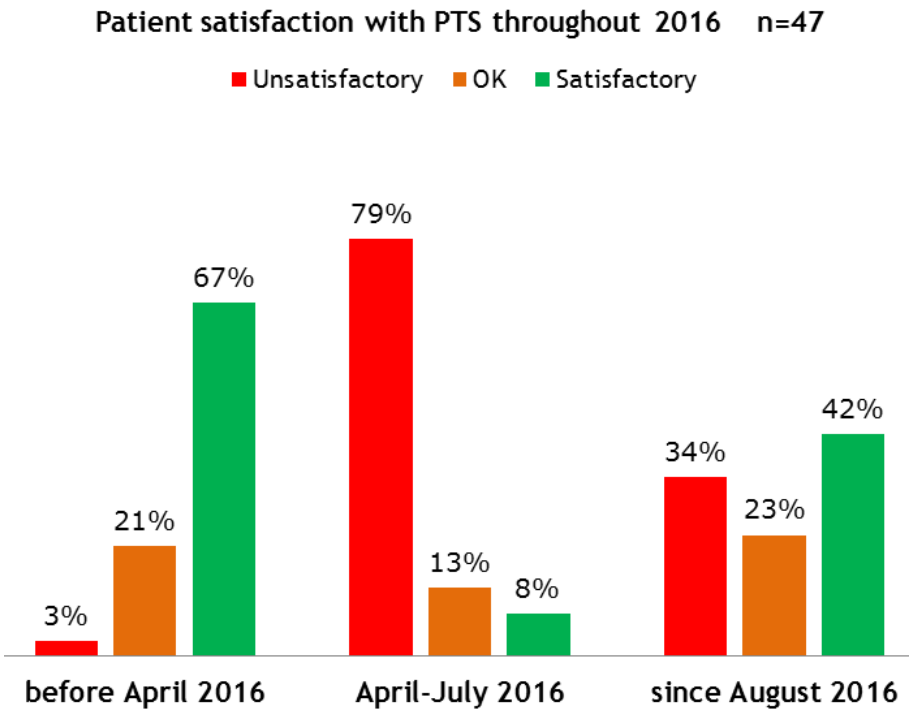
Patients reported some improvements in overall performance since August. Nevertheless only two thirds were satisfied and most people still noted ongoing significant issues particularly with the Saturday service. Key issues identified by patients about their current service were the following:

- Delays commonly experienced on Saturdays when private taxi firms were used.
- Poor customer service from some taxi drivers.
- Lack of understanding about health and care needs, and lack of empathy from some taxi drivers.
- Lack of continuity in drivers.
- Delays in services to return home.
- Difficulties in contacting the control centre to get information when problems arose.
- In sharp contrast to the above concerns the Medi4 transport service was praised for efficiency and professionalism.

Satisfaction levels during 2016 reflect this mixed pattern of performance, with 67% satisfaction before April when the contract was being delivered by South East Coast Ambulance Service NHS Foundation Trust (SECAmb). However from April until the end of July, the initial period of Coperforma delivering the service, nearly 80% of patients rated the service unsatisfactory. Satisfaction levels recovered from the very low level of 8% in this initial period to 42% in August and September 2016.

4.2 Performance and patient satisfaction over 2016





(Data available from 48 of the 50 people surveyed)

4.3 Performance in April – July 2016 (Coperforma)

Patients described a transition from a generally competent service to a service that was extremely poor and unpredictable. With the transfer of the contract, patients reported a virtual collapse of the service with frequent delays, 'no shows' and very limited ability to find out what was happening when problems occurred. Furthermore, when a service was provided it was often poor. One patient reported parts of the ambulance dropping off while travelling. Others told us of inappropriate vehicles being sent (e.g. not accommodating wheelchairs) and some drivers who did not know the location of the hospital and showing little empathy or understanding of the needs of renal patients.

The service previously provided by SECAmb was not reported to be perfect but many patients praised SECAmb, particularly valuing the predictably of the service, its professionalism and the continuity of drivers. For example, a number of patients commented that SECAmb would phone the night before their appointment and advise the pickup time in advance. Patients also commented that SECAmb staff were appropriately trained and were professional and empathetic in their treatment of the patient. People told us that Coperforma provided a service that was dramatically inferior to the service previously provided by its predecessor. Comments included:

- Transport was often late or failed to arrive, without any communication from the Coperforma's control centre.

- It was routinely difficult or impossible to get through to Coperforma by telephone.
- The service provided at weekends was markedly inferior.

During the weekends, Coperforma seemed to use a completely different transport system, relying on private taxi companies, and this significantly contributed to a worsening of the service. Overall the service was widely criticised by patients. Common themes included delays and 'no shows'. Patients also reported that drivers often lacked appropriate knowledge and were unwilling to help passengers when it was needed. Some transport came from as far as Portsmouth.

"Service was awful: always late, waiting 5 hours to be picked up from home and then several hours to come home. It was so stressful and tiring. Some people missed appointments altogether. Some drivers did not know where the hospital was and had no idea about dialysis."

"Chaotic! Always late picking me up from home; often spend 4 hours waiting to go home. Several times I had to get a taxi to the hospital in the morning."

"Chaotic. Frequently waited three hours to get home in hospital waiting room."

"Dreadful service: late pickup up to 4 hours and going home could also be 4 hours. Total chaos."

4.4 Performance in August – September 2016 (Coperforma)

Most patients acknowledged an improved service since August 2016 but significant levels of dissatisfaction remained, with particular concerns about the Saturday service.

However, patients were particularly impressed with the Medi4 ambulance service, which was used by Coperforma for some weekday journeys.

"A bit better. Majority of times on time. Have been times not picked up after treatment."

"Improve markedly last few weeks. Not able to fault".

"During week OK, but Saturdays very poor. Local taxi service used at weekends, poor service. Do not come on time. Variable courtesy."

"Very poor on Saturdays, no problem on weekdays; Saturday service dreadful; frequent delays both getting there and getting home."

"Satisfactory service during week; poor service on Saturdays. Twice in last month had to wait for 4 hours to be picked up from hospital on a Saturday."

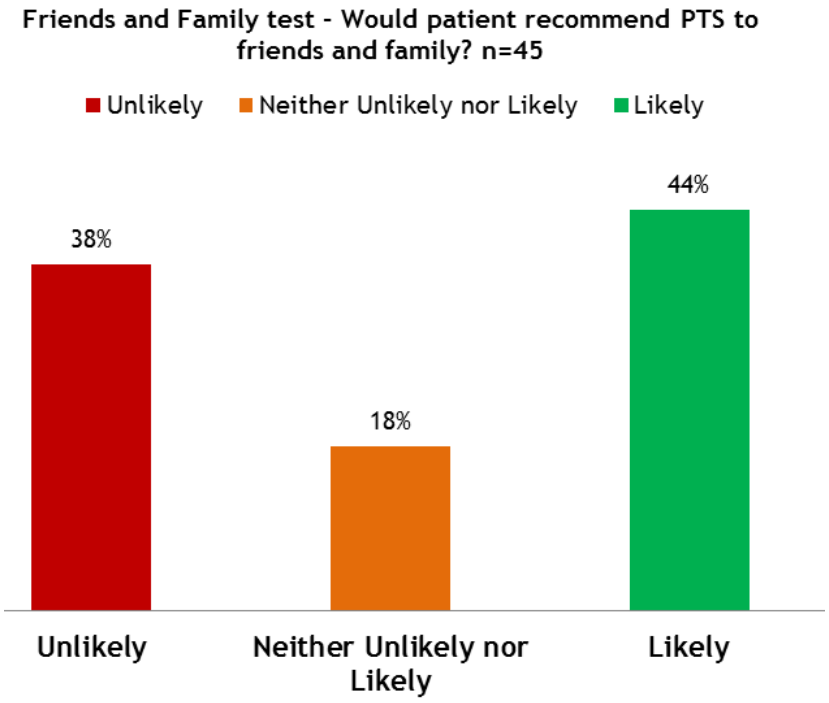
"Saturday service has been poor since April and has not improved."

"Weekdays OK, but Saturdays still very unreliable. Never know when they will arrive. Last Saturday I had to wait for 2 hours for return journey."

"Saturdays are a nightmare and I dread the day. It is so tiring waiting for transport – very stressful."

This patchy performance overall seems to be reflected in responses to the Friends and Family Test (FFT) question which asked if the patient would recommend the PTS to friends and family. The split between 'Likely' and 'Unlikely ' responses was fairly even, with 44% opting for 'Likely' and 38% 'Unlikely'.

We interpret the FFT responses, taken together with comments made by people in the survey, to reflect people being more happy with the face-to-face service they had from drivers but dissatisfied with the PTS system overall.



5. Personal impact on patients

The detailed personal accounts gathered by Healthwatch Brighton and Hove will be made available to the High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) Patient Safety and Service Quality Group. It will be a matter for HWLH CCG to determine whether patients have suffered clinical harm as a consequence of, and in addition to, the personal inconvenience of a severely disrupted service. It is not the role of Healthwatch to make clinical judgments, but it is clear that some of the people we interviewed had treatments shortened and re-arranged.

Healthwatch will also be sharing our findings in detail with the Brighton and Hove Safeguarding Adults Board to determine whether any of the patient experiences we have gathered constitute a legitimate adult safeguarding concern.

5.1 Length of time people had been attending for dialysis and using the Patient Transport Service and frequency of treatment

Patients routinely receive dialysis three times a week for a pre-arranged session, being treated on alternate days including Saturday. The Royal Sussex County Hospital provides morning, afternoon and early evening dialysis sessions.

Typically, a dialysis treatment will last four hours and if transport is provided within 1.5 hours of the treatment period, pre and post treatment, that would provide for a seven hour treatment day excluding travelling time. Even at its best, dialysis can be a tiring and physically demanding treatment. Healthwatch has no clear way of measuring the impact of long delays in addition to long treatment days, but people reported being weak, drained physically and emotionally, anxious and stressed by long waits and uncertainty.

All but one of the people we interviewed used the Patient Transport Service (PTS) for every treatment session three times a week. One person attended three times a week and used the PTS for two of these sessions, with a family member giving a lift for the third treatment session on a Saturday.

Those interviewed included patients who had only recently started their dialysis treatment and those who had been visiting the Department for several years.

Less than 6 months = 13 patients (28%)
7 months to 3 years = 14 patients (30%)
3 years or more = 19 patients (42%)

Total = 46 patients

Almost all the people answering this question (47 of 48) attended for treatment three times a week and from those, 47 out of 48 relied on the PTS for every treatment journey. Five people specified they attended on Saturdays, but this information was not systematically gathered.

5.2 How important is the PTS to people receiving their treatment?

Of those interviewed 94% described the PTS as being very important or vital to their being able to attend for treatment. No one described having any viable alternative travel options:

- 44% (21) of patients mentioned a specific health-related reason or combination of reasons preventing them from using any other form of transport. Feeling tired or weak after dialysis treatment was most frequently cited. Patients also mentioned the impact of other conditions or disabilities, e.g. not independently mobile, being treated for cancer, and being weak and frail
- 16% (8) mentioned that they were otherwise unsupported i.e. no friends, family or carer who could assist them with travel arrangements.
- 15% (7) reported that they had a long trip or lived in a very rural location, a likely reference to poor access to public transport.

5.3 Patients' comments on their experience of the PTS pre- and post-April 2016

Comments made by patients are provided in full in the table below:

No	Pre-April 2016	April – July 2016	August onwards 2016
1.	Mainly arrived on time, very good.	Complete uproar, never turned up, so 'rubbish'.	Pretty poor, late, I ring up and they don't answer. I got left behind one Saturday, someone drove me in, I get really poorly if I miss my dialysis. Saturdays are the worst, they never explain why things are not working

2.	I could phone up the night before and they were there, driver would come to the door and help me.	Noticeable difference, driver never got out of the car to see if I needed help. Always had to ring to be sure of the arrangements and find out whether a driver had been allocated.	Might be a bit better, mostly on time now.
3.	Drivers fantastic but there were difficulties with the control centre. Generally punctual could always get through to the control centre who were courteous but never offered an apology	Did not arrive or not on time, no apology or explanation given. Seemed like they were totally unaccountable. Had to 'bus it', two changes from Eastbourne.	Marked improvement in recent weeks but how the service can be viable with two crews transporting one person.
4.	No additional opinion offered.	Went downhill dramatically, never anyone on the desk in the call centre been left with the phone ringing over two hours.	A bit better ambulance during the week usually courteous – Saturdays, taxi service - variable punctuality and variable courtesy sometimes if I am slow they get fed up and drive away.
5.		Twice failed to get picked up after treatment but the hospital sorted it out. Treatment finishes 11.30am transport arrives maybe 2.00pm. I am blind and use a wheelchair. Driver does not help he just sits in the taxi and I have to ask hospital staff for help. Several times three vehicles would turn up at the same time; one for me, one for a	Has improved over the last two weeks.

		neighbour, one for both of us.	
6.		Prompt during the week, terrible problems on Saturdays – left in a wheelchair in the waiting room and cannot get to reception, waited four hours. Treatment started 7.30am got home 5.00pm	Always excuses. Coperforma rang to tell me how good they are now and were four hours late to take me to my appointment the following day. I have seen nurses give some frail patients a sandwich on Saturdays.
7.			Tuesday and Thursday always OK – Saturday 'luck of the draw'. If I complain a private taxi arrives. Saturdays have not improved since April
8.	Transport always arrived on time, you were phoned the night before and told the pick-up time. I could leave my flat and wait in the entrance hall to save the driver time.	Transport was chaotic. Week days service OK but Saturday a disaster. One Saturday in July I got home after dialysis when a taxi arrived to take me for my treatment. So they were either very late for that day or very early for the next Tuesday.	Still arriving very late for pick- ups. Two weeks ago I was in the transport going from Woodingdean to Preston Park where I live, when the ambulance was ordered back to the hospital. I was off loaded and had to wait and get a private taxi home – no explanation.

9.	Everything OK very few delays	I come from Lewes sometimes picked up very late once was forgotten and just left at the hospital.	Service is good even on a Saturday and I hope that continues
10.	On time, OK	No one came to pick me up for my evening appointments, I had to phone up and organise transport myself sometime two hours late sometimes I missed my treatment.	Regular driver comes all OK with renal trips but I also have a digestive disorder and those OP appointments the PTS is problematic.
11.		Multiple drivers arriving for the same pick up; double bookings sometimes booking was cancelled; chaotic management of appointments.	Regular driver now sometimes late but helpful and polite.
12.	Service good no delays	Disorganised and late	Service OK now
13.	Service good no delays	Disorganised and late	Service OK now
14.	Service good no delays	Disorganised and late	Service OK now
15.	Service good no delays	Disorganised and late	Service OK now
16.	SECAmb was good; the drivers knew us and we knew them, always contacted us the night before.	Service was awful, always late. Waited for five hours to be picked up and then often several hours to get home. Some people missed their appointments completely. These people do not seem to realise we cannot miss our treatments.	Some drivers do not have a clue about where the hospital is and no idea about dialysis. Sending inappropriate vehicles for a wheelchair user.

17.	They looked after me – on time both journeys	Chaotic, always late being picked up. The hospital would make us well then wait four hours, getting stressed going home. Sometimes I missed my carer and had no one to prepare food. Several times I got my own taxi in the mornings. Quite often I stretched out on the seats in the waiting room and tried to close my eyes, I felt so drained. Its uncomfortable waiting four hours in a chair	Service has 'picked up' considerably – usually on time happy with the service now
18.	Everything worked really well, phone call the night before.	Frequently waited three and half hours to get home, one day a car arrived to take me to hospital 30 minutes after I arrived home from my treatment. Another day three cars arrived for me all at once.	Settled down, get the same 3 drivers, look after me well no delays, not at all stressful.
19.	Everything fine	Dreadful frequent four hour waits, total chaos.	Perfect
20.	No real problems	Always late and late getting to and last to finish treatment.	No real change
21.	There were problems but OK on the whole.	More problems, drivers changed a lot, no answer when phoned up left message no call back.	Has settled down
22.	Service good, no delays.	Disorganised and late.	Service OK now – very important to have the same driver.

23.			Last week picked up on different occasions by two drivers, one from Canvey Island the other from Nottingham, both being put up in the Preston Park Hotel. Neither had any idea how to get around Brighton.
24.	Not perfect but better than Coperforma. Volunteers were good	Late	Tuesdays and Thursdays OK, Saturday dreadful – overall, a bit better but still erratic. In the evenings its pot luck who takes you home. A couple of times I arrived home at 11pm when I had a 4pm transport slot to bring me home.
25.		About the same as now	On the whole good
26.	Service good no delays	Disorganised and late	Service OK now during the week; a friend is on standby at the weekends in case service fails or is very late
27.			On time minimal delays
28.	Service good no delays	Disorganised and late	Service OK now during the week; poor on Saturdays
29.	Service good no delays	Disorganised and late	Service OK now during the week poor on Saturdays.
30.	Service good, no delays.	Not delayed but drivers very unhelpful. Would watch me struggle rather than get out of the car and help me.	Service OK now
31.		Haphazard	About 10% trips delayed

32.	Service good, no delays	Disorganised and late.	Service OK now 80% of time, delayed 20% of time – staff helpful but ambulances are uncomfortable.
33.	Always delays never the same driver.	Very long delays especially going home, never the same driver.	Always late arriving, two-three hour delays going home. Driver got lost took 3.5hrs to get to Uckfield. Still unhappy with the service
34.			Arrives on time, occasional delays going home, but generally well organized.
35.		Arrives on time; delays about 20% time, drivers reliable and helpful. Couple of drivers are from Nottingham.	Usually arrives on time; delays about 20% time.
36.			Reported by son – father (patient) finds the PTS dreadful but does not have speech following a stroke and finds it difficult to communicate this.
37.	Service good, no delays	Disorganised and late	Service OK now – if late, difficult to get issues resolved by phone, never an explanation
38.	Service good no delays	Disorganised and late.	Service OK now
39.			Always late, failed to turn up on two occasions. Two separate taxis for him and a neighbour.

40.			Always late – recent experience got in car with two others, first trip to Seaford, second to Preston Park and the third to Crawley – no one seems to have a route planner. I have had drivers from Chelmsford and Thames Valley.
41.		Once a driver arrives they are good but delays.	When interviewed lady had been waiting two hours to go home with no news of transport arriving she was the only person left in the waiting room.
42.			Sometimes a little late
43.	Service good, no delays.	Disorganised and late. Drivers often did not seem to speak English or understand British culture; they would speak to each other in their own language. On one occasion driver did a three point turn and on-coming car crashed into them (driver said he needed to post a letter). Patient not hurt but required alternative transport.	Service OK now
44			Service unreliable- 'hit and miss'
45			Drivers good but system awful, always delays getting home.
46	Service good no delays	Disorganised and late	Service OK now

47	Service good no delays	Disorganised and late	Service OK now
48	Service good no delays	Disorganised and late	Service OK now
49	Service good no delays	Disorganised and late	Service OK now
50	Service good no delays	Disorganised and late	Service OK now

An interpretation of the comments made by patients indicates the following overall trends:

- A good service prior to April 2016, a disorganised and poor service from April to the end of July, an improving service from August onwards, a pattern that is repeated in about 30 (60%) of the 50 interviews. That fits well with the data reported in section 4.2 above where people scored their relative satisfaction with the service – here 65% reported that the PTS since August was 'OK' or 'satisfactory'.
- Saturday is identified as being consistently problematic with 9 (18%) people from 50 specifically recording an adverse comment about the PTS on that day. This is likely to be under-reported as not everyone will have been prompted to distinguish between weekday and weekend levels of service. Some people will not have treatment on a Saturday and that data was not systematically gathered, a deficit that should be avoided in future similar service reviews.
- Dissatisfaction with taxi drivers from April 2016 onwards, including lack of familiarity with the local area, being unhelpful, and not communicating well in English.
- Specific praise for one ambulance provider, Medi4.

It was beyond the scope of this review to assess how many people have abandoned the PTS in recent months. It is clear from informal discussions with patients that many have incurred unanticipated costs and considerable disruption to family life. It may be helpful to gather this information in the future to advise service planning and commissioning.

5.4 The personal impact of deficits in the PTS

Key:

1 = Missed hospital appointments

2 = Longer time needed for appointment due to delays

3 = Shortened treatment times

4 = Anxiety stress

5 = Child care other carer issues

No	1	2	3	4	5	Comments made
1				x		
2				x		Saturdays are a nightmare I dread the day
3				x		Saturdays stressful
4						Left feeling very ill after long waits
5				x		
6		x		x		
7		x		x		
8		x	x	x		
9						
10						
11				x		
12				x		
13				x	x	No missed appointments because they are filled in later - catch up sessions -
14						
15				x		
16				x		

17						No real problems
18				x		Uncertainty – just left in a waiting room – knew nothing –told nothing
19				x		
20				x		
21				x		
22						
23		x		x		
24						
25						No problems happy with the service
26			x	x		
27						
28		x		x	x	Disrupted family life
29				x		Concerned nurses have to work late
30				x		
31						
32						Delayed meals
33						
34				x		
35				x		
36						
37						
38				x		
39						
40			x			
41		x	x	x		

42						
43				x		
44						Person very unwell, multiple medical issues – no opinion reported
45						
46		x		x		Discomfort waiting in wheelchair
47						
48						Just made me feel so miserable
49						So tiring you just want to go home and rest
50						

- 26% (13) nil return
- 14% (7) reported longer treatment days due to travel delays
- 8% (4) reported shortened treatment sessions
- 56% (28) reported anxiety and stress as a result of deficits in the PTS
- 4% (2) reported associated problems with carer and family arrangements
- 2% (1) reported no problems associated with the service

There is considerable evidence of people having had their lives and routines severely disrupted and people having suffered avoidable anxiety and stress by defects in the PTS since April 2016. There is evidence that despite the majority of people reporting that services have generally improved since August 2016, some people were faced with persistent uncertainty, stress and anxiety in a service with elements of unreliability, particularly on Saturdays.

The review found no obvious evidence of severe or permanent harm being reported by patients. In addition those people delivering, analysing and reporting this service review were not competent to make clinical judgments around those issues. However, there have been some second or third hand reports of a few people whose personal resilience and morale has been so affected by deficits in the PTS that they considered ending their treatment. Healthwatch has not been able to verify these reports. It is important, in the interests of individual patients and the reputation of all the services involved, including those who commission these services, that this issue is thoroughly and robustly investigated in other similar

service reviews and other clinical areas. Healthwatch would encourage anyone who has first-hand knowledge of any person who has contemplated ending their treatment because of PTS problems to contact us through the Healthwatch Information line or IHCAS Service.

5.5 Patients understanding about the causes of delays in the PTS

Nil return = 29% (14)
No information ever given = 63% (30)

Reasons given for PTS deficits in service:

- Not enough drivers (on Saturdays)
- Poor information available to Coperforma
- Lack of vehicles
- Traffic problems
- Total service is really busy
- Other patients hold up the transport
- Blame SECAmb for not telling Coperforma what was involved in providing this service
- Phone system does not work properly
- "They are on the way"
- Lack of training and proper organisation
- Other people's fault
- Drivers don't know the local area and get lost and delayed

No one interviewed indicated that they had received a clear explanation for delays and other deficits in the PTS. Almost all those expressing a view on this issue indicated that they had never received any explanation, or that they did not know the explanation for problems with the service. People indicated a wide range of reasons that derived either from sources such as drivers, letters from Coperforma, media, hospital staff, or from their own impressions having experienced the service directly.

It is clear that no simple, authoritative and creditable explanation for deficits in services were ever offered to patients. Healthwatch notes that renal dialysis patients are among the most physically ill, frail and vulnerable patients using the PTS. Dialysis is a life-sustaining intervention without which these people would not survive. NHS Commissioners and NHS-funded services have caused these people to live with continuing uncertainty about the PTS for months, and have not provided

adequate explanation for service failure. There has been a failure to communicate effectively with patients individually and collectively.

5.6 Making complaints

Nill return	No	Complained to:	Outcome
		PTS co-ordinator at hospital	She tried to resolve problem
		Renal Outpatient Department reception	Nothing
		Renal Outpatient Department reception	
		Coperforma telephoned	PTS arrived but late
		Coperforma	PTS started to arrive on time
		Complained to Coperforma in April	Got a letter apologising and saying they were short of staff
X			
		Phoned Coperforma many times	Never get through so I've given up
		As above	Once got a taxi at own expense and had that reimbursed
		Phoned Coperforma many times	Wasted a lot of money on phone calls
		Complaint made by manager of Care Home on my behalf. Phone was on hold for over an hour and her phone battery ran out	Got two letters of apology
X			
X			

X			
	x		
		Yes (unspecified)	‘Falls on deaf ears’
	x		
X			
		Yes (unspecified)	Nothing
X			
		Talked to drivers and the supervisor	Nothing
		Wrote to Coperforma about three months ago	Got a letter saying they were trying to improve the service
		Husband phoned and got angry.	They hung up on him
		I have written letters, completed forms and made phone calls.	Received a letter informing me that 88% of people are delighted with the service
	x		
		Complained to people ‘on the desk’ at hospital, can never get through to Coperforma. We give the drivers ‘stick’ but it’s not really their fault.	
		We had a survey and I told them how poor the service was.	They apologised and said they were trying to get the service right
		Complained to people ‘on the desk’ at hospital; can never get through to Coperforma.	
X			
		Complained a couple of times, wrote complaint in April.	No reply

X			
	x		
		Yes wrote to my MP and everyone I could think of and was on TV	I think I made a difference - I certainly raised awareness
	x		
		Yes several times	Nothing
		Yes several times	Received an apology
X			
	x		
	x		
		Mid-May got picked up but two more drivers arrived starting arguing between themselves and refused to leave. Insulted my 23 year old son (who has Autism). Hospital complained to CCG	Received an apology - no point in complaining to Coperforma; it is clear from other people that they simply send out the same standard letter of apology.
X			
		Complained to Coperforma	Standard letter of apology - platitudes
		Complained to Coperforma	Standard letter of apology - nothing happened to improve services
		Phoned Coperforma; could not get through to complain	
		Phoned and sent a written complaint	Now being picked up on time - but still separate vehicles arriving for two nearby neighbours
		Raised concerns at desk which is a waste of time	Nothing

		Yes, complained at the desk but in a wheelchair and cannot easily get from the waiting room to the desk.	Nothing
		Only informally	Nothing
		Yes but only to nurses and drivers and it's not their fault	Nothing
	x	No I just moaned about it.	

Complaint not resolved/response unsatisfactory = 63% (30)[3]
Complained satisfactory outcome indicated = 4% (2)
Had not made a complaint = 17% (8)
Nil return = 21% (10)

There is evidence of:

- No easy and systematic way of raising complaints and receiving a resolution 'on the day'.
- Complaining to Coperforma is difficult and often seems to result in receiving a standard format letter of apology.
- No systematic way of raising and resolving complaints about persistent or serious problems.

Informal feedback from Healthwatch researchers indicated that hospital staff, hospital-based PTS staff and most drivers tried to be helpful and resolve problems as they arose. These staff were generally seen as diligent, well-mannered and helpful but working with a deeply flawed PTS system.

[3] It is clear from the tone of comments received that having a standard letter of apology from Coperforma was not an acceptable resolution of complaints for these patients.

6. Examples of patients receiving Healthwatch Independent Health Complaints Advocacy

The Healthwatch Brighton and Hove Independent Health Complaints Advocacy (IHCAS) service is delivered by our partner, Brighton and Hove Impetus. IHCAS signposts, advises and can actively support people to make complaints about NHS services. We feel it is helpful to include some accounts from people who have had help making complaints about the Patient Transport Service (PTS) by our IHCAS service. Only one of these accounts relates to a patient receiving dialysis and so they are unrelated to the rest of this report. The examples provided below, however, illustrate that PTS problems have been present across other clinical areas and that Healthwatch Brighton and Hove is actively assisting people to make complaints.

Initials of client	Date of contact with IHCAS	Detail of complaint/experience of patient transport	IHCAS Actions	Coperforma response
Mr D	June 2016	75 year-old who uses oxygen cylinder has been let down on over five occasions by patient transport.	• Discussions over phone • 1:1 meetings to discuss client's experiences • Write complaint letter • Complaint letter approved by client • Complaint letter sent to CCG (2/8/16)	• Various letters stating Coperforma are investigation complaint • Last one received 27/9/16 apologising in delay in sending response

Mr M	July 2016	Complainant's husband, who receives dialysis, has missed a number of appointments due to the ambulance arriving too late. Service provided by Copoforma. Referral received from Carers Center Need translator	• Organised Interpreter and met 1:1 to discuss experiences • Wrote complaint letter - translated into XX language • Letter approved and sent to CCG • (August 2016) • Update client with progress	• Delay in CCG responding and investigating due to misunderstanding over surname. This has now been resolved • No response to date
Mrs W	June 2016	88 year old woman, living alone after caring for her husband who had a stroke last December and who is now in a care home. Mrs W also had a stroke, in January but has managed to remain in her home. 14th March 2016 - Ambulance over 2 hours late to go to an appointment at the royal, expected at 9 am ''but finally arrived, after calling again, after 11 am'' 21st March - Due at the hospital for a care review for 10.30am - was advised transport would not be on time so had to get a taxi.	Monthly telephone chat to check in how things are regarding experiences of health care Home visit to learn more details about experiences which includes concerns with GP surgery and BSUHT and medication. Arranged another home visit for December.	Note: Client did not want to make a formal complaint

		Ambulance late in returning her home but Mrs W says that the ambulance men were 'very nice and had to come all the way from Hastings, especially to pick me up'' 6th October 2016 – waited over 3 hours ''stuck in my wheelchair, with the brakes on, in the same spot '' to be collected and taken home from Royal Sussex. Mrs W is due her next appointment at the Royal on 25th November and has decided she will use a tax which is £16 each way.		
Mrs H		87 year old woman who leaves alone relies on patient transport to take her to various hospital appointments and Pain Clinic and has been let down on a number of occasions by service provided by Coperforma. Also concerned that the drivers are not trained Paramedics.	Monthly calls to chat and check in experiences of health services and improvement with use of patient transport	Did not want to make a formal complaint

7. Conclusions and recommendations

7.1 Providing a satisfactory service in the future

It is clear that the Patient Transport Service (PTS) service provided to patients at the Royal Sussex County Hospital (RSCH) Renal Outpatient Department had been deeply unsatisfactory since April 2016. While it improved from August 2016 there were persistent and unresolved deficits in the service. Healthwatch Brighton and Hove believes these failures contributed to the decision in November 2016 to terminate the contract with Coperforma and appoint South Central Ambulance Service NHS Foundation Trust (SCAS) to replace it.

In light of the decision to change the provider of the PTS for Sussex, this report offers important learning for future commissioning and delivery of the service. Healthwatch believes this report documents a deeply worrying cautionary tale and a textbook record about how not to go about delivering services to NHS patients.

Clinical staff at the RSCH Renal Unit reminded us that the PTS before Coperforma had not been problem free - there had been recurring performance issues for many years. A senior member of clinical staff was keen to point out "…the fundamental need for transparency and accountability directly to the patient…" They suggest that the PTS should have dedicated performance targets for renal patients and that monthly or quarterly validated performance reports should be prominently and publically displayed.

Recommendations:

- Even though there is a transitional period between providers, urgent and immediate action is still required by service providers and commissioners to correct persistent deficits in service, particularly on Saturdays.
- This report should be used by SCAS to develop a clear and creditable action plan to recover this service in order to re-establish confidence among patients, NHS staff and the public.
- Robust and simple complaints procedures need to be put in place to resolve problems as they arise and to address more serious and persistent problems.
- There should be dedicated PTS performance standards for renal patients, with performance reports publically and prominently available.
- Commissioners and service providers should promote Healthwatch and our associated Independent Health Complaints Advocacy Service (IHCAS) service

prominently, along with other relevant representative organisations and advocacy services.

- Healthwatch provides IHCAS, and this service should be considered when seeking to improve complaints assurance for the PTS in the future.

7.2 Comments from patients about the service and recommendations about how the new provider can improve it

The patients we interviewed made suggestions about how the PTS might be improved. In addition to the issues raised elsewhere in this report they were concerned about some of their experiences:

- Patients could not understand how it was possible to get their appointment arrangements so wrong. Almost all attend treatment sessions at standard times for fixed periods on the same days and these arrangements have often been in place for years. Coperforma and their sub-contractors were not expected to provide an emergency service but a largely predictable and routine service.
- The uncertainty about transport arriving meant some patients will have risen very early to dress and be ready immediately the transport arrived, often long before their appointment times.
- If they did manage to get through on the phone to Coperforma, they were often given inaccurate and conflicting information about when transport would arrive, increasing their anxiety levels and uncertainty.
- Some drivers were rude and even threatening. Many patients were concerned that their transport was not clean or hygienic or roadworthy. Drivers sometimes drove erratically and patients questioned whether they were able to deal with a medical emergency.
- There were multiple journeys that did not make best use of vehicles, separate vehicles carrying individual people to similar destinations, multiple vehicles turning up for the same pick-up, drivers and vehicles travelling long distances to make pick-ups, and drivers and vehicles from all over England being accommodated locally.

Recommendations:

- Clear standards for call centre performance, vehicles, drivers and punctuality should be made explicit to people receiving the service.
- Drivers should receive proper training to know how to deal with patients.
- There should be a simple way for breaches in service standards to be reported and escalated.

- There should be same-day resolution for minor breaches of standards.
- Financial penalties should be imposed for service providers breaching service standards.
- There needs to be better use of technology – some parcel delivery services allow a customer to track a package from warehouse to delivery, timed to the minute. The PTS should provide similar technology to give patients and their family greater certainty about when their transport will arrive.

7.3 Rebuilding confidence in the PTS for patients, the public and the professional community

Confidence in the PTS across Sussex has been deeply damaged. Continuing claims that the service has improved have not gained traction and have often been dismissed as not credible. With the departure of Coperforma there is an ideal opportunity to rebuild confidence.

Clinical staff at the RSCH Renal Unit have suggested that the Clinical Commissioning Groups (CCGs) and Coperfroma consider closely what actions helped the PTS to start to recover and improve over August 2016 and that 'lessons learnt' are shared with the new providers. They suggested that the following helped to improve the service: reallocating back office staff to create a dedicated dialysis team for Brighton and its satellites; training clinical staff in use of the patient transport portal improved communication and lightened the load for call centre staff.

Recommendations:

- Commissioners should establish current and future PTS performance with independent and expert verification. Healthwatch stands ready to assist with that process.
- A wider account of deficits in the PTS should be undertaken by gathering patient experiences across Sussex and in other specific clinical areas such as cancer services. The High Weald Lewes Havens (HWLH) CCG's Patient Safety and Quality Assurance Group could lead and coordinate that process involving Healthwatch and using other expert and independent verification as required. The principal aims may be:
    a. To establish an accurate historic record.
    b. To establish performance baselines for future service review involving patient experiences other than those reported solely by the commissioners and providers of the PTS.
    c. Healthwatch Sussex-wide have already offered to assist with that process and it is important that this work goes ahead regardless of the replacement of Coperforma as the service provider.

- A learning event should be held to identify lessons learnt and to inform the future provision and commissioning of the PTS in Sussex.

7.4 Learning lessons and building a learning community

The Internal Audit Agency independent review identified deficits in the mobilisation of the PTS in Sussex from April to mid-May 2016. Even though we are currently in a transition period between providers, this report indicates that many of those problems are unresolved and persistent. There is concern from patients, the public and the professional community that there may have been deep flaws not just in the delivery of this service but also in the commissioning process:

- Consultation and engagement in the commissioning process has revealed that:
    a. a lack of involvement of Healthwatch organisations, as the official and independent Health and Social Care 'consumer watchdog', has proven to be a weakness and;
    b. a seeming failure to refer a major and risk-laden change in service provision to the relevant local authority Health Overview and Scrutiny Committee process removed an opportunity to further test the suitability of the intended provider.
- The model of commissioning was a competitive process that does not seem to have allowed learning and warnings from South East Coast Ambulance Service NHS Foundation Trust to have been heard and held at the heart of the process
- The planning and mobilisation process was seemingly devoid of external and independent scrutiny, where commissioners lacked expertise in patient transport and did not seek out that expertise until after the service had substantially failed.

Recommendations:

- A further independent review should consider the commissioning process that awarded this PTS contract to Coperforma with a view to learning lessons and improving future commissioning.
- The results of that review should be made public and should materially inform future commissioning.
- The combined CCGs in Sussex should consider the viability of a model of commissioning that allows one CCG to act on behalf of the others as a lead commissioner, and their capacity to service it.
- Overview scrutiny and independent review processes should be clearly built into future similar commissioning.
- A full and transparent investigation of the financial implications of this service failure should be undertaken with the results made public. The financial impact of the Coperforma failure should also take into account the

costs to the NHS of clinical and administrative staff having been constantly diverted from their duties to fire-fight and resolve patient transport issues. Any recommendations should materially inform future commissioning processes.

7.5 The role of Healthwatch, the Care Quality Commission, performance monitoring and quality assurance

The failure of the PTS in Sussex from April 2016 was so profound that it is probably not an exaggeration to say that many organisations in the political and professional community were not at all sure how to respond. Issues were raised with no ready or easy answers. At Healthwatch we were poorly resourced to address this service failure. Healthwatch is supported very well by Brighton and Hove City Council, particularly given budget pressures in the City. However, compared to the size of the NHS and social care system, Healthwatch resources are very small. We continually balance maintaining a busy programme of service review planned in advance against being available at short notice to address topical and urgent issues. Healthwatch undertook this review in just two weeks, mobilising 150 hours of volunteer time and our IHCAS with no additional cost to the taxpayer. In the same period Healthwatch was also responding to a range of other consumer concerns e.g. local GP practices being reconfigured (some in special measures), Brighton and Sussex University Hospitals NHS Trust and SECAmb responding to adverse Care Quality Commission (CQC) inspection reports and going into special measures, emerging local concerns over social care funding pressures, and feeding back on findings from our Outpatient Department report.

Healthwatch has escalated concerns about the PTS to Healthwatch England (HWE) and the CQC. HWE is assisting us in finding other local Healthwatch organisations with PTS problems, and we aim to share learning locally and across the national Healthwatch network. The CQC inspected Coperforma, and their report is available to the public.[4] NHS England is the body responsible for providing quality assurance for CCGs, and from the perspective of Healthwatch they have been largely invisible in responding to this service failure. Over 2015/16 NHS England rated HWLH CCG 'good' overall and 'good' for 'planning', 'finance' and being 'well led'.[5]

[4] Coperforma Demand Management Centre Care Quality Commission's Quality Report published on 01/11/2016

[5] CCG Assurance Annual Assessment 2015/16

Recommendations:

- Clear inspection and independent quality assurance processes should be in place for PTS. As the lines of service delivery grow longer and further away from direct NHS control, the question about how quality and performance can be effectively assured has to be asked. This is particularly the case where there might be a lack of clarity about what body has the responsibility to inspect and quality-assure the service, i.e. who should have inspected Coperforma when it was essentially a 'call centre' which serviced sub-contractors who actually provided the transport service.
- HWE, the CQC and the NHS should consider how local Healthwatch organisations can best be supported when responding to major service failure.

8. Appendices

8.1. Brighton and Hove Clinical Commissioning Group Response

8.2. Renal Dialysis PTS interviews questionnaire

NHS
Brighton and Hove
Clinical Commissioning Group

David Lilley
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Hove Town Hall
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BN3 4AH

16 December 2016

Dear David

Re: Users' perspective on the Patient Transport Service April – September 2016

Thank you for inviting the CCGs to comment on the factual accuracy and recommendations laid out in the above Healthwatch Brighton and Hove PTS report. We welcome this independent view of Patient Transport Service. Please find a summary of our feedback and comments below which includes a response to your further questions of the 16 December. Brighton & Hove CCG has taken the opportunity to discuss the report with colleagues from High Weald Lewes & Havens CCG.

As you are aware the Sussex CCGs commissioned an independent review into the procurement and mobilisation of the Patient Transport Service (PTS). In addition the Patient Safety Group, chaired by a senior GP, with representation from Sussex Healthwatch, was formed to determine the impact on patient experience and safety. The learning from these reviews, together with the additional feedback gained through the Sussex wide learning event held on 14 November, which included attendance from commissioners, providers, procurement, patient and stakeholder groups from across Sussex will be fed into the phased transition of the patient transport service from Coperforma to South Central Ambulance Service (SCAS).

We welcome the broader advocacy role of Sussex wide Healthwatch together with this report from Healthwatch Brighton and Hove and are pleased to note that the themes articulated in it resonate completely with those found in the TIAA and Patient Safety reports noted above, which have already been fed into and are informing the service transition plan and future service model.

As you are aware the CCGs have publically apologised to all patients, families and carers across Sussex regarding the impact of the failures in the patient transport service and I would wish to reiterate the fact that all the Sussex CCGs are giving the transition period between the two services and the learning from the last six months significant attention. We welcome continuing to work closely with Healthwatch Brighton & Hove over this period of time. I always welcome feedback from our partners, but would ask that the Healthwatch look at this as a collective commissioning responsibilities rather that an issue with High Weald Lewes Havens CCGs.

I have taken each of the recommendations and responded to them in turn. As you will be aware, some of the recommendations are in areas that you feel we should focus on for future procurements and I have provided detailed responses where I can.

1. Providing a satisfactory service in the future

- Even though there is a transitional period between providers, urgent and immediate action is still required by service providers and commissioners to correct persistent deficits in service, particularly on Saturdays.

CCG response
The Sussex commissioners continue to work with Coperforma to ensure the service to patients is maintained and improved, has stated publically its commitment to address the deficits in the current service provision moving forward and to apply the learning during the phased transition to the new service provider.

- This report should be used by SCAS to develop a clear and creditable action plan to recover this service in order to re-establish confidence among patients, NHS staff and the public.

CCG response
All commissioners of this service are working closely with SCAS on the service from 1st April 2017. It is important that we mobilise this service safely to SCAS and we are clear on the outcomes we are expecting through the service specification and the transition plan. Internally I have asked that John Child, our Chief Operating Officer takes the full executive lead for our organisation representing Brighton and Hove at the Programme Board which is monitoring the current service and proposed transition and developing the relevant governance and assurance frameworks.

- Robust and simple complaints procedures need to be put in place to resolve problems as they arise and to address more serious and persistent problems.

CCG response
SCAS has a well-tested complaint procedure and policy. I have asked John Child, Chief Operating Officer and Soline Jerram, Director of Clinical Quality and Patient Safety to provide me with further assurances that this has had further service user testing before the service transfers to SCAS.

- Commissioners and service providers should promote HWBH and our associated IHCAS service prominently, along with other relevant representative organisations and advocacy services.

CCG response
I take this as a wider point about how we as health commissioners are working closely with HWBH. As you are aware since coming into post I am keen to engender closer working between our organisations. I firmly believe that the population should have access to a thriving Healthwatch and I am keen to discuss further how we can work together in the future.

- Healthwatch Brighton and Hove provides independent complaint audit services (IHCAS) and this service should be considered when seeking to improve complaints assurance for PTS services in the future.

2. Comments from patients about the service and recommendations about how the new provider can improve it

- Clear standards for call centre performance, vehicles, drivers and punctuality made explicit to people receiving the service.

CCG response
SCAS has a standard operating procedure that will be followed on service commencement. I have asked our clinical leadership team to review this standard operating procedure to ensure we are confident that this will meet the needs of our population

- Drivers should receive proper training to know how to deal with patients.

CCG response
It is our expectation that all our service providers have robust recruitment, selection, induction and ongoing training policy for working with patients. The PTS Service Specification has clear standards in place which state that all transport provider staff must be competent in undertaking all responsibilities of their role, including (but not limited to) policies on:

- *Equality and Diversity;*
- *Safeguarding children and vulnerable adults;*
- *Disability and Human Rights Awareness;*
- *Dementia awareness;*
- *Mental capacity and Deprivation of Liberties Safeguards (DoLS); and*

- *Conflict resolution and customer care*

This will be reviewed at the Clinical Quality Review Meeting with the SCAS. I have asked Soline Jerram, Director of Clinical Quality and Patient Safety to review this with SCAS going forward.

- A simple way for breaches in service standards to be reported and escalated.

CCG response
SCAS has a standard operating procedure that will be followed on service commencement. I have asked our clinical leadership team to review this standard operating procedure to ensure we are confident that this will meet the needs of our population. The PTS service Specification requires the provider to establish "Clear escalation protocols to resolve issues in a prompt and timely manner, particularly with regard to maintaining patient flows across the system and resolving delays in transporting patients discharged from acute providers." and "An escalation protocol for internal incidents to ensure rapid movement of patients to their intended destination."

- Same-day resolution for minor breaches of standards.

CCG response
SCAS has a standard operating procedure that will be followed on service commencement. The PTS service Specification requires MSP to establish "Clear escalation protocols to resolve issues in a prompt and timely manner, particularly with regard to maintaining patient flows across the system and resolving delays in transporting patients discharged from acute providers." and "An escalation protocol for internal incidents to ensure rapid movement of patients to their intended destination." This will be mandated for SCAS as the new provider.

- Financial penalties for service providers breaching service standards.

CCG response
The NHS standard contract has the provisions for financial penalties for service providers that are breaching service standards and I will ensure that this is monitoried through the appropriate contractual route with the new provider

- Better use of technology – some parcel delivery services allow a customer to track a package from warehouse to delivery, timed to the minute. PTS services should provide similar technology to give patients and their family greater certainty about when their transport will arrive.

CCG response

We are exploring the opportunities for the use of IT solutions to improve the experience for our patients. At present we are focused on ensuring that there is a smooth transition to the new provider and will work with SCAS on these further innovations after 1 April 2017.

3. Rebuilding confidence in PTS services for patients, the public and the professional community

- Commissioners should establish current and future PTS performance with independent and expert verification. HWBH stands ready to assist with that process.

CCG response

Brighton and Hove Healthwatch will be aware that the Sussex CCGs have taken this action and have widely shared the appointment of an expert Patient Transport Advisor in August 2016 to provide independent advice and verification and continue to work with stakeholder groups, some with Healthwatch representation including, the Patient forum, Sussex Kidney Patient Association, Patient Safety Group, Trust provider Group.

- A wider account of deficits in PTS should be undertaken by gathering patient experiences across Sussex and in other specific clinical areas such as cancer services. The HWLH CCG's Patient Safety and Quality Assurance Group could lead and coordinate that process involving HWBH and using other expert and independent verification as required. The principal aims may be:
    - To establish an accurate historic record.
    - To establish performance baselines for future service review involving patient experiences other than those reported solely by the commissioners and providers of Patient Transport Services.
    - Healthwatch Sussex-wide have already offered to assist with that process and it is important that this work goes ahead regardless of the replacement of Coperforma as the service provider.

CCG response

Brighton and Hove Healthwatch will be aware that the Patient Safety Group has already gathered patient experiences across Sussex from other clinical areas. Sussex commissioners will ensure the learning from this informs the transition and future PTS.

- A learning event should be held to identify lessons learnt and to inform the future provision and commissioning of PTS services in Sussex,

CCG response

An independently facilitated learning event took place on 14 November 2016, with wide stakeholder representation, including attendance from Healthwatch Sussex. The Programme Board has requested a full communication and engagement plan to support the transition to

SCAS to ensure that patients, their families, carers and other stakeholders are fully aware of the new service well in advance of commencement.

4. Learning lessons and building a learning community

- A further independent review should consider the commissioning process that awarded this PTS contract to Coperforma with a view to learning lessons and improving future commissioning.
- The results of that review to be made public and to materially inform future commissioning.

CCG response
These two actions have been completed and I would request that the report reflects this. The independent review into the adequacy of the procurement and mobilisation of the service, have been shared widely and the outcomes considered at the lessons learned meeting held on 14 November. I can confirm a representative from the Royal Sussex County Hospital Renal Dialysis Unit was invited to attend but cancelled with late notice due to pressing clinical matters. I can confirm that outcomes from the event will be circulated once received from the external facilitator.

- The combined CCG's in Sussex to consider the viability of and their capacity to service a model of commissioning that allows one CCG to act on behalf of the others as a lead commissioner.

CCG response
Each CCG is accountable for its own decisions and actions. I take this responsibility very seriously within Brighton and Hove CCG. No CCG can make decisions on behalf of other CCGs and the role of the lead commissioner is to coordinate actions and responses. At the lessons learned meeting on 14th November 2017 it was noted that the existing Memorandum of Understanding between the Sussex CCGs that supports this process requires review to ensure that it accurately reflects the responsibilities of the lead commissioner and associate commissioners.

- Overview scrutiny and independent review processes to be clearly built into future similar commissioning.
- A full and transparent investigation of the financial implications of this service failure should be undertaken with the results made public. The financial impact of the Coperforma failure should also be taken into account the costs to the NHS of clinical and administrative staff having been constantly diverted from their duties to fire fight and resolve patient transport issues. Any recommendations should materially inform future commissioning processes.

CCG response
These areas are both covered in the TIAA reports recommendations and the CCGs have already taken account of them in the PTS phased transition and mobilisation plan to the new provider.

In response to your additional questions regarding the independent report I can confirm two independent reports were commissioned by Sussex CCGs. The first is the TIAA report reviewing the transition and mobilization of the PTS contract which has been published. The second is a review of the PTS procurement arrangements which is currently in draft. This report is being reviewed by NHS South of England procurement for comment and accuracy. It is anticipated this report will be published in early 2017.

I can confirm the total cost of the PTS contract is £62 million over five years which represents 0.5% of the total Sussex NHS commissioning budget. All Sussex CCGs' annual accounts, annual reports and the reports of their independent external and internal auditors are published on the CCG websites. I expect that the financial implications of the PTS contract and its transfer to SCAS will be covered in these documents.

5. The role of Healthwatch, the Care Quality Commission, performance monitoring and quality assurance

- Clear inspection and independent quality assurance processes should be in place for PTS. As the lines of service delivery grow longer and further away from direct NHS control, the question about how quality and performance can be effectively assured has to be asked. This is particularly the case where there might be a lack of clarity about what body has the responsibility to inspect and quality assure the service i.e. who should have inspected Coperforma when it was essentially a 'call centre' which serviced subcontractors who actually provided the transport service.
- Healthwatch England, the Care Quality Commission and NHS should consider how local Healthwatch organisations can best be supported when responding to major service failure.

CCG response
I acknowledge the issues that you have raised and suggest we work together to be clear about the assurance role for Healthwatch in this context. I would add that there are clear quality assurance and inspection processes in place for PTS which are articulated in the service specification and NHS contract requirements. The CCGs monitor PTS in the same way it contract performance manages all healthcare providers, regardless of the provider being independent or NHS. Patient transport providers also come under the national regulatory responsibility framework of NHS Improvement and the CQC.

In summary I would like to reiterate my thanks for your report and I do hope you have found my response helpful.

With best wishes

Yours sincerely

Adam Doyle
Chief Accountable Officer
NHS Brighton & Hove Clinical Commissioning Group

healthwatch Brighton and Hove

Renal Dialysis PTS interviews

Patients only interviewed if they have used PTS to attend appointments at the unit.

Visiting the Renal Dialysis Unit

Q1 How long have you been coming to the unit?

Q2 How frequent are your visits currently?

Why are you using PTS?

Q3 How important is PTS in being able to receive your treatment?

Using PTS

Service before April 2016

Q4 How satisfactory was the PTS service you received before April 2016?

Very Unsatisfactory	Unsatisfactory	OK	Satisfactory	Very Satisfactory
☐	☐	☐	☐	☐

Q5 Please describe your experience.

Prompt issues that can be mentioned:

Did transport arrive on time?
How long were delays if experienced?
If delays - on what proportion of journeys were delays experienced?
How was the quality of transport provided - appropriateness of service etc?

Q6 Please describe a typical PTS experience in early 2016 (before April).

PTS service April - July 2016

Q7 How satisfactory was the PTS service you received between April and July 2016?

Very Unsatisfactory	Unsatisfactory	OK	Satisfactory	Very Satisfactory
☐	☐	☐	☐	☐

Q8 Please describe your experience.

Prompt issues that can be mentioned:

Did transport arrive on time?
How long were delays if experienced?
If delays - on what proportion of journeys were delays experienced?
How was the quality of transport provided - appropriateness of service etc?

Q9 Please describe a typical PTS experience in this period

PTS service August - currently

Q10 How satisfactory has the PTS service been since August 2016?

Very Unsatisfactory	Unsatisfactory	OK	Satisfactory	Very Satisfactory
☐	☐	☐	☐	☐

Q11 Please describe your experience.

Prompt issues that can be mentioned:

Did transport arrive on time?
How long were delays if experienced?
If delays - on what proportion of journeys were delays experienced?
How was the quality of transport provided - appropriateness of service etc?

Q12 Please describe a typical PTS experience since August.

Impact of PTS problems (if experienced)

Q13 Please describe the impact of PTS problems on yourself or your treatment

Prompt issues that can be mentioned:

Missed hospital appointments?
Longer time needed to attend appointments due to delays?
Shorter treatment times?
Anxiety, stress?
Issues about care of children/family members?

Cause of delays (if experienced)

Q14 What reasons, if any, have been given to explain delays/problems?

Q15 What do you think is causing the delay/problems?

Raising concerns/making a complaint

Q16 Have you attempted to raise a concern or make a complaint about PTS?

Q17 What happened?

Q18 If not, why have you not complained?

General assessment of PTS service recieved since April

Q19 Please comment on the overall quality of the service you have received since April

Prompt issues that can be mentioned:

Competence of drivers
Health and Safety
Ability of driver to communicate
Driver's knowledge to get to hospital
Appropriate medical knowledge of staff

Friends and Family Question

Q20 How likely are you to recommend the PTS service to friends and family if they needed similar care or treatment?

Very Unlikely	Unlikely	Neither Unlikely nor Likely	Likely	Very Likely
☐	☐	☐	☐	☐

Additional comments and consent

Q21 Are there any other issues about PTS you want to raise?

Q22 Do you give consent for Healthwatch Brighton and Hove to share the information you have provided with PTS regulators (e.g. CCG and CQC)?

Yes ☐

Q23 Are you willing to do a short follow-up interview with Healthwatch to discuss your experience with PTS in more detail?

Yes ☐

Q24 Contact details if consent is given:

Name

Phone number

email