HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 23rd July, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 23rd July, 2010, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone: **01622 694486**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr A D Crowther, Mr G Cooke, Mr K A Ferrin, MBE, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Cllr J Cunningham, Cllr C Kirby, Cllr M Lyons, and Cllr Mrs M Peters
LINk Representatives (2):	Mr M J Fittock and Mr R Kendall

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item — Timings

1. Substitutes

2. Declarations of Interests by Members in items on the Agenda for this meeting.

3. Minutes (Pages 1 - 6)

4. Meeting Dates for 2011

The Committee is asked to note that the following dates have been reserved for its meetings in 2011:-

Friday 7 January 2011	Friday 22 July 2011
Friday 4 February 2011	Friday 9 September 2011

Friday 25 March 2011	Friday 14 October 2011
Friday 29 April 2011	Friday 25 November 2011
Friday 10 June 2011	

All meetings commence at 10.00 am at County Hall

5.	Diagnostics - Waiting Times (Pages 7 - 30)	10.10 – 11.20
	BREAK	
6.	Update on Health and Transport (Pages 31 - 120)	11.30 – 12.20
7.	Pharmaceutical Needs Assessment - NHS Eastern and Coastal Kent (Pages 121 - 124)	12.20 – 12.35
8.	Update on Dover Healthcare (Pages 125 - 128)	12.35 – 12.40
9.	Forward Work Programme (Pages 129 - 130)	12.40 – 12.45
10.	Update on Referral to the Secretary of State for Health (Pages 131 - 144)	12.45 – 13.10
11.	Committee Topic Discussion (Pages 145 - 146)	13.10 – 13.30
12.	Date of next programmed meeting – Friday 3 September 2010 @ 9.30am	

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

15 July 2010

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 11 June 2010.

PRESENT: Mr G A Horne MBE (Chairman), Mr B R Cope (Vice-Chairman), Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr R L H Long, TD, Mr C P Smith, Mr R Tolputt, Mrs J Whittle, Mr A Willicombe, Mr R Brookbank (Substitute for Mr A D Crowther), Cllr J Cunningham, Cllr M Lyons, Mr M J Fittock and Mr R Kendall

ALSO PRESENT: Cllr John Avey, Mrs A Burnand, Mrs C Davis, Cllr R Davison, Ms T Gailey, Cllr P Gulvin, Mr R Kenworthy, Mr R A Marsh, Miss N Miller and Mr M Willis

IN ATTENDANCE: Mr P D Wickenden (Overview, Scrutiny and Localism Manager) and Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Membership

The Overview, Scrutiny and Localism Manager drew a number of Membership changes to the attention of the Committee. Mr Adrian Crowther had replaced Mr Jeremy Kite. The East Kent Borough Co-Optees were confirmed as Mr Charles Kirby and Mr Michael Lyons. The West Kent Borough Co-Optees were confirmed as Mr John Cunningham and Mrs Marilyn Peters.

2. Minutes

(Item 3)

RESOLVED that the Minutes of the meeting held on 26 March 2010 are correctly recorded and that they be signed by the Chairman.

3. Accessing Mental Health Services: Adult and Older People's Inpatient Services

(Item 4)

Part A: East Kent Health Economy

Lauretta Kavanagh (Director of Commissioning for Mental Health and Substance Misuse, Kent and Medway PCTs), Joanne Ross (Lead Commissioner for Mental Health, NHS Eastern and Coastal Kent), Dave Woodward (Social Care Commissioner for Mental Health, Kent Adult Social Services), Linda Caldwell (Lead Commissioner for Older People's Services, NHS Eastern and Coastal Kent), Sue Gratton (Head of Integrated Commissioning, NHS Eastern and Coastal Kent), Erville Millar (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust),

James Sinclair (Executive Director of Social Care and Partnerships, Kent and Medway NHS and Social Care Partnership Trust), and Nigel Lowther (Kent and Medway NHS and Social Care Partnership Trust) were present for this item.

(1) As Lead Commissioner for Mental Health on behalf of the three Primary Care Trusts in Kent and Medway, as well as joint commissioning lead with Kent Adult Social Services, Lauretta Kavanagh undertook to provide an overview of the strategic context of mental health services in Kent. The two Local Authorities and three PCTs had recently produced a draft strategy for improving the mental health and wellbeing of people in Kent and Medway called Live it Well. This was built around the twin aims of promoting good health and improving access to services.

(2) Talking specifically about NHS Eastern and Coastal Kent, the PCT had agreed a dementia strategy with Kent County Council in 2005. The subsequent National Dementia Strategy had specified that early diagnosis was key, as was the support of carers and providing appropriate levels of community support. In terms of adult and older people's inpatient services, the NHS had provided a detailed breakdown of the wide range of services provided and this was included in the information provided to Members in the Agenda pack.

(3) In response to a question about how decisions about mental health provision were made, Lauretta Kavanagh explained that the PCT and social services assessed the needs of the community and produced a Joint Strategic Needs Assessment. Kent and Medway NHS and Social Care Partnership Trust (KMPT) was the largest provider of mental health services, but were not the sole one. There were numerous independent providers also, and so the actual bed stock available was larger than that indicated in the papers.

(4) There has been a reduction nationally in the number of acute mental health admissions and Crisis Resolution Home Treatment teams had been established to act as gatekeepers to acute care and provide acute care in people's homes if it was appropriate. It was conceded by representatives of the NHS that there had been a degree of failure in communicating the relatively narrow criteria in accessing crisis services i.e. those who would otherwise need to be admitted into an acute setting.

(5) Crisis services should not be the first port of call for patients and so community services were being enhanced. Borough and District Councils in East Kent were working with the NHS in developing supported accommodation units.

(6) There were a range of other initiatives, such as 6 Admiral Nurses in East Kent who were able to provide specialised support for carers and the Alzheimer Society run café which enabled peer support and for the needs of carers to be picked up. It was admitted that respite services needed to be further developed and that they needed to be flexible as to times and locations.

(7) The scheme to improve access to psychological therapies ('talking therapies') had reached the third year in the first three year cycle of a six year programme. Referrals had increased by 20% and waiting times for accessing these services ranged from 4 to 17 weeks. A target of ensuring that waiting times were no longer than four weeks has been built into performance targets expected of providers by commissioners. One Member made the point that there were often calls for Councillors to use grant money to help fund counselling services for teenagers.

(8) Although children's mental health services were not the focus of the meeting and detailed responses were not possible, Erville Millar took the opportunity to raise an issue about the caseloads of Tier 3 CAMHS workers in West Kent and Swale, which were around 300 per person, as opposed to the 80 which was recommended.

(9) Several Members noted that the system had improved greatly since large institutions such as Chartham were used across the board, but felt there was need for greater reassurances that community provision was in place and adequate to meet the demand before any further reduction in inpatient services.

(10) Moving on to consider secure accommodation, Erville Millar made the point that those with mental health needs were more likely to be victims of crime than to commit them. 82 medium secure beds are provided in Kent, in Dartford and Maidstone. Kent and Medway NHS and Social Care Partnership Trust (KMPT) were the only provider of forensic mental health services in Kent. Reoffending rates were much lower for those patients who were placed in secure accommodation compared to being put in prison. This was because of the emphasis put on assisting people to reintegrate back into society while resident in these specialised services.

(11) In response to a specific question about the St. Martin's development, Erville Millar stated that construction would commence in December 2010 with patients able to access the new facilities in April 2012.

Part B: West Kent Health Economy

Lauretta Kavanagh (Director of Commissioning for Mental Health and Substance Misuse, Kent and Medway PCTs), Julia Ross (Director of Strategy and Communications, NHS West Kent), Paul Absolon (Social Care Commissioner for West Kent, Kent Adult Social Services), Emma Hanson, Joint Commissioning Manager for Dementia Services, Kent Adult Social Services/NHS West Kent, Erville Millar (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), James Sinclair (Executive Director of Social Care and Partnerships, Kent and Medway NHS and Social Care Partnership Trust), and Nigel Lowther (Kent and Medway NHS and Social Care Partnership Trust) were present for this item.

(12) Spending on mental health accounts for around 14% of NHS spending in England and there was much discussion as to how this worked in practice through both parts of the meeting. Some Members expressed scepticism that the formula used for allocating funding truly matched the demographic picture of Kent. Representatives of the NHS explained that while there was currently no tariff in mental health in the way there was for acute services, work was being carried out and it was unlikely that it would operate in the same way and would be most usefully structures around care pathways. The point was made that block contracts could be useful and flexibility was the key to any successful financial structure.

(13) A range of financial levers were open to commissioners in order to try and improve service quality, such as Commissioning for Quality and Innovation (CQUIN) payments, which make a proportion of the contract payment dependent on achieving certain quality standards. Performance indicators were part of every contract.

(14) Mark Fittock, a representative of the Kent LINk, informed the Committee that they were carrying out an investigation into mental health services and the report would be presented to the Committee later in the year. A representative from West Kent outlined how service users were continually being involved in service development, and that the Kent LINk had been invited to participate in the Commissioning Delivery Teams established by NHS West Kent.

(15) Picking up on the earlier discussion on crisis services, Erville Millar explained that one local success concerned early onset psychosis. This affected 1 in 100 people between 14 and 35 and patients were now engaged rapidly to enable them to manage their condition and avoid admission to hospital.

(16) Tunbridge Wells Borough Councillor John Cunningham outlined the findings of a report into mental health services produced by a joint committee of Maidstone and Tunbridge Wells Councils. Hard copies of the report were made available for Members. He highlighted the good work being carried out by the anti-stigma Time to Change campaign in which KCC and KMPT were partners. He highlighted one of the recommendations which called on Kent County Council to provide more support for patients to undertake voluntary work to ease them back into work. The Sunlight Centre in Gillingham was given as an example of good practice.

(17) Representatives from both the NHS and KCC welcomed the work carried out in producing the report. Erville Millar stressed that the key point about mental health is that it is all around us and that in an organisation the size of KMPT 700 staff could be experiencing mental health problems at any one time. Paul Absolon from Kent Adult Social Services added that there was a need to be creative in engaging the community, including the use of social networking sites.

(18) Questions were raised about the number of rehabilitation beds and the length of stay. It was explained that the 21 rehabilitation beds were quasi-residential and involved mental health professionals inculcating life skills in the residents, without which they would need even longer stays in hospital and that the average length of stay for a year had to be judged in this context. Erville Millar added that admitting mental health patients was often to do them a disservice and all the alternatives needed to be considered, especially those that enabled home care. He added further clarification in that there were two population sets who accessed rehabilitation services, those who needed new skills to enable independent living and those for whom the prospect of independent living had passed.

(19) It was around the area of delayed transfers of care, involving those people who should not be in acute settings, that the greatest need for co-operation between the NHS and social services was felt to exist.

(20) In response to a specific question from a member of the public attending the meeting, Erville Millar stated that respite care bookings at Priority House were being honoured pending a proper review.

(21) Picking up on an earlier point, it was revealed that there are 12 Admiral Nurses across Kent and that this is the highest concentration in England.

(22) Despite acknowledging much of the good work that was done, Members still had concerns that in West Kent, as in East Kent, there were major challenges in

mental health and that there was a need to ensure community provision was available and of the appropriate standard before bed numbers were further reduced. Julia Ross from NHS West Kent extended an open invitation to any Member who wished to explore this topic in more detail to get in contact.

4. Further Information on Dentistry
(Item 5)

(1) RESOLVED that the additional information supplied by the NHS be noted.

5. Paediatric Audiology Services in West Kent
(Item 6)

(1) The Chairman provided a verbal update on this issue. It had been brought to his attention that paediatric audiology assessment services were being improved in West Kent in the sense that satellite services were being provided in three community hospitals but that services in Maidstone were going to be removed until suitable premises could be located. A meeting with those running the service had taken place and correspondence exchanged with NHS West Kent. This is included in the Appendix to these Minutes.

(2) The Chairman undertook to further pursue this issue and report back to the Committee at a later date.

6. Committee Topic Discussion
(Item 7)

(1) Members felt that given the complexity of the issues around mental health the Committee had only really begun to scratch the surface and while they gained a lot of useful information, they needed an opportunity to pursue the subject to a deeper level. In particular there was a need to see what can be done once a patient leaves acute care.

(2) There was a sense that a fuller and more frank exchange of information would enable the Committee to support and assist the NHS in achieving the aim of improving service provision for the people of Kent.

(3) The Overview, Scrutiny and Localism Manager outlined a range of ways in which a deeper mutual understanding between the NHS and KCC could be developed, including shadowing NHS Trust Non-Executive Directors and taking on the role of rapporteurs.

7. Date of next programmed meeting – Friday 23 July 2010 @ 10:00am
(Item 8)

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 23 July 2010

Subject: Item 5. Intended Outcomes: Diagnostics – Waiting Times.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. Two sets of questions are set out below, both of which the meeting will look to having answered by the end of the meeting: the strategic questions, of particular interest to members of the public, and the more detailed questions. The detailed questions have been sent to the attendees in advance of the meeting.

(3) Please note that it is the intention that cancer services will be considered at a future meeting, and this meeting will focus on the key diagnostic tests covered under imaging, physiological assessments and endoscopies.

2. Hierarchy of Questions

(1). Strategic Question

(1) How successful is the NHS in Kent at ensuring people receive the appropriate diagnostic tests in a timely fashion?

(2). Detailed Questions

(1) How many people resident in your PCT area undergo the key diagnostic tests each year and what information can you provide about waiting times over the last two years?
(2) How many people have their diagnostic tests carried out in a) acute hospitals b) community and primary care settings? Do the waiting times differ depending on setting?
(3) How much is spent on diagnostics?
(4) What role does patient choice play in choosing where and when to have a diagnostic test?
(5) Are there any areas of weakness in delivering diagnostic tests which have been identified and what measures have been put in place to improve the situation?

(6) Is there any relevant PALs data you can provide regarding diagnostic tests in your health economy?
(7) In general, what changes have there been to how and where diagnostic tests are carried out in recent years?
(8) What plans have been, or are being made, to modernise pathology services across Kent?
(9) How are test results communicated to a patient's GP, how long does this normally take, and are there any specific challenges in this area?
(10) Specifically on the topic of audiology, how long are waiting times for replacement hearing aids, and does the length of time for an appointment depend on whether a full test is required?
(11) Can you please outline how paediatric audiology assessment services are organised in your health economy, and whether there any changes being planned or undertaken?

3. Recommendations

(a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 23 July 2010

Subject: Item 5: Diagnostics – Waiting Times.

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1. Introduction.

(a) A *diagnostic test or procedure* is one which is used to identify a person's disease or condition and so allows a medical diagnosis to be made.

(b) This is in contrast to a *therapeutic procedure* which involves actual treatment of a person's disease, condition or injury.

(c) The settings where diagnostic tests are carried out vary on the test, staff, and equipment required.

(d) In recent years waiting times for diagnostic tests have been recorded by the Department of Health as part of the target for a maximum of an 18-week referral to treatment waiting time. In the December 2009 NHS Operating Framework, one of the supporting measures for the 18-week target is the number of patients waiting less than 6 weeks for a diagnostic test.

(e) A revision to the NHS Operating Framework was published on 21 June 2010. The following is an extract from the section on 18-week waiting times[1]:

"NHS organisations have made significant improvements in access to elective care. Average waiting times now need to be reduced, in line with international experience. Accountability to patients and greater information transparency, through patient choice and the move towards GP-led commissioning, should now make long waits unacceptable. Performance management of the 18 weeks waiting times target by the Department of Health will cease with immediate effect.

"To maintain progress during 2010/11:

- commissioners should maintain the contractual position and GPs and commissioners will want to ensure that any flexibility to improve access reflects local clinical priorities; and
- referral to treatment data will continue to be published and monitored. Commissioners will want to use the median wait as an additional measure for performance managing providers."

[1] Department of Health, 21 June 2010, *Revision to the Operating Framework for the NHS in England 2010/11*, p.7, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116860.pdf

2. Definitions of diagnostic tests

(a) The following are the diagnostic tests for which data has been collected along with a brief description:

(b) Part 1 - Imaging

1. Computed Tomography (CT, sometime referred to as a CAT scan).

    a. This uses x-ray techniques and allows a radiologist to take a series of pictures across the body and view images I two or three dimensional form. It can show organs such as the liver, spleen, kidneys and pancreas in great clarity.

2. Magnetic Resonance Imaging (MRI).

    a. Similar to a CT scan, this uses magnetism and radio waves in order to build up a series of cross-sectional images of tissue.

    b. MR angiography (MRA) uses MRI technology to assist with the diagnosis and treatment of heart disorders, stroke and blood vessel diseases.

3. Non-obstetric ultrasound.

    a. This uses high frequency sound waves for examining soft tissue and fluid filled organs such as the bladder and gall bladder.

4. Barium Enema.

    a. This procedure uses x-rays to examine the large bowel and is preceded 48 hours before the test by a special diet and laxative preparation.

5. DEXA Scan (Dual-energy X-ray absorptiometry).

    a. This uses low doses of x-rays to determine bone density.

(c) Part 2 – Physiological Measurement

1. Audiology – Audiology Assessments.

    a. This term covers a wide range on hearing and balance assessments including referral for hearing aid assessment, tinnitus assessment and paediatric hearing services following newborn screening.

2. Cardiology – echocardiography.

a. High frequency sound waves are used to produce images of the heart and are used in the diagnosis of heart failure, blood clots and other conditions. The two most common methods of carrying out the procedure are:

i. thransthoracic echocardiogram (TTE) where the probe is placed on the external chest wall; and,

ii. transoesophageal echocardiogram (TOE) where a probe is passed into the oesophagus mounted on a flexible tube.

3. Cardiology – electrophysiology studies (EPS).

a. This is an invasive procedure carried out in a cardiac catheterisation lab. Catheters with multiple electrodes are placed at specific sites within the heart and provides a detailed analysis of the heart's electrical conduction system.

4. Neurophysiology - peripheral neurophysiology.

a. Two tests are covered by this term – Nerve Conduction Studies (NCS) which uses surface electrical stimulation to measure the function of nerves and muscles; and,

b. Electromyography (EMG) which measures the electrical activity of the muscle through a concentric needle electrode being inserted in the muscle and is used in conjunction with NCS and other clinical examinations to investigate causes of muscular weakness, spinal problems, Motor Neurone disease and other disorders.

5. Respiratory physiology - sleep studies.

a. This covers a range of techniques and technologies to diagnose a variety of sleep-breathing problems such as obstructive sleep apnoea.

6. Urodynamics - pressures & flows.

a. This is an umbrella term covering measurements of the ability of the bladder and urethra to fulfil their functions.

(d) Part 3 – Endoscopy.

1. An endoscope is a flexible cylindrical instrument equipped with fibre optics and used for a direct visual examination of any part of the interior of the body.

2. Colonoscopy.

    a. This is an examination of the lining of the colon (large bowel) and is sometimes used to confirm the results of procedures like a barium enema.

3. Flexi sigmoidoscopy.

    a. This is an examination of the lining of the rectum and lower colon and is sometimes used to confirm the results of procedures like a barium enema.

4. Cystoscopy.

    a. This is an examination of the bladder and urethra to aid the diagnosis

5. Gastroscopy (Upper Gastro Intestinal endoscopy).

    a. This is an examination of the upper part of the gastrointestinal tract and may follow other tests such as x-rays.

NHS
West Kent

Diagnostics- Waiting Times

Introduction

This paper provides information on diagnostic waits within NHS West Kent and shows the improvements made in waiting times over the past two years. This paper informs the Health Overview Scrutiny Committee of the improvements that have been made in diagnostic wait times within NHS West Kent based on data from April 2008 to April 2010.

It is noted that the Health Overview and Scrutiny Committee intends to examine cancer waiting times at a later date. However, the tests covered in this report will include people whose outcome results in a diagnosis of cancer as the figures are not held separately.

It is also noted that the HOSC has requested information on key diagnostics and therefore this report does not cover pathology, which is classed as a diagnostic although there is no national requirement to report activity or waiting times for pathology testing. However within the answer to question 9, Pathology is referred to.

The population in NHS West Kent is around 674,000. The majority of diagnostic testing is carried out in the acute sector at Maidstone and Tunbridge Wells Trust and Dartford and Gravesham NHS Trust.

Overview

The NHS Improvement Plan set out the target of a maximum 18 week start to treatment waiting time by December 2008 and that was the first time that the target included a waiting times target for diagnostics. This was then set at 6 weeks maximum wait for the diagnostic element of the pathway and the guidance stated that zero breaches should be met as rapidly as possible after March 2008.

The definition of a diagnostic test is a test or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made.

When measuring the waiting time, the clock starts when the request is made and stops when the patient receives the test or procedure. If a patient cancels or misses an appointment for a diagnostic test/procedure then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled/ missed.

If a patient is waiting for more than one test then the clock is measured separately for each one.

The recording of wait times is split between 15 key diagnostic tests and all others. The 15 key tests fall into 3 broad categories as follows:

Imaging –

- Magnetic Resonance Imaging (MRI),
- Computed Tomography (CT),
- Non-obstetric ultrasound,
- DEXA Scan,
- Barium Enema

Physiological Measurement –

- Audiology,
- Cardiology (echocardiography and electrophysiology),
- Neurophysiology,
- Respiratory physiology (Sleep Studies),
- Urodynamics

Endoscopy -

- Gastroscopy,
- Colonoscopy,
- Flexi Sigmoidoscopy
- Cystoscopy

Questions and Answers

1. **How many people resident in your PCT area undergo the key diagnostic tests each year and what information can you provide about waiting times over the past two years?**

Answer: Currently approximately 180,000 diagnostic tests per year are carried out in West Kent. Table 1 show the number of patients undergoing each of the 15 key diagnostic tests over the past two years. It should be noted that the numbers below are the number of tests not the number of patients.

Table 1

Name of Test	**2008/09**	**2009/10**
Magnetic Resonance Imaging	18,460	21,063
Computed Tomography	41,915	45,812
Non-obstetric ultrasound	55,243	59,152
Barium Enema	607	310
DEXA Scan	3,801	3,128

Audiology - Assessments	23,733	24,219
Cardiology – echocardiography	12,099	13,240
Cardiology – electrophysiology	26	48
Neurophysiology – peripheral neurophysiology	987	697
Respiratory physiology – sleep studies	264	472
Urodynamics – pressures & flows	630	648
Colonoscopy	3,849	4,283
Flexi sigmoidoscopy	1,614	1,896
Cystoscopy	3,531	4,052
Gastroscopy	5,557	5,992
Totals	**172,316**	**185,012**

Table 1b shows;

- The average number of weeks spent waiting time for each of the 15 diagnostic tests.
- The actual number of patients waiting longer than 6 weeks for each of the 15 diagnostic tests.

Table 1b

Name of Test	**April 08 Average weeks spent waiting**	**Number of Patients waiting > 6 weeks**	**April 09 Average weeks spent waiting**	**Number of Patients waiting > 6 weeks**	**March 10 Average weeks spent waiting**	**Number of Patients waiting > 6 weeks**
Magnetic Resonance Imaging	2.3	33	2.2	0	2.0	0
Computed Tomography	1.1	0	1.5	0	1.6	2
Non-obstetric ultrasound	1.4	5	1.7	0	1.5	0
Barium Enema	0.2	4	0.2	0	0.3	0
DEXA Scan	2.5	7	1.1	0	1.5	0
Audiology - Assessments	0.4	84	0.4	92	0.3	2
Cardiology –	2.0	21	2.2	0	2.7	9

echocardiography						
Cardiology – electrophysiology	5.5	0	0	0	0	0
Neurophysiology – peripheral neurophysiology	2.5	1	3.6	0	2.2	3
Respiratory physiology – sleep studies	2.1	0	4.0	1	3.0	0
Urodynamics – pressures & flows	3.4	0	3.0	0	3.0	1
Colonoscopy	2.6	14	2.5	3	2.7	16
Flexi sigmoidoscopy	2.6	7	2.4	0	2.8	1
Cystoscopy	3.2	14	2.5	1	2.5	0
Gastroscopy	2.6	19	2.7	2	2.5	10
Totals	**2.3**	209	**2.0**	99	**1.9**	44

2. **How many people have their diagnostic tests carried out in a) acute hospitals b) community and primary care settings? Do the waiting times differ depending on setting?**

Answer: The majority of diagnostics carried out in West Kent are carried out in either an NHS or private provider acute setting. A small number of tests are carried out via community provision (Table 2). Where provision is available in both a community and acute setting there is no significant difference in waiting times.

Table 2

Provider	**Service**	**Number of Patients Seen**
Snodland Medical Centre, Snodland	echocardiography	924
Preston Hall, Maidstone	audiology	912
Sevenoaks Hospital, Sevenoaks	audiology	732
Edenbridge Cottage Hospital, Edenbridge	audiology	312

Cardio-Thoracic Consortium Ltd (CTC), Kings Hill	Doppler	253

3. **How much is spent on diagnostics?**

Answer: There are two ways in which the PCT pays for diagnostic testing. The first is where the test is requested by clinicians in primary care, which is known as direct access. An example of this is a GP requests a chest x-ray to aid diagnosis before making a referral for onward care. The second is where a test is requested by clinicians in secondary care. The cost of these diagnostics is included in the tariff price the PCT pays as part of our acute contracts. An example of this is where a patient attends an out patient appointment and the clinician requests the chest x-ray. This means that it is not possible to provide the total value of diagnostic tests. Table 3 shows for the current financial year 2010/11 the indicative budget for direct access diagnostics in the acute setting is

Table 3

Speciality name	**Sum of SLA plan 2010/11 £,000**
Direct access cardiology	11,238
Direct access Pathology	7,120,599
Direct access radiology	4,234,773

4. **What role does patient choice play in choosing where and when to have a diagnostic test?**

Answer: Where diagnostic provision is available from multiple providers patient choice is available through discussion between the referring clinician and the patient. NHS West Kent has worked in conjunction with PBC groups and the private sector to ensure alternate provision is available where appropriate.

5. **Are there any identified weakness in delivering diagnostic tests which have been identified and what measures have been put in place to improve the situation?**

Answer: Due to changes in the accreditation several providers withdrew provision of semen analysis. This left NHS West Kent with provision from only the William Harvey Laboratories at Ashford and Guys hospital. Due to the limited sample stability and associated difficulties with sample collection upon arrival Additional provision in Tunbridge Wells has now been commissioned via a private provider. The PCT is also actively engaged in discussions with Medway FT to re-introduce provision of their service. It is expected that Medway provision will recommence in September.

6. **Is there any PALS data you can provide regarding diagnostic tests in the health economy?**

Answer: One complaint was received around reporting times for x-rays from Darent Valley Hospital during the Christmas and bad weather period 09/10. This complaint was fully investigated and responded to.

7. **In general, what changes have there been to how and where diagnostic tests are carried out in recent years?**

Answer: There have been no significant changes in diagnostics during the last few years. Greater choice of provision has been made available by the introduction of private sector provision including access to radiology at Beneden Hospital for patients living in the Weald and to Fawkem Manor hospital for patients living in the Dartford, Gravesham and Swanley.

Brain Natriuretic Peptide (BNP) analysis prior to requesting an echocardiogram is now standard across NHS West Kent. Community provision of echocardiograms was introduced as part of the cardiology GP with special interest (GPwSI) service run from the Snodland Medical Centre.

8. **What plans have been or are being made to modernise pathology services across Kent?**

Answer: The Kent and Medway pathology network has acted as the hub for the modernisation of pathology services across Kent for over four years. During this time pathology has undergone a series of service redesign including increased automation, changes in the staffing skill mix and the merger of Haematology and Clinical Chemistry to create a Blood Sciences discipline.

The Network has recently commissioned a partner (through a tendering process) to assist in the service modification and reconfiguration of the whole network. This will deliver full business cases (FBCs) to meet the projects aims. These are:

a. Produce FBCs for the service modification and reconfiguration of the network to ensure best value is both available and provided
b. Identify other potential options within the constraints of service modernisation, financial resources, clinical adjacencies and local NHS re-configuration
c. Identify areas of risk
d. Identify potential areas of cost savings
e. Identify best use of facilities, staffing, financial resources and equipment.
f. Fully involve representative staff from all laboratories across Kent and Medway

9. **How are test results communicated to a patients GP how long does this normally take and are there any specific challenges in this area**

Answer: Results are communicated via a written report, with the exception of Pathology which is sent via electronic transfer. Reports are normally received within 72hrs of release. Pathology data is normally available to the GP within 24hrs of release.

10. **Specifically on the topic of audiology , how long are waiting times for replacement hearing aids and does the length of time for an appointment depend on whether a full test in required?**

Answer: The waiting times for a replacement hearing aid are between 1 to 2 weeks for a straight replacement. If a full test is required the waiting times are 2 to 4 weeks. The increased waiting time is because the addition of a hearing test increases the appointment time by 15 minutes and cannot be undertaken by an ATO (Assistant Technical Officer).

An additional factor is earmoulds - if the mould is serviceable or if the aid has a life fitting the aid can be replaced immediately. If not, a new mould needs to be made. Priority moulds have a two week lead time and standard moulds have a five week lead. New moulds can be posted to patients that are able to self fit avoiding the need for attendance. If the patient is unable to self fit they may have to attend a clinic to be fitted with the replacement aid as a follow-up.

11. **Can you please outline how paediatric audiology assessment services are organised in your health economy and whether there are any changes being planned or undertaken?**

Answer: All new born babies are initially screened as part of the new born hearing screening programme (on maternity wards). In addition, children who are found to have hearing difficulties either by health or social visitors , school nurses or GP's are referred into paediatric services for initial assessment and from there onto paediatric audiology services. A number of community clinics run by consultants and audiologists exist across the primary trust area. These clinics are based at Hawkhurst, Sevenoaks and Gravesham community hospital. The service currently provided at Preston Hall is due to be phased out, and discussions around future provision in Maidstone are ongoing. The waiting time for these clinics is currently 4 weeks.

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NHS
Eastern and Coastal Kent

Sheila Pitt
Head of Cancer, Long Term Conditions and Therapies
NHS Eastern and Coastal Kent

Diagnostics- Waiting Times

Introduction

1. This report has been compiled to address the subject of diagnostic waiting times. This has been a challenging area for NHS Eastern and Coastal Kent (NHS ECK) in terms of commissioned providers meeting the national target of zero numbers of people waiting longer than 6 weeks for their test. The report demonstrates the size of the challenge and shows the improvements made in waiting times over the past two years.

2. It is noted that the Health Overview and Scrutiny Committee intends to examine cancer waiting times at a later date, however, the tests covered in this report will include people whose outcome results in a diagnosis of cancer as the figures are not held separately.

3. It is also noted that the HOSC have requested information on key diagnostics and therefore this report does not cover pathology which is classed as a diagnostic although there is no national requirement to report activity or waiting times for pathology testing. However within the answer to question 9 Pathology is referred to.

4. The population in NHS Eastern and Coastal Kent is around 710,000. The majority of diagnostic testing is carried out in the acute sector at East Kent University Hospitals Trust and Medway Foundation Trust. The PCT is working towards developing a greater range of diagnostic service within community settings.

Overview

5. The NHS Improvement Plan set out the target of a maximum 18 week start to treatment waiting time by December 2008 and that was the first time that the target included a waiting times target for diagnostics. This was then set at 6 weeks maximum wait for the diagnostic element of the pathway and the guidance stated that zero breaches should be met as rapidly as possible after March 2008.

6. The definition of a diagnostic test is a test or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made.

7. Tests carried out as part of a national screening programme (such as mammograms for breast screening or colonoscopy for bowel screening) are not included in this report as they are monitored separately and will be reported to HOSC within the cancer waiting times report. However, any subsequent diagnostic that is triggered by an abnormal screening result will be included but not identified separately.

8. When measuring the waiting time, the clock starts when the request is made and stops when the patient receives the test or procedure. If a patient cancels or misses an appointment for a diagnostic test/procedure then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled/ missed.

9. If a patient is waiting for more than one test then the clock is measured separately for each one.

10. The recording of wait times is split between 15 key diagnostic tests and all others. The 15 key tests fall into 3 broad categories as follows:

Imaging:

Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Non-obstetric ultrasound, DEXA Scan, Barium Enema

Physiological Measurement:

Audiology, Cardiology echocardiography, Cardiology electrophysiology, Neurophysiology, Respiratory physiology (Sleep Studies), Urodynamics

Endoscopy:

Gastroscopy, Colonoscopy, Flexi-Sigmoidoscopy, Cystoscopy

The 'other' tests include colposcopy, laparoscopy, bronchoscopy, nuclear medicine, unspecified imaging, lung volumes and gas exchange. This group of tests is reported quarterly and expectations are for zero breaches.

11. The position at April 2008 showed over 3,000 people waiting more than 6 weeks within the 15 key tests. The majority of these were within endoscopy and Dexa scans. The detail is provided within the response to question 1.

12. It has been challenging to resolve all the issues with our diagnostic providers as the tests are diverse and the responsibility therefore of a number of managers within provider services.

13. By April 2009 although the position was markedly improved, with about 380 people waiting longer than 6 weeks the PCT was concerned that despite assurances that

the position was being resolved, evidence of progress was patchy. The majority of breaches at this time were for neurophysiology.

14. Only 2 tests regularly maintained a zero breach position throughout 2009. These were barium enemas and cardiology electrophysiology. The major challenge during the year was the fluctuating position of endoscopy breaches at the main provider.
15. Through contractual performance management arrangements an action plan was agreed to address all breaches. This was monitored weekly and reported on monthly.

16. By April 2010 the number of breaches had reduced even further to just 14. The position for endoscopy has been zero breaches since March 2010 and sustainability is being monitored.

17. The reasons for the breaches that continue are a combination of unexpected events such as patient unavailability or equipment failure. In order to address issues that are within the control of the provider, such as equipment failure or staffing, the PCT has requested plans from all diagnostic test areas to achieve a regular 4 week wait time. This will then allow a 2 week buffer to manage the unexpected challenges as they arise.

Questions and Answers

1. **How many people resident in your PCT area undergo the key diagnostic tests each year and what information can you provide about waiting times over the past two years?**

Answer: During the past two years over 250,000 diagnostic tests per annum have been carried out across NHS ECK. It should be noted that the numbers below are the number of tests not the number of patients. Table 1a show the number of diagnostic tests for each of the past two years within an acute setting for NHS ECK patients.

Name of Test	2008/09 Number of tests	2009/10 Number of tests
Magnetic Resonance Imaging	40,916	49,648
Computed Tomography	62,846	72,198
Non-obstetric ultrasound	88,772	89,327
Barium Enema	3,927	3,729
DEXA Scan	5,010	4,543
Audiology - Assessments	18,662	16,814
Cardiology – echocardiography	11,004	10,674
Cardiology – electrophysiology	25	28

Neurophysiology – peripheral neurophysiology	3,853	3,803
Respiratory physiology – sleep studies	1,045	1,348
Urodynamics – pressures & flows	686	679
Colonoscopy	4,876	5,323
Flexi sigmoidoscopy	1,657	1,985
Cystoscopy	3,452	3,618
Gastroscopy	5,598	6,380
Totals	**252,329**	**270,097**

Table 1a

Some diagnostic tests are now commissioned within primary and community settings. Many of these services only commenced in 2009/10 on an "Any Willing Provider" contractual basis that does not offer guaranteed levels of activity or value (Department of Health guidance on this form of contract does not allow the PCT to agree contract values or activity levels, but we can identify an indicative expectation of these). It is expected that additional providers in the community will be identified and contracted with during 2010/11 and beyond.

The average numbers of weeks patients have had to wait for their diagnostic test has reduced from 7.04 weeks in April 2008 to 2.38 weeks in April 2010. During this two year period there have been many variations in the waiting time performance of the 15 key tests. An example of this is neurophysiology where, due to staffing issues, the actual number of patients waiting increased from 193 in 2008 to 252 in 2009. The service was based around an individual specialist, which meant that the tests were not being done and the number of patients waiting increased whenever that individual took leave. To resolve this, additional specialist time was provided through locums (now being made substantive) specifically to address the waiting list. Individual breach reports are requested as a breach occurs to fully understand why the 6 week target has not been achieved and to seek assurance that remedial action has been taken to address the reason why it happened. Table 1b shows for the last two years, the average waiting time for each of the 15 diagnostic tests and the actual number of patients waiting longer than 6 weeks for each of the 15 diagnostic tests.

Name of Test	April 08 Ave weeks wait	No. waiters > 6 weeks	April 09 Ave weeks wait	No. waiters > 6 weeks	April 10 Ave weeks wait	No. waiters > 6 weeks
Magnetic Resonance Imaging	2.84	42	2.49	12	2.29	1
Computed Tomography	2.33	20	2.42	18	1.75	0
Non-obstetric ultrasound	2.61	50	2.31	5	2.21	8

Barium Enema	2.18	2	2.24	0	1.76	0
DEXA Scan	8.50	550	2.03	0	1.71	0
Audiology - Assessments	3.32	1	2.97	1	2.52	0
Cardiology – echocardiography	3.04	11	2.86	2	2.88	2
Cardiology – electrophysiology	0	0	0.00	0	0	0
Neurophysiology – peripheral neurophysiology	6.58	193	7.48	254	2.32	1
Respiratory physiology – sleep studies	4.18	26	4.35	22	2.43	0
Urodynamics – pressures & flows	11.93	70	5.65	19	3.52	2
Colonoscopy	19.09	847	3.55	9	3.03	0
Flexi sigmoidoscopy	15.50	290	3.58	1	3.47	0
Cystoscopy	8.92	169	4.32	31	2.62	0
Gastroscopy	14.68	784	3.58	14	3.26	0
Totals	**7.04**	3055	**3.32**	388	**2.38**	14

Table 1b

2. **How many people have their diagnostic tests carried out in a) acute hospitals b) community and primary care settings? Do the waiting times differ depending on setting?**

Answer: The majority of patients have their diagnostic test in acute settings and these are reflected in Table 1a.

The PCT also has community contracts for some diagnostic services although these are not required to be recorded in the monthly reporting figures. The waiting times in community and primary care settings are all below six weeks as patients can access the services locally and each individual practice makes their own booking arrangements. Table 2 shows estimated levels of community based diagnostics already under contract

Diagnostic Test	**Localities**	**Estimated level of activity in 2010/11**
Non- obstetric ultrasound	Tenterden, Ramsgate and Whitstable	4721
Echocardiography	Canterbury, Whitstable and Tenterden	497
Audiology assessments	Whitstable, Ramsgate,	2900

	Deal, Sittingbourne, Ashford, Folkestone. Dover, Wye and Margate	

Table 2

3. How much is spent on diagnostics?

Answer: There are two ways in which the PCT pays for diagnostic testing. The first is where the test is requested by clinicians in primary care, which is known as direct access. An example of this is a GP requests a chest x-ray to aid diagnosis before making a referral for onward care. The second is where a test is requested by clinicians in secondary care. The cost of these diagnostics is included in the tariff price the PCT pays as part of our acute contracts. An example of this is where a patient attends an out patient appointment and the clinician requests the chest x-ray. This means that it is not possible to provide the total value of diagnostic tests. Table 3 shows for the current financial year 2010/11 the indicative budget for direct access diagnostics in the acute setting is

Contract line	**2010/11 Value (£ 000s)**
Direct access cardiology - EKHUFT	794,2
Direct access pathology - EKHUFT	12,087,8
Direct access radiology - EKHUFT	6,900,6
All Direct access diagnostics - MFT	1,601.5

Table 3

The community and primary care contracts are on a cost per case basis at agreed prices which are generally below the national tariff or locally agreed tariff for diagnostic tests. It is estimated that the spend on services as described in Table 2 will be in the region of £750,000

4. What role does patient choice play in choosing where and when to have a diagnostic test?

Where a GP requests a diagnostic test it is expected that a discussion takes place with the patient as to which location they attend for their diagnostic test. The PCT continually endeavours to ensure that every opportunity for provision outside normal working hours is explored within both current and new contracts. To this end EKHUFT radiology services have moved to opening from 8am - 8pm seven days a week from the beginning of July 2010. Other providers are encouraged towards weekend and evening appointments being made which is more convenient for patients.

5. Are there any identified areas of weakness in delivering diagnostic tests which have been identified and what measures have been put in place to improve the situation?

The majority of diagnostic activity sits within EKHUFT and it is the responsibility of NHS ECK to performance manage this contract. Responsibility for performance management of Medway Foundation Trust lies with Medway PCT. There is a process for raising performance issues between PCTs. However, the number of breaches at MFT have been minimal to date.

The following areas were highlighted as areas of weakness:
Endoscopy services at EKHUFT. There appeared to be very little progress made in reducing to zero the numbers across the 4 endoscopy disciplines. Zero breaches were not achieved and there were wide monthly fluctuations in breach numbers. A weekly endoscopy meeting was established to discuss and resolve operational issues and to monitor the situation.

Neurophysiology at EKHUFT. This service was being run by a single specialist and was affected each time leave was taken. Therefore numbers breaching ranged from 250 in March 2009 increasing to 333 in May 2009. There was no permanent solution being offered to this issue by the provider at that time.

As part of an ongoing action plan to resolve the breach position EKHUFT agreed to achieve 100 waiters by the end of October 2009 and zero breaches at the end of December 2009. Failure of the Trust to meet these agreed targets resulted in a formal performance notice being served on EKHUFT in February 2010. This required the Trust to provide, within 5 working days, robust action plans and trajectories, which would give an assurance to the PCT that a sustainable position of zero breaches would be achieved by March 2010. Failure to achieve this could have resulted in the PCT withholding monies from the contract.

Measures that were put in place include the appointment of 4 locum endoscopists (with plans for substantive appointments to these posts), procurement by the PCT of a community based endoscopy service to increase capacity and for neurophysiology, the permanent appointment of additional qualified staff.

To date EKHUFT have made significant improvements with only 10 breaches in April and 1 breach in May reported. The PCT continue to monitor performance on a monthly basis.

6. Is there any PALS data you can provide regarding diagnostic tests in the health economy?

The PALS team have identified the following number of enquiries and comments from April 2009 to June 2010 within the following areas from across NHS Eastern

and Coastal Kent. The PALS team have responded to all of the enquiries. Table 4 shows the spread of the 78 enquiries across all diagnostics.

Name of Test	Number of enquiries
Magnetic Resonance Imaging	28
Computed Tomography	8
Non-obstetric ultrasound	2
Barium Enema	2
Cardiology – echocardiography	2
Audiology - Assessments	6
Endoscopy	30

Table 4

7. In general, what changes have there been to how and where diagnostic tests are carried out in recent years?

The focus of the PCT is to provide care closer to home for our population. Diagnostic testing is included in this aim. In June 2008 NHS South East Coast published a vision document "Healthier People, Excellent Care – a vision for the south east coast". This pledged that for planned care diagnostic tests would be available on the local high street. Within NHS ECK the provision of primary care diagnostic services has begun as reflected in the answer to question 2. We continue to seek further opportunities to deliver more locally based, safe and cost effective services for patients. Both patients and clinicians continue to be engaged in working with us to achieve this.

8. What plans have been or are being made to modernise pathology services across Kent?

The Kent and Medway Pathology Network are currently seeking a partner (through a tendering process) to assist in the service modification and reconfiguration of the whole network. This will deliver full business cases (FBCs) to meet the projects aims. These are:

- Produce FBCs for the service modification and reconfiguration of the network to ensure best value is both available and provided
- Identify other potential options within the constraints of service modernisation, financial resources, clinical adjacencies and local NHS re-configuration
- Identify areas of risk
- Identify potential areas of cost savings
- Identify best use of facilities, staffing, financial resources and equipment.

- Fully involve representative staff from all laboratories across Kent and Medway

9. How are test results communicated to a patients GP, how long does this normally take and are there any specific challenges in this area?

Pathology test results are communicated electronically to GPs and these are sent out every 4 hours. During 2009 GPs across NHS ECK were asked whether they wished to receive a paper copy of the test results in addition to the electronic version. 90 practices responded and all requested an electronic copy only. The target time for a routine test response to GPs is 24 hours. For more specialist tests results may take longer depending upon the type of request e.g. cellular pathology can take 5 days, specialist microbiology could be 5 to 10 days, some histology may take 3 weeks. These extended result times reflect the way the test is carried out i.e a culture may need time to grow.

The major challenge within this area is the roll-out of Electronic Pathology requesting and access by GPs. A pilot project was conducted at 4 sites across NHS ECK and following a comprehensive evaluation there will be a phased implementation across all of NHS ECK This will enable GPs to not only request a test but enables the GP to see all pathology test results that their patients may have had either as an in-patient or from attending an out-patients clinic where a test has been requested. The timescales for completing this phased implementation are yet to be formally agreed.

In terms of reporting of other diagnostics, the turnaround time will be dependent upon the type of test. We use Key Performance Indicators within our contracts to specify some reporting requirements. Reporting on urgent x-ray should be within 72 hours of the test, while routine x-ray reporting should be no longer than 2 calendar weeks. Staffing issues at the provider do impact on this at times.

10. Specifically on the topic of audiology, how long are waiting times for replacement hearing aids and does the length of time for an appointment depend on whether a full test is required?

There is currently about a three week wait for replacement hearing aids, dependant on how recently patients have had an audiogram. If this is longer ago than 6 months then a full test will need to be undertaken. Patients requiring a full test will wait an average of 6 weeks from referral through to the fitting of a new aid.

As HOSC are aware 3 years ago EKHUFT had an average waiting list of 85 weeks for audiology. There continues to be improvement and sustained investment of almost £2m. Current performance sees over 96% of patients being fitted within 8 weeks, and 88% fitted within 6 weeks.

Waiting times are not dependent on types of test and patients requiring a replacement aid due to upgrade are able to do so within the above profile. Patients requiring a new aid due to faulty or damaged apparatus are treated as requiring a full hearing test and upgrade to ensure that no deterioration in a patient's condition is missed.

11. Can you please outline how paediatric audiology assessment services are organised in your health economy and whether there are any changes being planned or undertaken?

All new born babies are initially screened as part of the new born hearing screening programme. In addition children who are found to have hearing difficulties either by health visitors, school nurses or GP's are referred into EKHUFT paediatric services for initial assessment and from there to paediatric audiology services. A number of community clinics run by consultants and audiologists exist across the primary trust area. The average wait for these services is reported to be between 6 and 8 weeks.

To: Health Overview & Scrutiny Committee – 23 July 2010

By: Martyn Ayre, Kent County Council;
Andrew Cole, Eastern & Coastal Kent NHS;
Martine McCahon, West Kent NHS;
David Hall, Kent County Council.

Subject: **Item 6: Health and transport**

Classification: Unrestricted

Summary: A progress report following a presentation to the Committee in November 2009.

FOR INFORMATION

Introduction

1. In November 2009, a report was given verbally to the Committee in response to its request to be briefed about what was being done by the health economies in Kent and KCC to improve the arrangements that are made for patients to attend health facilities and for relatives, carers and friends to stay in touch with people when in hospital.

2. The Committee asked for a further report on progress in due course. The presentation of this report is very timely as it coincides with the publication of research by Kent LINK into transport access to health services, which will be reported to the Committee as part of this item on the agenda.

Policy and service background

3. Patient transport services – PTS (ie the provision of non-emergency, ambulance services) - are provided by the National Health Service to convey eligible patients from their homes to hospitals and other clinical settings to access treatment and healthcare services. Such transport can be provided directly by the NHS through an NHS body's own PTS or by a private company or organisation with whom it contracts.

4. Patients may occasionally be specifically assisted by a service provided by a voluntary organisation but in the main, volunteer-based schemes are utilised by patients who do not meet the PTS criteria set by the Department of Health but are signposted to volunteer-based schemes if attendance may be otherwise impeded by non-clinical reasons. Volunteer-based schemes are provided by a number of different organisations and being independent organisations, each will have their own 'rules' and ways of working and each will be funded by a different combination of funding sources.

5. From the patient's or carer's perspective, the issues about accessing healthcare are wider than just patient transport services – and as experience frequently has shown in Kent, accessibility can be for them a key (sometimes almost THE key) consideration in the matter of service reconfigurations. Similarly, although beyond the strict remit of patient transport services, issues such as public transport availability and car parking charges figure significantly in the accessibility issues as understood and experienced by patients attending healthcare facilities and, especially, by those without ready access to a means of private transport to visit someone who is a hospital in-patient.

6. The presentation to this Committee in November 2009 sought to show how health economies in Kent and KCC were striving to improve their planning and operational arrangements so that all agencies acted in a more joined-up approach that makes better sense to patients and the wider public. In particular, two events were highlighted – a seminar in May 2009 organised by Eastern & Coastal Kent PCT and another organised by KCC in September 2009, bringing together purchasers and providers, patients and patients' representative organisations, the NHS, the voluntary sector and local government. The seminars were intended to bring greater coherence to how patient transport services – and the wider access and public transport issues – are handled.

7. Much has been done. Much is still being done. Much remains to be done. Some of what has happened in the last 10 months is a continuation, hopefully an improvement, on what was already happening previously. Some of it is undoubtedly new and improved. What is clear is that better coordination of planning and commissioning, together with better communication (amongst NHS bodies and between NHS, voluntary sector and local government partners and between the agencies and the public) is beginning to be reflected in a better experience for users of patient transport services. The report being presented by Kent LINK will evidence this whilst making clear that there is no room for complacency.

8. Those preparing this report have been posed four key questions on behalf of this committee:
    - what are the main issues facing patients in accessing healthcare outside their homes?
    - what are the main issues facing family and friends in maintaining contact with those in hospital?
    - what work is being carried out to improve access and to make better use of the transport available?
    - what opportunities are there for agencies to work together more effectively?

9. The next two sections of the report set out specific response to these questions. Those with lead responsibilities for commissioning patient transport services in the two primary care trusts serving the east and the west of the county have prepared these responses regarding their respective health economies.

Eastern and Coastal Kent Non-Emergency Patient Transport Services (PTS)

10. The purpose of NHS Eastern & Coastal Kent, as set out in our strategic commissioning plan, is to improve how patients in our community are treated and cared for, to prevent ill-health and to reduce health inequalities. This is particularly relevant to the future model of elective care which seks to deliver care closer to home in a way that maximizes effectiveness and efficiency. In addition, the wider health economy continues to seek to reduce variations in services to ensure a consistent, equitable and quality patient experience. Effective and efficient non-emergency patient transport services (PTS) are therefore integral to supporting this direction.

11. Whilst significant progress has been made in achieving this, it is inevitable that for some specialist services, delivering quality elective care services on a more localized basis is not practicable and there becomes a greater reliance on non-emergency patient transport services.

12. Delivering an effective non-emergency patient transport service requires more than merely transporting patients from their home to their chosen place of care; the wider health economy must also ensure that people know what services are available and how to access locally fast, appropriate assessment, treatment, care and support services.

13. NHS Eastern and Coastal Kent continues to work closely with partner agencies and public engagement groups to identify areas where patient transport services are most in need of improvement. In order to make informed decisions, the findings and feedback from the groups indicated below have been vital:
    - NHS- and KCC-led transport events (2009)
    - Transport for Health Working Group
    - Kent LINk Transport project (2010)
    - Patient and public feedback surveys
    - Harder to Reach Groups Register
    - Virtual Panel Groups
    - Health Matters Reference Group
    - Other stakeholder involvement, e.g. local GPs and practice-based commissioners.

    As a result of these engagement programmes, four key areas have been identified which provide the principle direction of travel for PTS.
    - Communication
    - Commissioning and Contracting
    - Eligibility criteria
    - Needs assessment

What are the main issues facing patients in accessing healthcare outside of their homes?

14. Whilst there are many issues in accessing healthcare services that are raised through a variety of media by patients and public, e.g. service quality, availability of particular services, proximity of services to a patient's home, accessibility or eligibility to a service, equity of provision across a wide geography, this paper addresses the specific issues that relate to non-emergency patient transport services.

15. Following a number of public engagement events and multi-agency work to assess current patient transport needs, the following highlights the key issues for residents of NHS Eastern and Coastal Kent in accessing non-emergency patient transport services. The challenges are multi-faceted and can range from specific issues with PTS providers, to coordination with healthcare providers to more generic issues e.g. with the location of new services and the availability of public transport networks.

- The mixed urban and rural geography of Eastern and Coastal Kent makes delivery of an efficient and equitable PTS to all residents challenging.

- There is a perceived lack of readily accessible and available information to patients and non-patients about health and non-health patient transport services that are available across all localities. This is particularly challenging for patients who are travelling longer distances in areas where they may be less familiar.

- There is a perceived lack of information about alternative transport options, e.g. public transport or volunteer services (including accurate schedules and timetables) which are available for those patients who do not meet the eligibility criteria for PTS.

- There are often complex and highly confusing processes for accessing PTS arrangements requiring patients to interact with multiple providers or multiple agents within the same provider.

- Whilst feedback indicates that the vast majority PTS experience is of a high standard for the vast majority of patients, there are incidents of reliability and performance issues; examples of this have included excessively wide pick-up windows or unacceptably long journey times often accompanied by early pick-up times.

- Poor patient experience of PTS is often more prevalent for patients living in rural localities, areas of deprivation and/or some distance from principal centres of health provision such as Margate, Canterbury, Ashford, Maidstone and Gillingham.

- This is often exacerbated by unsuitable sizing of public transport especially in rural areas e.g. reduce size/increase frequency in rural areas.

- Patient care plans, including appointment times, are often not coordinated with the patient's home locality and available transport options; PTS often considered as an after thought and this can be exacerbated with the patient's age and condition.

What are the main issues facing family and friends in maintaining contact with those in hospital?

16. Included in the public engagement events indicated in (1) above was the opportunity to identify the key patient transport and access issues for family and friends of those in hospital:

    - Parking capacity – lack of availability in and around healthcare premises.

    - Parking costs – exacerbated due to long stay patients. (NHS ECK has undertaken a review on parking charges in the South East Coast and charges in East Kent comparatively reasonable).

    - Public transport arrangements for less mobile family and friends.

    - Information to be better promoted about 'Green Travel' options.

    - A national Car Parking consultation was undertaken earlier in the year to which East Kent Hospitals University Foundation Trust and Eastern & Coastal Kent NHS both. responded.

What work is being carried out to improve access and make better use of the transport available?

17. A Transport for Health Working Group (THWG) is in place – this is a multi-agency approach between Kent County Council, NHS Eastern and Coastal Kent, NHS West Kent, NHS Medway, Kent LINk, voluntary organisations, health and non-health transport providers including the patient/public representation. The focus is on four main priorities as follows:

    - **Communication**
      This project aims to improve communication about services available (funded or non-funded, health or non-health) to those who are eligible and alternative services for non-eligible patients. It also aims at communicating the eligibility criteria and the consistent use of this to referrers/GPs.

- **Commissioning and Contracting**
  This project aims to ensure that a quality and value for money patient transport service is commissioned and to ensure that robust contracting is in place. A service specification is currently in development. This is in line with national and regional criteria. These are shared with the THWG in order to gain input from the multiple agencies, including patient and public input into the development of the local service specification. Regular performance management of Providers is now in place. This has been extended to include patient and public input to identify improvement opportunities.

- **Eligibility Criteria**
  A patient's eligibility for PTS is determined against strict criteria. This project aims to ensure that the eligibility criteria, on the basis of clinical need, are reviewed regularly and are in alignment with national and regional criteria. In doing so, the use of consistent and fair eligibility criteria based on medical need is also ensured.

- **Needs Assessment and Feedback**
  This project aims to understand locality transport needs and issues, and to identify any gaps to improve the existing services. In addition, feedback will also be gained from patient, public and stakeholder events, for e.g. in the form of patient satisfaction surveys to improve the service.

18. In addition, NHS Eastern and Coastal Kent has robust performance management processes in place with local providers of non-emergency patient transport services in order to ensure performance levels are maintained. Part of this process is to work closely with the NHS Eastern and Coastal Kent''s Customer Services team and the respective providers to review any compliments, comments, criticisms and complaints and ensure opportunities for improvement are identified.

What opportunities are there for agencies to work together more effectively?

19. Kent County Council and NHS Eastern and Coastal Kent have jointly hosted two Kent-wide transport events. Outputs from these events have informed the direction of the THWG in order to identify opportunities for more effective multi-agency working. Examples of these opportunities include:

- Patient transport needs should be considered in all commissioning plans but are especially important for newly built or relocated healthcare services where services are remote from public transport links .

- There are opportunities for greater integration between health and non-health transport planners.

- Robust and clearly communicated eligibility criteria are critical in ensuring effective and efficient PTS. Once established, criteria should be robustly applied, however there are opportunities to provide greater support to those patients not meeting eligibility criteria.

- Services should be near the patient wherever possible or practical, making better use of local capacity and reducing the need to travel.

- There may be opportunities to incentivise those patients who can use public transport, releasing capacity for those patients for who public transport is not a viable option..

- Opportunities exist to work more closely with patients, healthcare professionals and PTS providers to link transport to more personalised/individual care plans.

- There is a need to enhance the availability of up-to-date information regarding public transport in a way that is easily accessible to all residents to aid decision-making for and by the patient.

- Consider could be given to alternative, off-campus/out of town parking and shuttle services to main healthcare sites.

- Opportunities exist to improve integration with out-of-area providers, i.e. those providing PTS for eastern and coastal residents to out-of-area facilities.

West Kent NHS Non-Emergency Patient Transport Services

What are the main issues facing patients in accessing healthcare outside of their homes?

20. **Availability of public transport.** Bus and rail services do not always link up to provide a seamless journey. Patients experience difficulties in accessing healthcare when faced with early morning appointments and by lengthy or arduous journeys. In cases where patients are attending the hospital for elective day case treatment they maybe required to arrive at 7am.

21. **Car parking and associated charges.** The challenge that parking facilities and associated charges present to patients is most apparent with hospital trusts. Dartford and Gravesham NHS Trust (DAG) and Maidstone and Tunbridge Wells NHS Trust (MTW) are the two main hospital trusts utilised within West Kent.

22. Car parking facilities at Darent Valley Hospital are managed by Meteor. Patients and visitors use the 400 space facility at daily charges ranging from £1 and £5 dependant on their length of stay. The concession offered is a weekly ticket for £20.

23. MTW applies a minimum charge of £1.50 and a maximum of £6.00 and offers concessionary rates for patients receiving radiotherapy, chemotherapy and dialysis. Of the 1,339 car parking spaces at Maidstone Hospital 504 are reserved for patients and visitors, 38 are disabled parking bays and 9 are drop off spaces. Of the 460 car parking spaces at Kent & Sussex Hospital 177 are reserved for patients and visitors, 38 are disabled parking bays, 14 are drop off point and 4 are reserved for voluntary drivers.

24. There is free onsite parking at four of the six community hospitals in West Kent with the exceptions being Gravesham Community Hospital (GCH) and Sevenoaks Hospital. At GCH charges range from 60p to £10. At Sevenoaks hospital there is pay and display parking on site, and some free on-road parking. There are free dedicated parking bays for blue badge holders apart from at Sevenoaks Community Hospital where disabled patients use the pay and display facilities. All hospitals in West Kent offer a porter and chair transportation service within the hospital buildings for patients who have mobility needs.

25. **Awareness of transport providers and help with transport costs.** Patients are often not aware of alternative means of transportation to healthcare sites and help available with travel costs. Where DAG and MTW transport offices assess patients as ineligible for transport, they provide the names and numbers for the volunteer transport agencies. Both transport offices have patient leaflets. MTW is in the process of producing an updated leaflet to reflect transport options that are currently available. In addition to public transport, patients may be eligible for the non-emergency patient transport service (PTS), volunteer transport services and may also be entitled to receive help with their transport costs through the Hospital Travel Costs Scheme and NHS Low Income Scheme.

26. **Patient Transport Services.** Non-emergency PTS activity is the non-urgent, planned transportation of patients with a medical need to and from a NHS health service provider, and between health service providers. This service is free of charge where the eligibility criteria, based on medical need, are met by the patient. The main providers in West Kent are the DAG and MTW Trusts. There is differing service provision of PTS across West Kent reflecting the services being offered, including operating times, and the different processes in place for the booking of transport. Some patients also find the requirement to be ready to be picked at least one hour prior to their appointment time inconvenient.

27. **Complaints and breaches in standards in West Kent.** Over the past two years NHS West Kent has received six formal complaints regarding PTS. These include lack of transport being provided by Kings, DAG and East Kent Hospital Trust, unclear processes concerning the booking of transport and patients not meeting the eligibility criteria for PTS. The provider of PTS must have the capacity to meet the demand from patients who meet the eligibility criteria, have robust processes for booking transport and ensure adherence to the SEC wide eligibility criteria.

What are the main issues facing family and friends in maintaining contact with those in hospital?

28. **Parking at hospital and associated charges**. MTW offers concessionary parking for visitors to patients in the Intensive Care Unit and parents and guardians of children in hospital and free parking for birthing partners, inpatients on maternity wards, and relatives of patients who have been in hospital for more than ten days. A recent update can be found at Appendix 1.

29. **Public transport.** Same as for patients' outlined at 1.1 above.

30. **Remote communication facilities.** Each bed bay at Darent Valley Hospital has a telephone with an individual telephone number enabling patients' family and friends to speak to patients directly without having to go through the nurses' station. Use of the internet is included in the television charge. The bedside telephone service at MTW sites is also operated by Hospedia (Patient line). While patients calling out are charged 10p per minute to UK landlines, family and friends are charged 39p or 49p per minute for off peak and peak calls respectively.

What work is being carried out to improve access and to make better use of the transport available?

31. **Commissioning for care closer to home.** The strategic direction of national health care policy is for the provision of care in local communities, closer to people's homes. NHS West Kent's commissioning arrangements reflect this shift in care setting which is aimed at providing healthcare that is more accessible and convenient to patients. Services available in primary and community settings include Ear, Nose & Throat, dermatology, cardiology, respiratory, minor surgery, vasectomy and ophthalmology. In line with the shift in care settings, NHS West Kent is reviewing its PTS contracting arrangements to ensure there is PTS available to and from primary and community care sites.

32. **Improved signposting.** The PCT's Primary Care Booking Office, commissioned transport and care providers signpost patients to alternative sources of transportation and help with travel costs should they be eligible. Providing more information to patients about their choices is intended to enable patients to make transport arrangements most suitable to their circumstances.

33. **Review of commissioning arrangements for PTS.** The work of NHS West Kent's PTS Steering Group informed the development of the South East Coast Strategic Health Authority (SEC SHA)-wide Service Specification and Eligibility Criteria for PTS. All nine PCTs within the SEC SHA have agreed to implement these with their PTS providers as a means of improving quality and patient experience.

34. **Utilisation of voluntary transport services.** In addition to signposting patients to voluntary transport agencies, NHS West Kent recognises the particular usefulness of commissioning services from voluntary transport agencies. Voluntary agencies are particularly useful in circumstances where patients need to get to local providers and do not need medical attention en route.

35. **Review of transport to Pembury.** MTW has appointed a designated Transport Officer for the new PFI hospital at Pembury who is undertaking a review of the transport links to the hospital with views to promoting improvements. Plans are to increase the number of car parking spaces available for patient and visitor use.

36. **Car parking facilities and associated charges.** It is expected the Department of Health's NHS Car Parking: Consultation on Improving Access for Patients which closed on 13 February 2010 will have an impact on the operation of facilities.

What opportunities are there for agencies to work together more effectively?

37. There are opportunities for the NHS to work more closely with Kent County Council, Kent LINks and transport providers including voluntary transport agencies and Arriva. Opportunities include:
    - Using the Steering Group as a forum for assessing need, reviewing service provision, designing services, shaping the structure of supply and planning capacity;
    - Increasing the level of voluntary transport agencies commissioned to meet demand;
    - Achieving greater clarity around transport for respite, continuing care and intermediate care patients;
    - Improving the level of patient and public engagement with transportation providers especially with regard to service design.

Conclusions

38. It is hoped that the updates that have been given in the preceding two sections can provide Members of the Committee assurance that sustained effort is being put into patient transport services and the other public transport and volunteer-based schemes to make the patient experience of accessing healthcare less fraught and to better ensure that people have ready and affordable access to assistance if they are not eligible in accordance with Department of Health criteria.

39. Agencies are also tackling the issues voiced by carers, relatives and friends but it is acknowledged that dissatisfaction will remain in some quarters where "NHS care free at the point of delivery" is interpreted as meaning entitlement to free transport or free car-parking. Agencies are working to ensure that there is a step-change improvement in the quality of information and sign-posting to affordable alternative means of access and ensuring that inability to pay for transport is not an obstacle to accessing healthcare or visiting a patient in hospital, whose recovery will often be aided by the benefits of regular visits for fiends and loved ones.

40. The findings and recommendations presented to the Committee today from the research undertaken by LINK, who are actively involved in the key planning

arrangements in both the East and the West of the County, contain no surprises and will be invaluable in helping guide further service-improvement efforts.

41. That said, the future changes announced recently in the NHS White Paper are likely to have a significant bearing on the *how* if not the *what* regarding future arrangements for patient transport services. Budget constraint across the public sector for the foreseeable future will require unstinting efforts on improving efficiency and new and creative ways to make sure that access issues do not deter or discourage patients from taking up the health care they need.

Recommendations

Members are asked to **NOTE** the contents of this report.

Martyn Ayre
Senior Policy Manager,
01622 694355 and martyn.ayre@kent.gov.uk

Background documents

None

Previous Committee References

Health Overview & Scrutiny Committee, 27 November 2009

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Appendix 1

MTW Transport Update

Public Transport

There will be additional public transport to the hospital. The routes, frequencies etc are still the subject of discussion between the Trust, KCC, TWBC and the bus operators.

However it is likely that there will be improvements to the services between the hospital and the towns of Maidstone, Tonbridge and Tun Wells.

The Kickstart bid by KCC, Arriva, TWBC, and the Trust for government funding to make significant improvements to the route between Maidstone, Pembury and Tun Wells was successful in March this year. However, due to recent treasury budget cuts, this award was subsequently withdrawn.
Discussions are now taking place on what improvements could still be made to this route.

In addition the trust has identified the transit corridors to the hospital from Tonbridge and Tun Wells as the most efficient and effective use of provision. These higher frequency routes would then link to train services to the town centres and other bus routes from further afield. Discussions on these potential improvements are also underway.

Car Parking

The original design of the hospital was based around a car parking split of 950 staff and 250 patients/visitors. The Trust plans to submit a planning application later this year to increase the patient/visitor provision to 353.
In addition the Trust is looking at a variety of ways to control demand for spaces at the hospital e.g. the implementation of smarter working practices.

Staff Transport

The Trust is undertaking numerous initiatives to reduce the number of staff travelling to the hospital in single occupancy vehicles. These will form a core component of the Trust's Travel Plans and will include measures to encourage car sharing, cycling and public transport use. In addition the provision of a staff minibus is currently being considered.

Patient Transport

The Trust runs a fleet of non emergency ambulances and a voluntary car driver scheme for eligible patients. In addition a number of external volunteer car services exist that provide a service for those unable to access the hospitals by other means.

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DRAFT

Access (Transport) to Health Services Report

Kent LINk Project no: 04

Medway LINk Project no: 02

July 2010

Central Office
KMN, Unit 24 Folkestone Enterprise Centre, Shearway Road, Folkestone, Kent, CT19 4RH
Tel: 01303 297050
E-mail: info@kmn-ltd.co.uk
Office Hours: Monday – Friday 8.30am - 4.00pm

Local Office
The Medway LINk, Avenue Business Centre, 17 New Road Avenue, Chatham, Kent, ME4 6BA
Tel: 01634 821135
E-mail: info@kmn-ltd.co.uk
Office Hours: Monday – Friday 8.30am - 4.00pm
(Answerphone available out of office hours)

EXECUTIVE SUMMARY

Introduction

Patient transport to health services is an emotive subject for people across Kent and Medway and was raised by LINk participants at the Kent LINk Annual Meeting in May 2009. It was agreed at that meeting that a project be developed to look at the issues people are experiencing with Patient Transport Services (PTS). This was a joint project between Kent and Medway LINks because patients living in some parts of Kent use services in Medway and vice versa.

The aims of the project (detailed at section 2.1 of this report) were to focus on PTS and provision by Hospital Trusts. The research and consultation for this project took place at a time when commissioning of NHS Patient Transport Services (PTS) was passing from Hospital Trusts to Primary Care Trusts (PCTs) and the PCTs were undertaking a review of local services, focussing on PTS, community transport schemes and public transport. As a result, this project was able to look at the state of existing provision of a range of transport options and give a voice to the experience of service users to help ensure that the outcomes of the reviews reflected these experiences.

Key Issues Identified

A lot of people found that the transport systems worked well for them, were convenient and provided by caring staff and they were keen to praise the work of the PTS crews and, in particular, volunteer drivers.

However, there were a large number of people who had less positive experiences. During the consultation stage of the project a range of issues was raised including journey times, lack of integration of appointment times with transport options, the inadequacy of public transport and difficulties with car parking. Concerns that were specific to PTS included the inflexibility and resulting inconvenience of the service, problems with the transport of carers and escorts, confusion around eligibility and problems with the transport of wheelchairs.

It became clear over the course of the project that awareness of PTS, community travel schemes and volunteer car schemes was low and needed to be addressed as a priority.

Key Recommendations

The following recommendations are a result of the community engagement and involvement activity carried out during March, April and May 2010 where patients and the public had the opportunity to talk about their experiences of patient transport, raise concerns about the services and make suggestions for improvements. They are not listed in priority order.

Recommendation One: PTS Booking System

- Appointment times need to take into account the condition of the patient, the length and timing of their journey, by whatever means they travel.
- Ongoing assessments need to be made of the patient's eligibility for transport services by clinicians.
- Bookings of PTS should be made by clinicians not patients.

Recommendation Two: Better Support for Voluntary Sector

- The capacity of volunteer schemes should be audited with a view to providing financial and other support to build their capacity and extend their availability to the less wealthy members of the community.

Recommendation Three: Improve Information about Eligibility Criteria

- Be open and clear about eligibility criteria
- Eligibility criteria and assessments for PTS need to take into account that people's needs change over time, make allowance for people with mental health issues and social factors.

Recommendation Four: Review Car Parking

- Disabled badge holders should be able to park anywhere in car parks at hospitals and health facilities without charge if disabled bays are taken.
- Trusts should review car parking in terms of sufficiency of supply, appropriateness of systems and learn from best practice, for example paying on exit rather than in advance.

Recommendation Five: Improve Information about Alternative Transport Options

- Up to date information on local public and community transport services should be available at all healthcare settings, with someone available to interpret the information for patients.
- A central information provider should be established to help signpost patients through the options available to them.

Recommendation Six: Work with GPs and Other Points of Referral to Improve Information and Communication for Patients about Transport Options

- All GPs, booking staff, receptionists etc. should be trained to signpost patients to all transport options whether patients are eligible for PTS or not.

Recommendation Seven: Improve Flexibility of PTS

- Ensure transport services are as flexible as possible to meet the challenges created by the changes in the way that people access healthcare.

Recommendation Eight: Improve Integration between Services

- Communication between providers needs to be improved with a view to better integrating provision of services across Kent and Medway.

Next Steps for LINk

The Access (Transport) to Health Services project is formally concluded with the publication of this report. The report has been submitted to LINk participants, NHS Eastern & Coastal Kent Primary Care Trust (PCT), NHS West Kent Primary Care Trust (PCT), NHS Medway Primary Care Trust (PCT), East Kent Hospitals University Foundation Trust, South East Coast Ambulance Service NHS Trust (SECAmb), Kent County Council's Health Overview Scrutiny Committee (HOSC), Medway Council and the project group. It will be submitted to the Transport for Health Working Group (THWG) to give a community voice to the projects they plan to take forward as the outcomes of the report directly impact on their work. LINk representatives will continue to be involved in this working group until the conclusion of its work. The report will also be available to the public, posted on our website and available in hard copy upon request.

CONTENTS

1. Introduction

Patient transport to health facilities is an important issue for patients as it has a major impact on their well-being and overall experience of healthcare. It is also an important service for the NHS as it helps them to meet their strategic objectives of reducing health inequalities, improving access to healthcare and reducing non-attendance at appointments.

There are now a lot more services being provided in community settings, and the increase in patient choice is impacting on the demand for transport as well as the level of co-ordination required within and across trust boundaries. For example:-

- Patients who travel to their GP for treatments instead of local hospitals
- The Choose and Book system where patients can choose where their treatment is provided so not necessarily at the nearest facility
- Changes to opening hours of GP clinics and hospital clinics
- Activities that are now being transferred to pharmacists e.g. medication reviews

2. Access (Transport) to Health Services Project

A great deal of work was done by the former Patient and Public Involvement Forums (PPIFs) around patient transport which was brought forward to the Kent LINk when it was launched in December 2008. Patient transport is historically an emotive subject for people across Kent and Medway and was raised again by LINk participants at the Kent LINk Annual Meeting in May 2009. It was agreed at that meeting that a project be developed to look at patient experience of patient transport services. This was a joint project between Kent and Medway LINks because patients living in some parts of Kent use services in Medway and vice versa.

2.1 Aims of the Project

1. To find out what systems trusts have in place to minimise transport problems for their patients, particularly the use of innovative approaches to addressing these problems, including working with partner organisations.
2. To see what level of consistency exists between trusts in the provision they make for patient transport, car parking, patients who are stranded at A&E, links with community transport schemes and the quality of travel information given out to patients.
3. To initiate a debate across Kent and Medway with a view to identifying best practice and promoting improved access to health services across the community of Kent.

2.2 Outcomes of the Project

The key outcomes of this project and this report are to highlight best practice, areas for improvement and make recommendations based on the views and experiences of communities across Kent and Medway. Those recommendations will then be put forward to the appropriate organisations and a response requested as to how they will take those recommendations forward.

2.3 Methodology

2.1 The first two aims of this project required research to be carried out into patient transport, what is available, where, when and to whom. The research was carried out in the following ways:-

1. Internet research into how and by whom services are provided, what the eligibility criteria is, how services are publicised, what costs are involved to the patients, Government guidelines and existing research
2. Attending meetings – Transport for Health Working Group and West Kent Patient Transport Services (PTS) Steering Group

3. Contact was made with the following organisations:
    - NHS Eastern & Coastal Kent PCT
    - South East Coast Ambulance Service NHS Trust
    - Kent & Medway NHS Health & Social Care Partnership Trust
    - Kent County Council
    - Medway NHS Foundation Trust
    - East Kent Hospitals University Foundation Trust
    - NHS Medway PCT
    - Medway Council
    - NHS West Kent PCT
    - Maidstone & Tunbridge Wells NHS Trust
    - Dartford & Gravesham NHS Trust
4. Letters were sent to community and voluntary sector organisations known to provide transport requesting information about their schemes
5. Information was gathered using the Community Transport Directory produced by Action for Rural Communities in Kent

The information was then summarised and included in this report enabling consistencies and inconsistencies across Kent and Medway to be identified, to highlight popular schemes and raise issues communities have with patient transport.

The final stage of the project was to find out what works and what needs improving based on patient experience. A series of mini debates/workshops were set up across Kent and Medway to give people the opportunity to have their say and share their experiences of PTS. Eight sessions were organised, two in East, two in Mid and two in West Kent and two in Medway. The discussion points from the debates were also put into online and paper survey formats to enable as many people as possible to have their say.

Visits were also carried out to community groups in their own settings including disability and carers groups, mental health service user groups, the Alzheimer's & Dementia Family Support Group, the National Council for Women and a number of Age Concern day centres. Visits and interviews with individuals who are regular users of health and transport services were also carried out at their homes. The information gathered throughout this part of the project can be found as Appendix 1 "Patient Experience". The take up by participants varied in different areas but nearly 200 people took part in the consultation. A further 18 people formed a project group which was involved in supporting the project and commenting and inputting into the report.

3. Patient Transport across Kent and Medway

Project Aim 1: to see what level of consistency exists between trusts in the provision they make for patient transport, car parking, patients who are stranded at A&E, links with community transport schemes and the quality of travel information given out to patients

3.1 NHS Patient Transport Services (PTS)

The commissioning and performance management of non emergency patient transport has recently been taken on by Primary Care Trusts (PCTs) from organisations such as acute, mental health, learning disability and community trusts which had responsibility for them until April 2010. The PCTs have undertaken reviews of the services locally and are feeding outcomes into the Strategic Health Authority with the objective of developing a standard set of eligibility criteria and service level agreements with providers. This work is being done in partnership with NHS providers, Councils, Public Transport operators, the LINks and other community and voluntary sector organisations.

As well as the changes in the way healthcare services are delivered that were outlined in the introduction, PTS providers face a number of challenges in delivering services, for example arriving to pick up a passenger and finding them undressed and not ready to travel. Rather than leave the passenger, the crew will help prepare them for travel putting them behind schedule.

East Kent Hospitals runs a 'Health Hopper' bus service between hospitals for patients, visitors and staff. This is a scheduled service which is free to patients if they show an appointment letter.

3.1.1 Provision for Patients Stranded at Accident and Emergency (A&E)

PTS is available 24 hours a day, 7 days a week and it is only booked PTS services that finish at 4pm. So people who miss their return journeys due to appointments running late or over, or who are stranded in A&E, still have the patient transport service available to them. People have raised the issue of being stranded at A&E but this seems to be a lack of knowledge amongst NHS staff and a lack of communication with the public.

3.1.2 Links with Community Transport Schemes

We identified very few links with community and voluntary transport schemes but one example of collaboration is that some hospitals provide free and convenient parking spaces for volunteer car schemes. Other community schemes have links to the hospitals, for example the SUN bus scheme in Swale which visits a number of healthcare settings including hospitals.

3.2 Eligibility Criteria

The Department of Health (DH) Eligibility Criteria is attached at Appendix 2. In summary, they state that:

Patients should travel "in a reasonable time and in reasonable comfort, without detriment to their medical condition".

Eligible patients are those:

- Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
- Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
- Recognised as a parent or guardian where children are being conveyed.
- Where a patient's escort or carer's particular skills and/or support are needed.

A patient's eligibility for PTS should be determined either by a healthcare professional or by non-clinically qualified staff who are clinically supervised and/or working within locally agreed protocols or guidelines, and employed by the NHS or working under contract for the NHS."

Eligibility criteria currently applied by some Trusts in Kent and Medway have some variations in the scoring procedures. For example, Dartford and Gravesham Hospitals have a fairly heavy weighting (2 of a total of 4 points that are needed to be eligible) for a patient that needs to be at hospital by 7am, Medway NHS Trust doesn't score against this criteria at all and East Kent Hospitals goes beyond the DH criteria, allowing for 'exceptional non-medical need', defined as the lack of availability of other forms of transport and the distance to be travelled. This is at the discretion of the patients GP or lead therapist. Medway Hospitals allows scoring of 1 point against a criterion of 'Is likely to be receiving bad news. See appendix 3 for examples of scoring and decision making criteria.

Although the differences are small, the fact that they exist and that others are at the discretion of the lead practitioner has the potential to create a situation where the patient is deemed eligible for transport at one trust and not at another. This should be addressed when the NHS South East Coast SHA produces new and consistent eligibility criteria (see section 4.3 of this report). However, care must be taken to ensure that local interpretation of the criteria doesn't allow for this kind of discrepancy to re-emerge as it greatly impacts on the patient.

3.3 Hospital Travel Costs Scheme (HTCS)

The HTCS is for patients with no medical need for an ambulance, who are not eligible for PTS and cannot meet the cost of travel to hospital or other health care facility where they need to receive NHS treatment. The scheme is available to those patients in receipt of Income Support, Income Based Job Seekers Allowance, Pension Credit Guarantee Credit, Working Tax Credit and/or Child Tax Credit. In some circumstances patients on low income may be entitled to partial or full refund on their travel expenses. An escorts expenses could also be reclaimed where it is considered by a GP/Consultant to be medically necessary for a patient to travel with an escort. Appendix 4 gives details of where to find more information about this scheme.

3.4 Information Provision

Availability of information about PTS and other transport options is patchy. The three East Kent Hospitals provide a leaflet which, while not mentioning PTS, details a range of options including Public transport, volunteer schemes and Kent Karrier. It also includes details of the Hospital Travel Costs Scheme and a warning that parking is limited at hospital sites. Maidstone & Tunbridge Wells Hospitals make a leaflet available to each patient at their bedside which gives information on service times, eligibility and details of additional services. They also have a summary available online and further information at outpatient clinics. East Kent relies on a contractual requirement for providers to place leaflets in health settings.

Information from GPs appears to be extremely variable, with some surgeries booking transport for the patient and others offering no unprompted guidance to patients.

All the Kent and Medway hospital websites mention PTS with some direct links on the home page, others require more searching. The information available ranges from East Kent Hospitals which publishes its eligibility criteria to Maidstone & Tunbridge Wells Hospitals which directs people to their GP. This inconsistency is often confusing and unhelpful to patients and their carers making PTS inaccessible to some.

It is also questionable whether the demographic requiring PTS is likely to have access to the internet.

3.5 Kent and Medway NHS and Social Care Partnership Trust (KMPT)

The way in which PTS is delivered across Kent and Medway varies a great deal for mental health service users. In West Kent services are commissioned and paid for by KMPT whereas in East Kent transport is provided by the staff of the trust collecting patients in the Trust's minibuses. This in itself raises problems with staff being unavailable to attend sessions because they are transporting patients. It also means there is no consistency across the Trust's area. Issues have been raised with the LINk around the booking of transport, the logistics of carrying Mental Health patients by drivers without appropriate training and the carrying out of the contracted process for handover of patients once they arrive at hospital.

3.6 Kent County Council (KCC) and Medway Council

Council funded transport services are mainly provided through commercial services under local contractual arrangements with other organisations. The services are a mixture of private and voluntary coordinated transport schemes.

Some direct provision of driver escort services is made for adults with learning disabilities. There are also a number of ways in which councils fund travel to hospital as a by product of other provisions made for care. For example, Crossroads provide a respite care service and when appropriate, the care worker will take the client to hospital. This service may be funded by the client's social care package through Medway Council, by direct payment or through the organisation's charitable funds.

3.6.1 Dial-a-Ride

KCC subsidises the The Kent Karrier service which is a fully accessible dial-a-ride service that takes its members directly from their door to the nearest town centre. Membership is £5 per year, with a small fee payable for each journey.

The scheme is available to people who have a medical condition that makes travelling on conventional public transport difficult (this must be authorised by a GP).

Dial-a-rides operate a pre-booked, scheduled service collecting passengers along the route. The service will stop to pick up and drop off between stops where safe to do so. While they do take people to hospitals and doctors surgeries, they cannot take passengers at a specific time which means that appointments must be booked around travel rather than travel booked around appointments.

3.6.2 Medway Mobility

Medway Mobility is a weekly bus service operated by ASD Coaches on behalf of Medway Council which is specifically designed for people in the Medway area who are frail and elderly or have a disability. The driver assists passengers on and off the bus, although it has been designed for easy access and is wheelchair-friendly. Users must register with the council for a pass and journeys must be booked at least a day in advance. The service takes passengers from as close as possible to their front door to the centres of Chatham, Rochester, Strood or Gillingham. It also serves Medway Maritime Hospital and Hempstead Valley. It operates from a different area each day of the week between 9.30 and 10am and returns between 12.30 and 1.30pm, again meaning that appointments can only be booked at specific times.

3.6.3 Community Buses

Community bus schemes are supported by KCC and Medway Council in areas that lack sufficient public transport services. Community groups bid for funding with an appropriate model for their locality, so the specifics of the services vary from scheme to scheme, area to area. They generally run a timetabled service, staffed by volunteer drivers, specific trips to shops, outings and excursions. The services are open to anyone to use and passengers pay a fare, which helps to fund the service.

These include schemes like the SUN (Swale Unified Network) Bus in Swale, a wheelchair accessible service operated by KCC in conjunction with Swale Borough Council. The service is available to any resident in a rural area of Swale who lives more than 500 metres from a normal bus route, or to residents in rural or town areas who have a mobility difficulty which means they cannot use standard bus, rail, or taxi services. However, this service is only available on specific days and times. The scheme also offers SUN car hire which is available at a discounted rate. SUN travel club membership is required to use the scheme

for which there is an annual membership fee of £5.00, which includes the use of the SUN Kent Karrier Minibus.

3.7 Volunteer Car Schemes

In their information audit of community transport provision in Kent, Action for Rural Communities in Kent identified 38 volunteer car schemes, "ranging in size from just 2 volunteer drivers...to several volunteer bureaux with more than 50 drivers and staff." For the most part, their drivers volunteer on an 'as and when' basis, with the centres phoning round for a driver who is available and willing to undertake the journey. Generally there was a positive response to the volunteer drivers with people saying they felt they were more caring and had more time to spend with them.

The number of journeys made by each scheme varies according to their size; with the largest identified (Thanet Community Transport Association) as undertaking over 22,000 journeys in a year. Providers of volunteer schemes estimate that up to two thirds of their journeys are to healthcare settings, the remainder meeting social needs, including visits to day centres and shopping trips.

Funding for the schemes is a mix of grants from KCC, local councils and the NHS, core contract work, applications to charitable trusts and fees charged to passengers. Most charge passengers around 40p a mile, which goes directly to the driver. There is also a mix of administration charges and membership fees which are used to support core funding.

Many volunteer car schemes are not advertised as they are already at capacity and are unable to take any more passengers; this is mainly due to the number of volunteers available. Concerns were expressed about drivers having their expenses capped at 40p a mile and the impact this is having on recruitment. The cap was introduced in 2002 when petrol was around 80p a litre.

3.8 Hospital Car Parking

Hospital car parking is an issue that was raised at every contact made with participants. The Kent and Medway LINks' response to a recent government consultation on the subject can be found at Appendix 5.

Parking services at Hospital Trusts in Kent and Medway are provided either directly by the Trusts or under Private Finance Initiative schemes. Parking costs vary from site to site as does the method of payment. Some operate a payment on exit scheme, others require payment in advance. The latter presents problems for people who don't know how long they are going to be at appointments.

The amount of disabled parking bays at hospitals and GPs clinics was raised by a number of participants. Medway Maritime Hospital operates a system where all official disabled badge holders are entitled to free parking onsite, whereas it was reported that at the William Harvey Hospital if all disabled spaces are taken up blue badge holders are required to pay to park in standard bays.

3.9 Public Transport

The majority of bus services in Kent and Medway are provided by private, commercial bus companies, for example, Arriva Southern Counties and Stagecoach in East Kent, although companies such as ASD Transport, Chalkwell, Kent Top Travel, Nu-Venture and others also provide services.

The operators provide many of the daytime routes without a subsidy and therefore the operator decides the route, timetable and fares. Both councils provide financial support for

a number of bus services that are not commercially viable and would not otherwise be provided. There are an increasing number of super low-floor buses in service, giving easy access for all users.

Train services are provided by the commercial provider Southeastern. Many of the stations that they operate from lack step free access. In order to meet their obligations under the Disability Discrimination Act, Southeastern offer an assisted travel service whereby passengers are met by a member of staff and assisted into and out of the station and on and off the train as necessary. At unstaffed stations or where no member of staff is available, they will meet the cost of a taxi from the nearest accessible station. However, it was commented that Southeastern ask for 24 hours notice for this scheme.

Public transport presents a particular issue for people living is isolated areas of Kent. A resident on Grain reported that a recent appointment at Maidstone hospital required a bus, then a train and then two more buses, a total 12 hour round trip including the appointment. There appears to be a growing use of 'Choose and Book' to address these issues, with people choosing to travel to London as the journey is often easier than travelling across Kent and Medway. It also presents an issue for frail and elderly people who don't qualify for PTS, particularly when they have appointments during rush hour and school travel times. Several older people told us that they just don't go to appointments that are made in these times. Accessibility also presented a major problem for some people, particularly when the journey requires one or more changes.

Issues around how public transport to healthcare impacts on people with mobility issues was highlighted by a report on older people's experiences of transport across the Borough of Swale. The report was produced in April 2010 by Swale Seniors Forum in partnership with Canterbury Christchurch University (Swale Seniors Forum c/o Swale CVS, Sittingbourne).

4. Current Service Improvements

Project Aim 2: to find out what systems trusts have in place to minimise transport problems for their patients, particularly the use of innovative approaches to addressing these problems, including working with partner organisations

4.1 Transport for Health Working Group (THWG)

This is a multi agency group led by NHS Eastern & Coastal Kent PCT and whose terms of reference state:

"The main purpose of the THWG will be to facilitate effective communication between 'transport for health' stakeholders across the NHS Eastern and Coastal Kent area, including specific links with Medway and West Kent. This partnership service improvement group will collaborate to deliver the NHS Eastern and Coastal Kent Non Emergency Transport Action Plan."

The focus for the group is all patient transport services, community transport schemes, and public transport, with service improvement being the cornerstone of the partnership work.

The main objectives of the group are to:

- Improve partnership working between the voluntary sector, the NHS, KCC, district councils, transport providers and all other appropriate stakeholders;
- Establish a document that links health and social transport provision in Kent, that is patient/public facing and which describes all available options and processes;
- Act on any existing service modifications/improvements required to meet the needs of the differing localities;

- Support a Joint Strategic Needs Assessment that advises on a set strategic direction for the PCT and partner organisations to improve Patient and Community Transport Services.

Organisations represented on this group are:

NHS Eastern & Coastal Kent PCT
Kent Count Council
NHS Medway PCT
NHS West Kent PCT
Kent & Medway LINks
Canterbury City Council
Maidstone & Tunbridge Wells Transport
Swale Borough Council
East Kent Hospitals
South East Coast Ambulance Service
Medway NHS Foundation Trust
Ashford/Dover Volunteer Centres
Age Concern
Stagecoach
Arriva
East Kent Association of Older Citizens Forums
East Kent Pensioner's Forum

The Kent LINk has secured opportunities for its representatives to work with this group on their projects and to feed directly into the THWG.

4.2 West Kent Patient Transport Services (PTS) Steering Group

The overarching purpose of the Steering Group is to guide the development and design of non-urgent Patient Transport Services across the NHS West Kent area.

The objectives of the group are:

- To inform the commissioning of PTS in NHS West Kent.
- To act as a forum for discussing the gaps and inconsistencies in the level and quality of current service provision across NHS West Kent.
- To define the common minimum standard of service patients should expect to receive.
- To explore what terms need to be included in the Service Specification, Eligibility Criteria and Minimum Data Set to effect a service which promotes equitable access and represents the best value for money.

Organisations represented on this group are:

NHS West Kent PCT Health Network
West Kingsdown Medical Centre
Tunbridge Wells Over Fifty Forum
Kent & Medway LINks
KCC

4.3 NHS South East Coast Strategic Health Authority (SHA)

NHS South East Coast SHA has facilitated the joining together of the eight PCTs across the South Coast to review current and develop new consistent eligibility criteria and service specifications for PTS. This group of PCTs will then adopt the new criteria and standards from April 2010 when PCTs take on responsibility for commissioning PTS.

4.4 Kent County Council Review – Health Overview and Scrutiny Committee

Kent County Council has been working with the PCTs to develop a joint approach to patient transport services. The full report is expected to be available later this Summer.

5. Public Consultation

Project Aim 3: to initiate a debate across Kent and Medway with a view to identifying best practice and promoting improved access to health services across the community of Kent.

5.1 Methodology

A series of mini debates/workshops were set up across Kent and Medway to give people the opportunity to have their say and share their experiences of PTS. Eight sessions were organised, two in East, two in Mid and two in West Kent and two in Medway. The discussion points from the debates were also put into online and paper survey formats to enable as many people as possible to have their say. The discussions focussed on the following set of questions:

- What worked well, did you have a positive experience?
- What didn't work so well, were you unhappy about something relating to patient transport?
- What do you think needs changing to ensure the patient's experience improves?
- What information was available to you and where?
- What wasn't available that you feel would have been helpful?
- If new information resources are to be developed what information do you think should be included? What format should that information be available in? Where should it be available?

The take up by participants varied in different areas but nearly 200 people took part in the consultation. Also 18 people formed a project group which was involved in supporting the project and commenting and inputting into the report.

5.2 Key Issues Raised During Consultation

This report already mentions some of the issues faced by patients and the public when accessing healthcare services, particularly those that are disabled, frail, elderly or who live in remote areas. The following is a representative sample of quotes, comments and extracts from the consultation which is available in 'Patient Experience' in Appendix 1.

5.2.1 Journey Times

Journey times, by whatever form of transport emerged as a key issue, particularly for those people that live in outlying areas, those that require treatment that is only available at certain locations or have medical conditions that make long journeys difficult. For example, travelling to phlebotomy clinics for diabetics as they are required to fast in advance of the test or people who have outpatient appointments that take a long time to complete, for example, dialysis.

"Our friend, who was diabetic, had to travel to the Kent & Canterbury Hospital three times a week to receive dialysis. She had to travel by PTS, leaving her house in Walderslade (Chatham) at approximately 11am, the ambulance then went to Sheerness to pick up other patients and then travelled on to the hospital. There was usually a wait to get a bed and then treatment time. The return journey was similar with our friend often returning home after 7pm and on some occasions later than that." LINk participant, Chatham

5.2.2 Inflexibility of PTS

The most common issue with PTS was around its inflexibility, with patients being told to be ready to travel at a specific time, with no indication of when they would be picked up. The ambulance will then make a number of pick ups meaning an early start, a long journey and late return for some patients.

Pressures on the service mean that when a patient's appointment overruns, rather than be left to stand idle, the transport is allocated to be used for another journey, leaving the patient to try and resolve the situation with busy ward staff. This becomes a particular problem when shifts change and the patient often has to start again.

"Transport has arrived after staff are supposed to have finished working for the day. Staff from the unit end up taking people home in the unit minibus." Patient, William Harvey Hospital

5.2.3 Appointment Times

These rarely take the transport needs of the patient into account. We had many examples of people who had inappropriate appointment times or the length of the journey involved for their condition.

"Admin staff seem to pay no attention whatsoever when making appointments to the distance the patient has to travel. For example a 9.30am appointment at Kings in London, no amount of telephone calls has enabled me to change this so we will have to travel through the rush hour to London with a sick man with heart and lung problems" LINk participant, Sevenoaks

5.2.4 Public Transport

For many patients, who are not eligible for PTS, particularly those who are elderly and/or disabled or live in outlying areas, public transport presents a number of problems.

"Residents of the Dover and Deal District areas encounter severe problems getting to Queen Elizabeth, Queen Mother Hospital (QEQM) by public transport. Anyone travelling by bus from the Deal area is forced to go to Sandwich where they need to change for Ramsgate and then change again for Westwood and QEQM. Research has shown that on the day I chose to travel to the QEQM, it took 6 separate buses and 7 hours to make the round trip with a 40 min break for lunch (equivalent to out patient appointment time) at the hospital. The equivalent journey by car was just 1 hour 20 mins including 40 minutes appointment time. I met and talked to several out patients making similar journeys from the Deal and Dover District. They all found the experience extremely time consuming and expensive, to say nothing of demoralising when they are poorly." Parish Councillor, Worth

5.2.5 Information

Information about the availability of transport to hospital whether by PTS or voluntary car schemes was poor. Visits to day care centres for the elderly revealed that even those who knew that the services existed had no idea how to access them, if there were charges or if they were eligible. Many are dependent on friends and family and have never been offered PTS or given appropriate information.

Provision of information by GPs surgeries was variable with some participants reporting that they had been told about services by their GP and others offering no unprompted advice or having little knowledge of what is available.

"I have never been told about or offered NHS transport" – LINk participant, Gillingham

5.2.6 Wheelchairs

Having appropriate transport available for wheelchair users was an issue that arose time after time. This is a particular issue where the patient uses a specialised chair.

"I have to use a footpath to reach the parking area near my bungalow, it is too far for me to walk safely with the aid of my walking stick alone, and so the (Volunteer Car Scheme)

driver has to take me in my Push Chair, this presents problems as they often have small cars and only the Transit Chair will fit" Member of the public by e-mail

"I suffered a severe stroke five years ago last November, have left hand side paralysis, suffer from epilepsy, sleep apnoea, and brittle bones. There is no possibility of being able to drive myself. I have a battery powered electric chair, but the Patient Transport Minibus Crews say that they are not permitted to take it." Member of the public, Gravesend

5.2.7 Carers/Escorts

Carers and patients raised a number of concerns around the need for more flexibility for carers to travel with patients.

"Letters about Patient Transport make it clear that carers are not welcome to accompany patients, except in special circumstances. That rule is too harsh, often there are spare seats available; frequently the crew/driver and I are the only occupants. I am certain that patient care would benefit from carers being encouraged to hear the consultant's advice themselves rather than rely on the vague recollection of a bewildered patient." Member of the public, Gravesend

5.2.8 Eligibility

There was very little understanding of which patients are eligible for PTS. There were also concerns about the way in which eligibility criteria are applied and the narrowness of the criteria across Kent and Medway.

Some patients had been told that they were no longer eligible, but had been given no reason, been informed of any right of appeal or told about alternative options.

"We are often asked by frail and elderly people if we can take them to their hospital/GP appointments. We always ask if they have asked for transport from the hospital/surgery and we are usually told that they are advised that if they can walk or are not blind then they are not entitled to the limited transport available." Community Group, Tunbridge Wells

"My sister lives in Higham which seems to fall between two stools; i.e., neither Medway nor Gravesham seem to be willing to take responsibility for the area. Public transport to and from Higham/Gravesend is almost non-existent. When my sister has to visit Darent Hospital she has to rely on myself or her in-laws. We recently enquired about hospital transport only to be told that as my sister can walk she is not entitled to such transport." LINk participant, Gravesend

"We have heard of a young disabled mother who needs to take her 13 yr old to a London hospital being refused transport when her husband is unable to get time off work to take them. She was told her child could travel alone!!!" Patients' Group, Sitingbourne & Sheppey

5.2.9 Booking Procedures

Booking patient transport presents problems for many people, particularly the frail, elderly or disabled. Many complained about the length of time it took to get through to the call centre, some found it difficult to cope and others had lost confidence in the system.

"I am a frequent user of Patient Transport at Darent Valley Hospital which should make booking future trips straightforward. However the booking clerk now refuses to make arrangements directly with me saying that the booking can only be made by the no doubt overburdened Ward Clerk. The result is that I have to phone Patient Transport to see if I have been booked in, if not then I have to phone the ward clerk to check that I have the right date for my appointment, and remind her that I need transport and ask her to book it

for me, after a decent interval phone Patient Transport to make sure that every thing has been sorted out, if not, phone the Ward Clerk again, and so on until I am satisfied, phone on the day of travel to check every thing is still in order and to confirm that I still need transport. In fairness they do sometimes call me, but I cannot reach my phone before they hang up, usually without leaving a message. It would help if they called on my mobile or if they used a line where the number was not withheld which prevents me from returning the call or even knowing who has called." Member of the public, Gravesend

5.2.10 Car Parking

As can be seen from the LINks' response to the Government's Car Parking Consultation at Hospitals, made in April 2010 (Appendix 5), this is an issue that divides opinion. What is clear is that it is an important issue in terms of availability, accessibility and cost, particularly for those who are regular users of healthcare facilities.

The issue isn't confined to hospitals, with respondents reporting parking issues at GPs surgeries.

"Transport is one of the ever present issues in this area and with a new hospital at Pembury, planned with a car park which is too small in the view of many of the local population, the problem will continue." LINk Participant, Tunbridge Wells

"Medway Hospital is very good with Blue Badge holders. They have a pay on exit system and will validate the tickets of blue badge holders allowing them free parking. However, the badge holder must be present, meaning there are problems if someone is rushed in or late for an appointment." LINk participant, Grain

5.3 Canterbury City Council Health Scrutiny Panel - Patient Transport to Hospitals Review 2009

The Health Scrutiny Panel at Canterbury City Council carried out a review into patient transport in the Canterbury and District area focussing on the patient's experience of non-emergency transport to the local hospitals. A copy of the full report can be found as Appendix 6.

The Panel's concern was that the quality of patient transport to local hospitals needed to be improved in terms of timing, punctuality, journey length, cost, comfort and information on transport choice.

The Panel held a series of meetings to gain an understanding of non-emergency patient transport services operating within the district. The Panel met with representatives from Canterbury, Herne Bay and Whitstable Volunteer Centres, NHS Eastern and Coastal Kent PCT, Kent County Council, Kent Karrier, Pensioners Forum and South East Coast Ambulance Service.

The Panel's review highlighted the key issues as: journey length and comfort, communication, booking of transport and patient satisfaction.

As a result of the Panel's review they have made the following recommendations

- Improvements to the patient transport booking system
- Improvements to communication between the different agencies
- Patient transport needs must be monitored and re-evaluated during treatment.
- The PCT must ensure that a consistent approach to monitoring patient satisfaction is taken by the various transport providers through the next review of contracts.

6. Summary and Recommendations

The Department of Health guidelines state that patients should travel in a reasonable time and in reasonable comfort, without detriment to their medical condition. This should apply to all patients whether travelling by PTS or other means. Care should be taken to ensure that patients' transport needs are considered as part of the delivery of their medical care.

There are a range of organisations providing services, including Local Authorities, commercial public transport, community transport, charities and the NHS. There appears to be very little communication or co-ordination between them, either in provision or information about services. This leaves patients, who are often frail or vulnerable, to navigate their way through a maze of options.

The way that people access healthcare is changing, transport services do not currently reflect these changes.

Eligibility criteria and assessments for PTS are mostly based on physical ability (mobility, sight, hearing and speech), with little or no allowance for mental health or other issues. Awareness of the transport options available is low, with many people dependent on friends and family, struggling on public transport or paying for taxis that they can't afford.

Car parking arrangements vary from trust to trust and many do not meet the needs of their patients or their visitors even though they may meet the minimum standards required of them.

The following recommendations are a result of the community engagement and involvement activity carried out during March, April and May 2010 where patients and the public had the opportunity to talk about their experiences of patient transport, raise concerns about the services and make suggestions for improvements. They are not listed in priority order.

Recommendation One: PTS Booking System

- Appointment times need to take into account the condition of the patient, the length and timing of their journey, by whatever means they travel.
- Ongoing assessments need to be made of the patient's eligibility for transport services to be made by clinicians.
- Bookings of PTS should be made by clinicians not patients.

Recommendation Two: Better Support for Voluntary Sector

- The capacity of volunteer schemes should be audited with a view to providing financial and other support to build their capacity and extend their availability to the less wealthy members of the community.

Recommendation Three: Improve Information about Eligibility Criteria

- Be open and clear about eligibility criteria
- Eligibility criteria and assessments for PTS need to take into account that people's needs change over time, make allowance for people with mental health issues and social factors.

Recommendation Four: Review Car Parking

- Disabled badge holders should be able to park anywhere in car parks at hospitals and health facilities without charge if disabled bays are taken
- Trusts should review car parking in terms of sufficiency of supply, appropriateness of systems and learn from best practice, for example paying on exit rather than in advance.

Recommendation Five: Improve Information about Alternative Transport Options

- Up to date information on local public and community transport services should be available at all healthcare settings, with someone available to interpret the information for patients.
- A central information provider should be established to help signpost patients through the options available to them.

Recommendation Six: Work with GPs and Other Points of Referral to Improve Information and Communication for Patients about Transport Options

- All GPs, booking staff, receptionists etc, should be trained to signpost patients to all transport options whether patients are eligible for PTS or not.

Recommendation Seven: Improve flexibility of PTS

- Ensure transport services are as flexible as possible to meet the challenges created by the changes in the way that people access healthcare.

Recommendation Eight: Improve Integration between Services

- Communication between providers needs to be improved with a view to better integrating provision of services across Kent and Medway.

7. Next Steps

The Access (Transport) to Health Services project is formally concluded with the publication of this report. The report has been submitted to LINk participants, NHS Eastern & Coastal Kent PCT, NHS West Kent PCT, NHS Medway PCT, South East Coast Ambulance Service, Kent County Council's Health Overview Scrutiny Committee (HOSC), Medway Council and the project group. It will be submitted to the Transport for Health Working Group (THWG) to give a community voice to the projects they plan to take forward as the outcomes of the report directly impact on their work. LINk representatives will continue to be involved in this working group until the conclusion of its work. The report will also be available to the public, posted on our website and available in hard copy upon request.

8. Acknowledgements

Thank you to all participants in this project for their time and for sharing their experiences. Thank you also to John Galimore, Cate Jackson, Valerie Jones-Ellis, Bernie Smith, Jim Hancock, John Goodfellow, Alan West, Lesley Soper, Jennifer Gibson, Elizabeth O'Reilly, Richard Iddenden, Robin Kenworthy, Jean Spain and David Morris who came together as the project group to support and input into this project.

‘Patient Experience’

Introduction
This appendix documents the valuable comments and experience brought to the Kent LINk by participants as part of the Access (Transport) to Health Services Project. The information has been intentionally kept anonymous apart from when a community group has come forward with information. The quotes and comments are taken directly from the workshops, individual interviews or group discussions and accurately reflects the concerns of people across Kent and Medway.

Contents

A selection of comments and quotes from people with experience of Patient Transport Services:

General
"I really do appreciate the Benefits I receive from the Patient Transport and the unfailing kindness shown to me by the drivers and their assistants without this service it would be virtually impossible for me to get to the hospitals" Individual, Gravesend

Journey times
"We had a friend who had to travel, by ambulance to Canterbury for Dialysis, three times a week. She was also diabetic. She was leaving her house in Walderslade (Chatham) at 11am (ish). The ambulance then went to Sheerness to pick up another person and then travelled on to Canterbury. There was usually a wait to get a bed and then they did the same thing in reverse usually getting home after 7pm and on some dates returning hours after that." LINk participant, Chatham

"Emergency Dental Services are now only available at certain places and these are usually along way away from Maidstone - anyone experiencing emergency dental pain / problems who have other physical or mental health issues can find real difficulty in getting to the clinic. Many specialitities are now only available at certain hospitals - i.e. Pain Management Clinics - travelling a long way for someone in acute pain can be very difficult." Voluntary Sector organisation, Maidstone

Public Transport
"Residents of Worth and the Dover and Deal District areas encounter severe problems getting to QEQM hospital for appointments by public transport. Anyone travelling by bus from the Deal area, or my own Parish Worth, is forced to go to Sandwich where they need to change for Ramsgate and then change again for Westwood and QEQM. I have now had an opportunity to check this for my-self. On the day I chose to travel from Worth, it took 6 separate buses and 7 hours to make the round trip with a 40 min break for lunch (equivalent to out patient appointment time) at the hospital. The equivalent journey by car was just 1hour 20 mins including 40 minutes appointment time. I met and talked to several out patients making similar journeys from the Deal and Dover District. They all found the experience extremely time consuming and expensive (over £5), to say nothing of demoralising when they are poorly." Parish Councillor, Worth

"I know of a Patient who has eye Problems who makes the journey From Tunbridge Wells to Maidstone hospital for a consultation which means an early start and two changes of Bus with a walk from Barming to Maidstone hospital. I advised her to seek treatment in London with the Choose and book process as that would be a simpler." LINk participant, Tunbridge Wells

"To get to Medway hospital I get a bus to Sittingbourne and change to one that goes to the hospital. The bus to the hospital very often has steps. When I was on crutches and having to visit the hospital I found it very difficult to get on the hospital busses. There are some easy access busses but not always so for people with poor mobility, wheelchairs or with pushchairs the journey can be a nightmare, or a no go. To go to Canterbury I catch a bus into Faversham, change to the Canterbury bus and take another bus, which has steps, at Canterbury bus station. Ashford hospital is like juggling time bombs as nothing connects. Canterbury now does Sunday scanning. The first bus from Teynham is 10.15 am, my appointment is for 9.10 am.

So I have no choice but to pay SCVS to get me there or risk making another appointment, and they can be like gold dust." Individual from Teynham

"Buses from Sheppey are reserved for school children between 8-10am and 2.30 – 5pm. The council also block books taxis, meaning that travel to appointments around these times is impossible". Debate at Swale Seniors Forum.

"There is no public transport whatever to get to Maidstone hospital from Sevenoaks and parking there has been much reduces making it impossible for patients visiting the eye department and for daily radiography treatment in the Oncology department." Voluntary sector group, Sevenoaks

Arrangements for new Hospital in Pembury
"The new Hospital on the way on the Pembury Site (has been) planned with a Car park which is too small in the view of many of the local population. (There is) a proposal for the NHS to support the first three years of an 'improved' Bus service with a large subsidy from funds that should be used to treat patients." LINk Participant, Tunbridge Wells

"Get the Kent bus map and time tables and look at the difficulty of bus journeys from Bat & Ball, Dunton Green, Riverhead to Pembury two buses becomes three or may be train and bus combinations Tonbridge and Sevenoaks rail stations are DDA compliant but I do not recall Bat & Ball and or Dunton Green being so." Who was this from?

Information
"Have never been told about or offered NHS transport." LINk participant, Gillingham

Wheelchairs
"I have to use a footpath to reach the parking area near my bungalow, it is too far for me to go safely with the aid of my walking stick alone so the (Volunteer Car Scheme) driver has to take me in my Push Chair, this presents problems as they often have small cars and only the transit Chair will fit." Member of the Public by e-mail

"I suffered a severe stroke five years ago last November, have left hand side paralysis, suffer from epilepsy, sleep apnoea, and brittle bones. No possibility of being able to drive. I have a battery powered electric chair, but the Patient Transport Minibus Crews say that they are not permitted to take it." Member of the Public, Gravesend

"My wife uses a specially adapted wheelchair. On several occasions I have been told that it can't be carried despite the ambulance being empty." Individual, Maidstone

Carers / Escorts
"Letters about patient transport make it clear that Carers are not welcome to accompany patients, except in special circumstances. That rule is too harsh, often there are spare seats available; frequently the crew/driver and I are the only occupants. I am certain that Patient Care would benefit from carers being encouraged to hear the consultant's advice themselves rather than rely on the vague recollection of a bewildered Patient." Member of the Public, Gravesend

Comfort

"I will never forget my one and only ambulance journey recently - There were no extra blankets on board (and no explanation of why). I was very poorly and very cold." LINk participant by e-mail

Eligibility

"We are often asked by frail and elderly people if we can take them to their hospital/GP appointments. We always ask if they have asked for transport from the hospital/surgery and we are usually told that they are advised that if they can walk or are not blind then they are not entitled to the limited transport available." Community Group, Tunbridge Wells

"My sister lives in Higham which seems to fall between two stools; i.e., neither Medway nor Gravesham seem to be willing to take responsibility for the area. Public transport to and from Higham/Gravesend is almost non-existent. When my sister has to visit Darenth Hospital she has to rely on myself or her in-laws. We recently enquired about hospital transport only to be told that as my sister can walk she is not entitled to such transport." LINk participant, Gravesend

"At one hospital appointment, the consultant surgeon asked me to try and walk to the ambulance, to assess how far I could walk with two sticks. After a long and painful struggle, I made it to the PTS desk. The next day I received a call from the PTS Manager to say that he was no longer eligible for PTS, but was given no reason. After involving the CAB, I discovered it was because I had managed to walk through the hospital." Individual, Tenterden

"We have heard of a young disabled mother who needs to take her 13 yr old to a London hospital being refused transport, when her husband is unable to get time off work to take them. She was told her child could travel alone!!!" Patients Group, Sittingbourne & Sheppey

"I have ME, sometimes I can travel on my own and sometimes I can't and need help. How would my eligibility be assessed?" LINk participant, Grain

Booking Procedures

"Now that I am well established as a frequent user of Patient Transport at Darenth Valley Hospital booking future trips should be straightforward. I should only need to phone a few days beforehand and perhaps on the day to confirm. However, they refuse to make arrangements directly with me saying that the booking can only be made by the Ward Clerk. The result is that I have to phone patient transport to see if I have been booked in, if not then I have to, phone the ward clerk, check that I have the right date for my appointment, and remind her to book transport for me. Then phone Patient Transport to make sure that every thing has been sorted out. If not, phone the Ward Clerk again, and so on, In fairness they do sometimes call me, but I cannot reach my phone before they hang up, usually without leaving a message. It would help if they called on my mobile or if they used a line where the number was not withheld which prevents me from returning the call or even knowing who has called." Member of the Public, Gravesend

The individual, a disabled woman, was in Medway Maritime Hospital and needed to be transferred to a London Hospital. Neither Trust would take responsibility for transporting her which resulted in her not going. Discussion with LINk participant, Medway

The individual has spinal arthritis, meaning that he has a loss of feeling in his hands and his feet are totally numb. He also has diabetes, which has led him to lose most of his sight. He is

able to walk a short distance using walking sticks but normally uses a wheelchair to get around. He makes the 40 minute journey to Ashford a round 40 times a year. He often tries to contact PTS to arrange transport, but says that the phone can ring for 15 minutes without being answered. He has lots of experiences of transport not turning up and him missing appointments, including with consultant surgeons. It can take 3-4 calls to clarify that PTS isn't coming. He is often picked up too late for early appointments, sometimes after the appointment time. The driver will often call ahead to let the clinic know that he is running late, when he arrives the clinic denies ever receiving the call and the appointment is cancelled. This means that he can be in transit or waiting for up to eight hours for nothing. He was recently received a letter giving him given one days notice for appointment in Folkestone. PTS said they were unable to take him as they require two days notice, he spent £100 on a taxi as this was his only option. On one occasion he was discharged after an operation. PTS were called half an hour before discharge, but he waited for five and one half hours without being offered food or drink. Conversation with Individual from Tenterden

"Kings College Hospital made no objection to sending my husband home by patient transport, but I did receive some objections from nursing staff because according to them the cost came out of their ward budget." Voluntary sector organisation, Sevenoaks.

"I was in a (telephone) queue for 45 minutes. When I finally got through, I was asked the age of the passenger, which I didn't have to hand, so I had to start the whole process again" Care Manager, Folkestone

Timing of transport

"His Wife, who has osteoporosis and epilepsy, had an out patient appointment at 3.15pm, the transport arrived at 3.05pm, too late for her to get there on time. The transport crew insisted on taking her saying, "you will be seen anyway". At the hospital they had to wait two hours for all the other appointments to end before they were seen. By this time, the x-ray unit had closed necessitating a separate visit. Patient transport services were also closed, and they had to wait until an alternative was arranged. That night she had a massive seizure that the individual feels was brought on by the stress of the day". Individual, Bearsted

"Staff seem to pay no attention…to the distance the patient has to travel. For example a 9.30am appointment at Kings in London, no amount of telephone calls has enabled me to change this so we will have to travel through the rush hour in London with a sick man with heart and lung problems." Voluntary sector organisation, Sevenoaks

"My mother-in-laws experience of patient transport services. The transport turned up at 9am instead of 10am for a 12pm appointment. She was the only pickup. When I spoke to the lady making appointments for the clinic she said that transport was a law unto themselves despite being given clear instructions." Senior Citizens Forum Swale

Appointment times

"Admin staff seem to pay no attention whatsoever when making appointments to the distance the patient has to travel. For example a 9.30am appointment at Kings in London, no amount of telephone calls has enable me to change this so we will have to travel through the rush hour to London with a sick man with heart and lung problems" Link participant, Sevenoaks

Car Parking
"Medway Hospital is very good with Blue Badge holders. They have a pay on exit system and will validate the tickets of blue badge holders allowing them free parking. However, the badge holder must be present, meaning there are problems if someone is rushed in or late for an appointment." LINk participant, Grain

"Transport is one of the ever present Issues in this Area and with a new Hospital on the way On the Pembury Site, planned with a Car park which is too small in the view of many of the local Population, and a proposal for the NHS to support the first three years of an "improved" Bus service with a large subsidy from funds that should be used to TREAT patients." LINk participant, Tunbridge Wells

'I am unable to walk very far. I have driven to my GPs surgery 3 times this week and been unable to find an empty disabled parking bay and have had to rearrange the appointment each time.'' Member of the public by telephone.

Information from Debates / Workshops

Rainham – 24 March 2010

General Comments
- Volunteer car scheme works well although not enough volunteers so limited to the number of journeys they can carry out. One off registration fee then 40p/mile. Local and London hospital journeys.
- GPs not statutorily obligated to do anymore than give patients information about transport, it is the patient's responsibility to take it further and go through the booking system.
- SECAmb is the Medway provider, negotiations on start time of drivers, review taking place to help get patients to their appointments on time.
- SHA discussions about patient contributions.
- All sector integration of transport schemes.
- Service Improvement Plans in contract between commissioners and provides informed by patient feedback, will help with future service planning, contracts – 5 year tender process.
- People want accessible transport not necessarily for free.

Booking System/Logistics
- Medway booking system does give information on other options available to patients who aren't eligible. Is information sufficient? Work in progress and being reviewed.
- If no physical / visual disability it is assumed patients are able to make their own way.
- Initial diagnosis at Medway, transferred to London hospital but no transport offered to get home, couldn't walk, picked up by car but painful for patient.
- Patients not always asked how they got to hospital in the first place.
- Escorts are permitted but it is based on patient's assessment and resulting decision.
- PTS booking system is based at hospital – discharge notes will include pts if medical need for patient.

Information / Communication

- People on benefits eligible to Local Authority refund on transport costs.
- Every GP surgery should advertise transport options, key phone number / helpline.
- Patients in hospital not necessarily made aware of transport alternatives.
- Service users discharged from ward, wait for medication can be long, patients worried about getting home.
- No adequate support for patients who don't have family / friends.
- Flyers rather than leaflet especially in GP surgeries as leaflets not always accepted in places due to Swine Flu.
- Helpline to talk you through the process.
- 0800 but also a landline for those who only have mobile phones.
- QEQM leaflet is good.
- Countywide leaflet being developed locality based.
- Information not easily accessible at moment.
- Information should be at source, health facilities, and options for those not eligible for PTS.
- PALS – not always good or helpful.
- Patients not necessarily understand the role of departments but have different expectations.
- On internet.
- Business card style is popular.
- Laminated posters are easy to keep clean.
- Libraries – health noticeboard in each library.
- Directory needed in Medway, providers would have to keep it updated though.
- Hard copy and on the internet.
- Texting service.
- Email.
- Contact sheet on websites.
- Instant messenger.
- Gateways.
- Trained volunteers could give advice and sign post people.
- Entry point needed / starting point, people don't know where to start.

Mental Health
- Chatham to Maidstone – MH issues / awareness. Travel to a new area hard for people to do along, cancelled appointment, patient given number but no further support.
- New criteria takes into consideration MH patients needs
- Appropriate support for MH patient to support their varied needs for attending appointments / clinics.
- MH – Self presented at A&E have to wait to see MH Team / psychiatric, no transport to get them home, taxi service provided by hospital not promoted to patients.

Access
- Isle of Grain, issues attending specific clinics.

Eligibility
- Patients not necessarily aware of PTS if they are eligible or not. GPs not all aware of options open to patients.
- Clinicians recommends patient is well enough to go home.
- Visually impaired patients are eligible to pts but escort (wife) wasn't able to go with patient.

- Disabled parent but child not eligible for pts, were told child should travel alone, parent couldn't take public transport.

Questions
- Is transport part of care plan for patients staying in hospital? Is there a medical need?
- Patients not eligible for PTS, no money, how do they get home?

Support
- Even when taking a taxi drivers not appropriately trained for some patients.
- Same taxi company used so same drivers do have an understanding.
- Taxi drivers – providers responsibility for ensuring contractual arrangements with taxi firm. Commissioner contractual – sub contractors must apply same rules eg CRB checks.

Chatham – 25 March 2010

General Comments
- Drivers friendly / helpful, no complaints, not been late for appointments - Help Hands – volunteer driver scheme.
- PTS late, drivers overworked, not their fault, appointment cancelled, drivers helpful though.
- London hospital ambulances / drivers poor, St Thomas / Guys Hospitals.
- Private cars are good.
- Volunteer driver services in Medway – Hands
- Medway volunteer drivers have been clamped whilst dropping off patients at hospital.
- Cross roads and dial ride are volunteer schemes.
- Medway Council 'out and about'.
- Volunteer drivers are scarce but are more caring – would prefer to use volunteer drivers rather than PTS. PTS drivers have targets to meet where volunteers do it because they want to.
- 'Feels like bums on seats = money'.
- Consideration not often given to patients conditions.
- PCT will now have overall responsibility for PTS.
- Currently has contract with SECAmb.
- Financial arrangement changing in Medway.
- THWG - Holistic review to include volunteer drivers and procedure for dropping off at hospital.
- Volunteer centres who run volunteer driver schemes – what is insurance / liability implications? Also liability of carer if patient falls etc disclaimer?
- If transport on tap may be misused by those not needing it necessarily.

Booking System / Logistics
- Booking problems, patients being left in waiting rooms for hours waiting for PTS.
- Logistics of pick ups /tying in with patients appointments.
- Timing of appointments unrealistic – affects public transport and the cost of taking public transport.
- Choose and book doesn't allow times to be chosen just location.
- Booking system – breakdown between links in the chain if you see different doctors / consultants
- Logistics of picking patients up / dropping off. Who and what type of patient?

- When booking transport better communications needed between patient / clinician and person on booking line.
- NHS Medway mapped patient process last August. Booking system centralised PTS and community transport – SECAmb does both.

Information / Communication
- PTS finishes at 4.00pm but patients aren't told that.
- GPs are not always referring patients for PTS. Comes out of their budget?? Affects priorities as they think 'can someone else pay for it?
- No apparent communications across departments, hospitals, GPs, breakdown in communications.
- Patient feedback – performance review meetings quarterly, Service Improvement Plans, key performance indicators – financial penalties.
- Leaflets, pictures for LD, English not first language etc.
- Needs to be simple.
- Point and pick example.
- Phone booking line, simplify, not multi options, person to person better.
- Booking system needs to be easy for people understand
- Write information from simple perspective – outside / in and consider visually impaired.
- Did speak to a person on the Medway / Maidstone booking line.
- Need one number.
- Process needs simplifying for new users. Can be easy to use if you've used it before.
- Not seen literature of PTS at hospitals.
- Infection control reduce number of leaflets.
- Laminated posters are okay.
- TV screens throughout hospitals and GP surgeries.
- Leaflets could be circulated to libraries.

Mental Health
- MH – Patient sectioned not always picked up until last, if sectioned should be ambulance and police. LD patients in similar situation.
- KMPT have separate contract arrangements for pts.
- Patients with MH not offered the right transport options whether sectioned or not.

Questions
- How does NHS Medway assess / review current service process? - Looks at aborted journeys / delays. Results not published. Comparable information so choices of providers can be made based on information. Providers under contract to report on aborted / delayed journeys. PCT holds them to account.
- A&E admittance = how do they get home? Taxi contract and acute pays for it. Taxi contract has own criteria – not a free service, paid for by acute for those who meet criteria.
- SECAmb driver are they obliged to ensure patient is delivered to their home / through the door? Insurance liability?

Canterbury – 26 March 2010

Group One
General Comments
- Drivers are wonderful.
- More patients very happy with service.
- It's the system not the service.
- Voluntary sector – shortest, not quickest route.
- Forgotten – had to get taxi (PTS).

Booking System/Logistics
- Pick up times 6 – 8, ready by 5.30pm.
- Long wait for service to get home. All packed up together so have to wait for person who takes longest at appointment.
- Providers getting dates wrong resulting in extra week in hospital.
- Unable to get through to providers.
- Late (pm) provision unsuitable for patient with dementia resulting in extra night in hospital
- Appointments for 9.30am – not picked up until 9.30am turning up early for return.
- Drivers can't always take patient to the door (if there are still passengers on board).
- Missed transport appointments to back of queue and left waiting until slot available.

Information / Communication
- Information not accurate, leaflet to be updated, free bus pass not until 9/9.30am, bus route wrong.

Eligibility
- Triple bypass – discharged, delivering letter to doctor and told to attend surgery, but no transport available.

Recommendations for Improvements
- Information should be sent out with outpatients appointment (initial appointment).
- Need map of hospital showing where to enter.
- Age of service group – may not have access to net or even telephone – how to communicate, need to talk to them and ask.
- Communicate with care workers.
- Have one point of entry for information.
- Have regular driver who knows patients (regular patients).
- Large print format.
- Legible map.
- Contact numbers for providers (that are answered), not premium numbers, not automated 'pick a number' services, alternative number if they can't get through to initial number.
- Complaints – who to contact.
- Info should be on web, age concern day centres, library, bus station, post office.
- In a credit card format.
- Contractual agreement with providers to be more specific for example max length that patient will wait (under discussion by PCT / provider).
- Transport planners at providers, rather than computerised system – duplication of services.

- Range of providers need to talk to each other.
- Mental health trust need own transport with drivers who have awareness of mental health issues.
- Clarification of responsibility of provider re duty of care (dropping at door).
- Pre booking needs to take into account patient requirements – distance / timing.
- Discharge times to be when pts is operating.
- Ward staff to make booking asap – waiting for medication adds to time waiting for PTS, should be taken into account.
- Patients need to know who to contact and communicate own needs (may have changing needs that impact on transport) concerns about late transport and missing appointments.
- Make sure that people using pts are given appointments at similar times so can travel together.
- Make sure that appointment timings take into account – public transport, bus passes, people at work.
- Regular feedback from users on experience, not just numbers, qualitative rather (or as well as) quantitative.
- New ambulances – lights obscured by wheelchair lift – EKHUFT
- Renal transport – ambulances taken home therefore not available when driver on leave or ill.
- Communicate with discharge nurses and integrate into process.

Group Two
General Comments

- Drivers and care received by ambulance and volunteer car drivers very good, kind
- Even if experience is bad – drivers are good.
- 999 ambulance response very quick, care good, fantastic service.
- Given choice of transport at St Martins (independent hospital) taxi was paid for as patient was eligible .
- Paramedics good services, rapid response (999).
- Volunteer drivers have more time to care, be on time etc.
- Voluntary schemes are short of drivers, so drivers coming from out of area which costs the patient more.
- Volunteer drivers organisations some logistical problems.
- Hopper under used, not advertised, patients might be able to get to local hospital to get on hopper bus to go to other hospitals, subsidised/free service for patients, KCC, EKHUFT.
- Estuary View – no transport to health services, transport not included in planning, Tesco bus running but only four mornings a week. Assumption people can get to GP which is not true.
- Withdrawal of transport services an issue to save costs, facilitated discussions, patients out spoken about it being vital. Patients offered to contribute but NHS said no because its provided by NHS that should be 'provide at point of need' and not allowed to charge patients. Affordability criteria for contribution if patients want to.
- Buses increased into Canterbury hospital during the day.

Booking System / Logistics

- Collecting from home by car is prompt.
- No specific times given to patients just time frame.
- Logistics of picking patients up needs looking at, made more effective.

- Patients in hospital not told what time being taken home so waiting around.
- Inappropriate transport for patients on occasions.
- Pts – lack of information given to drivers as to patients conditions.

Information / Communication
- Patients not asked if they need transport of any kind.
- GPs not asking or telling people of options.
- Lack of information about patient's condition for transport, allocation of appropriate transport compromised, also need information about how patients can get into transport eg from ward, do they need wheelchair etc.
- Patient should be told how long they will have to wait.
- Kent & Canterbury no waiting place for people being picked up, no where to sit and wait to be collected. Lack of information, there is space allocated but no signs.
- No information/waiting areas.
- Staff in WHH didn't know where to get on, hadn't heard of bus.
- Bus not clearly marked as inter hospital bus (hopper bus) KCC/EKHUT.
- WHH hard to get information at reception area.
- Patients not told how much luggage they can take into hospital/home on patient transport – holistic approach needed.

Mental Health
- YP mental health ward closed at Thanet now at WHH but patients directed to PALS for travel information but PALS don't have that information.

Eligibility
- Reviewed eligibility criteria more generous than expected now allows for clinicians to have more scope – not too restrictive.
- Patients not told about eligibility criteria.

Questions
- If GPs refer a patient for pts who pays?
- WHH inter hospital (hopper) bus (with Kangaroo picture) hard to find information in hospital or on website. No pick up/drop off information.
- Will report go to HOSC? – Yes! Martyn is taking a report on 'transport and health' to HOSC in July. We should get in touch with the Local Medical Committee (LMC) because GPs are their statutory responsibility.

Recommendations for Improvements
- Raise awareness of eligible and what alternatives are.
- Carers feeling pressured to take MH patients to hospital because of waiting times for PTS and this isn't appropriate if MH patient needs more appropriate transport and support.
- Circulate information via Age Concerns, Pensioner forums, PALS and other networks who can disseminate.
- Leaflets are available for non eligible patients but not readily available.
- GPs need to be using common sense about referring patients for transport – could administrator in surgery do that/be responsible for offering advice and information to patients? GPs should be asking patients if they need transport as part of referral to secondary care.
- Stand/notice in all hospitals, clear signposting for patients wanting transport.

- Appointment letters to include transport information, more consistently if being done already.
- Phone number – couldn't get through, couldn't talk to someone.
- Each NHS organisation has its own booking system – review looking at possibility of one integrated booking system.
- Local volunteer centres with local knowledge organise their transport more effectively, centralised system in East Kent. More local intelligence for logistics, 'local is more efficient'.
- TV sets in local surgeries to advertise information.
- Online information? Not necessarily the first place people will look.
- Word of mouth very effective.
- Speakers at forum meetings, community events, fayres, community centres, KCC gateways, KCC wardens.
- Could hopper bus be used by visitors and staff as it is under used?

Notes from Isle of grain Disabled and Carers Group

One participant said that the island has a high incidence of diabetes, cancers, ME, MS etc possibly to do with the high levels of industry and agricultural chemical in use around Grain.

They had a couple of issues that started to emerge. The main one is about access to phlebotomy services, but this was indicative of the general problems they have accessing healthcare.

The Brice centre has the nearest Phlebotomy Clinic, a 24 mile round trip on an unreliable bus service. It can take 45 minutes to get there, they can wait 2 1/2 hours for their appointment and then the journey home including waiting for the bus. over four hours out when you are fasting.

One person was given an appointment at Maidstone hospital. To get there requires a bus, then a train and then two more buses. A 12 hour round trip including the appointment.

There was conversation around the need for carers to travel so that they can help cope with information about the medication that the patient is given.

They said that they had no idea who to contact about PTS. They also said they wouldn't know who to complain to. But if they did they would be too ill or worried about 'being blacklisted' to complain.

They would like simple information about what is available, the basic options available with a telephone number of someone they can speak to. I have since e-mailed Joy with this information. They felt this information should be on A4 posters and displayed in doctors surgeries. They also suggested that the information is carried in local community publications, for example Grain has the 'Grain Village News' which is published by the Parish council. This would mean that the information could be kept up to date.

One participant said that he left hospital unable to walk after a leg operation and wasn't offered PTS. They felt that Doctors and nurses needed to be educated about transport and be more aware of patients needs in this regard.

A participant with MS asked how the eligibility criteria would be applied to her as sometimes she can cope, other times she can't.

Medway Hospital was very good with Blue Badge holders. They have a pay on exit system and will validate the tickets of blue badge holders allowing them free parking. However, the badge holder must be present, meaning there are problems if someone is rushed in or late for an appointment.

Notes from Winslow Forum, Kent & Medway NHS and Social Care Partnership Trust

We were invited to attend the Winslow Forum meeting to listen to members' issues and concerns regarding patient transport.

There were two main areas for concern that came forward.

1. Booking process:

- The booking process has changed from being done over the telephone, to being done by fax and now it is done via email. There were few problems, patients left waiting etc when bookings were done over the phone but faxes went missing leaving patients without transport. The email system seems better because it is easier to follow them up.
- "if booking repeat journeys for repeat appointments patients not always picked up for second appointment."
- Regular appointments are an issue, emailed PTS Booking system with full details.
- Bookings used to be done on telephone and then had few problems. Then asked to fax bookings through but often they went missing so patients would be left waiting and no transport would come, now been asked to email which has made chasing up easier as there is proof of email.

2. Logistics

- Patients left waiting to attend day treatment, picked up late, taken back early so don't benefit from full treatment. Miss out on social benefits of day centre.
- Not drivers fault, not organised logistically enough, coordinated properly.
- People spending long time sitting on minibus.
- Patient ambulances used now / EKHUT minibuses.
- Good experiences, fleet of cars.
- People wait around a long time after appointments, some times even until staff are closing up for the day, KMPT have taken people home in this situation on their minibus.
- Ambulance drivers don't always take patients up to the front door, people have been left in Arundel Unit reception and then wandered off.
- Drivers are supposed to handover patients to ensure their safety but they don't, patients get left in reception.
- Mini bus drivers are under pressure to pick people up in a short space of time. Different locations to different destinations, now have to seek management permission to take someone not on their list even if they live in the same street as someone who is on the list, drivers have to take the first patient and come back so they have permission to take them.
- Main problem is logistics not necessarily drivers, needs better planning.
- Decisions to pick up / take home down to managers not drivers which causes delays.

- KMPT pay for volunteer drivers in West Kent but system is different across East Kent.
- Drivers not mental health awareness trained, lack of understanding, when a patient refused to go with a new driver the KMPT staff had to go and pick him up.
- Example: a patient attending the day clinic for anxiety therapy was kept waiting at home beyond the pick up time, arrived late for the therapy and then had to wait a long time after the session which made her situation worse.
- Canterbury and Thanet have their own minibus for collecting patients but it means staff are away from the centre during sessions.
- Repeat transport is treated as a one off booking; transport has to be rebooked every week.
- Transport often arrives too late to get there in time for appointment meaning that the treatment is rushed.
- I have seen two different drivers picking up two people in the same street.
- My next door neighbour travels to ten hospital for something different and is sent in a separate bus.
- Central logistics means that there is no space for local decision making.
- The routes are sometimes badly planned; I have gone from Hythe to Dymchurch and then back to Hythe.
- Waiting and long journeys increase problems for people having therapy for anxiety. Particularly when transport is late for the appointment or people are left waiting a long time for their journey home.
- Transport has arrived after staff are supposed to have finished working for the day. Staff from the unit end up taking people home in the unit minibus.
- Handover is insufficient. Patients don't get taken to their front door. One patient was found wandering outside the hospital by a relative.
- A patient with Dementia asked the driver to drop him in town, which the driver did.
- People are grateful for the service and tend not to complain.
- Some provision of volunteer car service, costs covered by KPMT. However the patient doesn't know whether they will be picked up by bus or car.
- First visits by anxious or agoraphobic people are unlikely to happen without transport.
- It is unclear whether drivers are trained in mental health awareness.
- It would make more sense for the day hospital to have its own transport co-ordinator.

Information from Online and Paper Surveys

Online Surveys

What worked well, did you have a positive experience?	What didn't work so well, were you unhappy about something relating to the patient transport?	What do you think needs changing to ensure the patient's experience improves?	What information was available to you and where?	What wasn't available that you feel would have been helpful?	What information do you think should be included?	What format should that information be available in?	Where should it be available?
We have a lot of satisfied clients that use our service constantly.	Not enough parking - we have drivers that will not go to Maidstone Hospital at the moment because of the lack of parking Our drivers are using a parking permit that is long out of date, because there has been a new company take over parking at Maidstone hospital, and nothing has been done to address this issue. Appointments at the last minute - hospitals etc do not take into account patients having to organise transport for these last minute appointments Cancellations & re-bookings - there are an awful lot of cancellations and re-bookings made by hospitals, doctors etc and again it is not taken into account the costs incurred by the volunteer transport when having to re-arrange, and also it is not taken into account that last minute cancellations may have prevented another patient from getting transport to a different appointment.	All of the above needs addressing - parking designated for voluntary transport would be a start All hospitals operating the same system for voluntary car schemes so that one card or similar could be used to cover all hospitals, which would make administration and use a lot easier.			Who is entitled to what transport, and what clients should do if they are not entitled. Any costs involved How much notice is needed for each transport scheme and what times they operate from and to.	On-line Leaflets at relevant places e.g. hospitals, doctors surgeries etc. Posters explaining the options in the same places, plus in the local community	see above + local radio and hospital radio

What worked well, did you have a positive experience?	What didn't work so well, were you unhappy about something relating to the patient transport?	What do you think needs changing to ensure the patient's experience improves?	What information was available to you and where?	What wasn't available that you feel would have been helpful?	What information do you think should be included?	What format should that information be available in?	Where should it be available?
	Bariatric transport - delay in vehicle from Folkestone and lack of staff training in use - stretcher too narrow	use approved contractors like London do with AST who can send appropriate trained staff with correct equipment a lot quicker cutting down stress etc to patients	none		details on ways people can be moved giving a database to regular users at control so to avoid in appropriate vehicles being sent and that way cutting delays and costs to service		at control centre and a web giving community place to register and fill in info / update
None.	Ambulance took 4 hours to arrive.	Patients should be told that transport is available, what form it will be, and will it be a minibus full of people being delivered all over the Medway towns, taking over an hour for the last person, or individual transport for one person.	None.	Everything . Have never even been told that transport was available.	The fact that transport is available, when and how do you get it.	On line, and in a discharge information pack.	To the patient.

What worked well, did you have a positive experience?	What didn't work so well, were you unhappy about something relating to the patient transport?	What do you think needs changing to ensure the patient's experience improves?	What information was available to you and where?	What wasn't available that you feel would have been helpful?	What information do you think should be included?	What format should that information be available in?	Where should it be available?
Using Swale Volunteer Centre's Social Car/Volunteer Transport Scheme. I find the volunteer drivers that provide the transport using their own cars very friendly and helpful and nothing is too much bother. The costs are very affordable and I find the service a real lifeline and don't know how I would get to my hospital appointments without it.	In the past when I was younger I used public transport but living on the Isle of Sheppey - it is very difficult to use public transport to get to Medway Hospital.	The Swale Volunteer Car Scheme I mention above is only open to take bookings in the morning - it would be very helpful if they had more grants and money given to them so they were open all day and you could then book cars more easily. It would also be good to be able to book transport at short notice.	A friend told me about Swale Volunteer Car Scheme and I have used it ever since - it would be helpful if better information about these types of services were sent to you with appointment information.		About all the various means of getting transport to Hospitals	A variety of different formats including poster, leaflets and also on the internet.	Libraries, community centres, Doctor's surgeries and posted to you with appointment information
none	none	none	none	none	disabled	large & braille	Library,hospitals,doctors council offices

What worked well, did you have a positive experience?	What didn't work so well, were you unhappy about something relating to the patient transport?	What do you think needs changing to ensure the patient's experience improves?	What information was available to you and where?	What wasn't available that you feel would have been helpful?	What information do you think should be included?	What format should that information be available in?	Where should it be available?
Transport of husband to Robert Bean Lodge Day Centre Tuesdays very reliable and with friendly staff.	N/A	N/A	Visit from Day Centre Staff at our home	N/A	What we already have, e.g.. phone number of Day Centre, names of staff.	Printed sheet.	Given to Carer at patients home.
no experience	no experience	no experience but suggest that to protect taxpayers' money a nominal fee is charged to prevent potential misuse of this as a free taxi service (when everyone has to pay to get to hospital)	no experience	no experience	relevant charges	websites and via GP verbally	websites and via GP verbally
I live in Medway but I had an accident in London and was a patient at the Chelsea and Westminster Hospital for 5 days. When I was discharged they sent patient transport for me on three	My sister in law with advanced dementia and incontinence is being cared for at home with occasional relief visits to a nursing home. Transport is needed but not co-ordinated, causing great anxiety and avoidable delays and confusions. Council based social services for the elderly/care and nursing homes/NHS hospital transport/domiciliary services do not interface smoothly at all in Medway and it seems to me there is no one person who has overall	Stop ticking boxes about "putting the patient first" and actually start doing it.	Without asking - none	Someone with the authority and the time to co-ordinate actions			

occasions to take me in for checks, x-rays and plaster cast removal. This was a great help to me.	authority to organise it - not the GP nor the Care Manager or anyone else I have come across.						
Being dropped close to clinic	The cost of using the Volunteer Bureau		None had to search, age concern referred me to vol. bureau after I phoned them a couple of times	Any information. Have higher rate mobility allowance, but Dr. ticked box for no transport needed, I walk with 2 sticks and cannot get on a bus-steps are a great problem. In same GP practice, a car owner/driver was organise a hospital car for a follow up appointment, although already back at work ! Consistency would be nice.	Who is eligible Where to apply and maybe the cost	All that is needed	with any and all appointments sent out Dr's surgery

What worked well, did you have a positive experience?	What didn't work so well, were you unhappy about something relating to the patient transport?	What do you think needs changing to ensure the patient's experience improves?	What information was available to you and where?	What wasn't available that you feel would have been helpful?	What information do you think should be included?	What format should that information be available in?	Where should it be available?
2 Occasions .....NO	1) told to get myself to A&E K&C Hospital by nurse at Dr's surgery.....suspected deep vein thrombosis.... and to take overnight bag. I had to call an acquaintance to take me. I was kept in.... congestive heart failure.....patient transport not mentioned. 2) follow up visit to cardiac for echo cardiogram.....again patient transport not mention....had time to set up.....had to take private taxi ..... £14.00 each way....	Suggest better publicity for BOTH cases..... at Surgery, at Ward, at Appointments everywhere!!	Nothing	Information about service.....pretty basic	WHO to contact WHERE to contact WHEN to contact HOW to contact EMERGENCY CONTINGENCY	POSTERS HANDBILLS CLUSTER POINT WEB SITE	at point of service in appropriate style and language for distribution to individuals who are there in person or who are written to for appointment
Ambulance Service works Well	Not aware of anything not working .Some local's comment about the Out Patient Ambulance Service and having to be ready to go hours before it arrives then going on long journey picking up other Patients.	Not so much of change . Being aware that in the Maidstone Tunbridge Wells area the distances between the Hospitals and therefore the different Services provided by each of the sites, Could mean quite long journeys on slow bumpy Busses and two or three of those on a journey which could take all day in some cases, and by	Available information not the best. Appointments should contain information on all routes to the Site. Bus Rail Car and details of Parking costs. If a local Park and ride service is available it should be published. I.E As far as I know	Info' on Car Parking and Bus Services To / from any of the local hospitals.	Everything to do with getting to and from the Hospital Site including maps	Leaflet with Diagram + some information on distances.	Should be sent when appointment is made by the hospital or GP

		Patients who are not well.	there is NO service from Maidstone Park and Ride to Maidstone Hospital, But Why Not have such a service.				

We run a volunteer transport service at the Volunteer Bureau and are overwhelmed by people who need transport to hospital appointments as well as to doctors/dentists/chiropodists etc. People who use our service do so because they are unable to use public transport for reasons such as health (mental and physical) and finances.	I am constantly surprised at the types of people turned down for hospital transport. Recent example is a pensioner turned down despite the fact she had to go every day for 4 weeks to Maidstone from Tunbridge Wells for cancer treatment. She couldn't afford a taxi and felt too ill to use a bus. She had no relatives available to take her.	Service needs to be expanded.	n/a	n/a	phone numbers for all local transport should be on appointment letters	Leaflet and on hospital web sites	hospitals, doctors surgery

Paper Surveys

What worked well, did you have a positive experience?	What didn't work so well, were you unhappy about something relating to the patient transport?	What do you think needs changing to ensure the patient's experience improves?	What information was available to you and where?	What wasn't available that you feel would have been helpful?	What information do you think should be included?	What format should that information be available in?	Where should it be available ?

					Full details of public transport at the information desk.	Bus and train timetables	Front Foyer
My neighbour has had excellent service from car transport, necessary to organise and have cataract operation.	The above mentioned neighbour did not know that she had to request transport in the first place! I will recount a sorry saga about my blind cousin who has recently had a spell in Maidstone Hospital. The phoned his wife to say that he would be home at 12pm, then 2pm then 4pm. She said 'don't bother' I will get my son-in-law to come and get him.					The main format must be telephone. People with cataracts for instance can't read printed matter, then deaf may not hear the phone There needs to be a link up with the patient's doctors and carers to ensure no wasted transport.	
I travelled by local bus. Original appointment made at hospital to suit bus times. That appointment cancelled by hospital. New appointment	Return bus infrequent. I was able to walk up to A2 road to catch 132 bus (every 10 mins) but physically disabled patients could face a long wait for return buses.	Hospital appointments staff need to be aware of bus timetables and discuss suitable appointment times with patients, especially disabled. The real solution is a much improved public transport service.	Bus timetables available from Council contact points.	Some indication of how long I was likely to be in outpatients so that I could plan my journey home.			

made which didn't fit bus times, but I caught an earlier bus and took a book to fill in hours wait.							
Netcare treatment (as NHS patient), Netcare provided free taxis to/from their unit to/from home on three occasions (as a matter of course). Excellent service.	Polyclinic Estuary View - appalling lack of transport resulted in me having privately funded transport. Now partly changed - Tesco provide free bus service Tues-Fri mornings only; hardly an adequate service.	Pre-building planning of how patients are going to get to any new services Parking - paying in advance (at certain hospitals) is most unsatisfactory, as length of visits are rarely predictable Giving free parking to patients needing ongoing visits to hospitals, clinics etc.	GP mentioned (in passing) that Tesco was now providing a (limited) bus service to Estuary View.	Old health centre (Whitstable) failed to give travel information - was not even raised by them (all car owners perhaps!)	Eligibility for free transport Cost - if appropriate Availability	Verbally (notices are rarely read by the public) and some can't see anyway.	At GP surgeries and all health facilities and to be given at time of booking appointments/automatically.

When my operation was cancelled at the last minute due to the snow in December the ward arranged for transport to take me home as there were no buses available. The driver and assistant were excellent and got me home safely and made sure I got down the steps and into my house.	I haven't had any other experience as I'm usually collected by family or arrive by bus. I have to get two buses and have to make sure I leave an hour before my appointment. I have heard that patients find that they can be collected and have to go round collections of other patients which can be annoying or uncomfortable. waiting to be picked up or waiting to be taken home. Also, some missed their appointment say for physio. I was at one appointment and talking to a lady who had arrived and had two appointment or was sent off for an x-ray and missed her return transport by a few minutes and although staff had sent to arrange transport she was waiting for a very long time. A nurse saw her and was surprised she was still there and went to find out why.	Communication between departments Patient collecting and return times more flexible Making sure patients arrive in time for appointments and are seen on time.	None.	Information when coming into a hospital for an appointment as to what? I could be entitled to hospital transport, but who would arrange it?	Who and when patient transport is available. Who to contact. Is there a costs. Is there a voluntary organisation that could be used?	Leaflet.	As above. At Doctors surgeries and information centres.
			None available	Transport to hospitals and psychiatric clinics, GPs surgeries .g. Ramsgate to Canterbury needing physical support.	Times and places for pick up in walking distance from house (limited).		In GPs surgeries information desk!, local papers, link news, mencap news.

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Eligibility Criteria for Patient Transport Services (PTS)

Eligibility Criteria for Patient Transport Services (PTS)

PTS eligibility criteria document

Prepared by
DH Ambulance Policy

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

Document Purpose	Best Practice Guidance		
ROCR Ref:		**Gateway Ref:**	8705
Title	Eligibility Criteria for Patient Transport Services (PTS)		
Author	Department of Health		
Publication Date	23 Aug 2007		
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Finance, PTS provider representative organisations and groups		
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, Directors of Finance, PTS provider representative organisations and groups. It will also be available on the internet for any interested parties.		
Description	Following responses to a thirteen-week consultation this document provides revised eligibility criteria for non-emergency patient transport services		
Cross Ref	Chapter 20 of the NHS Finance Manual		
Superseded Docs	PTS Guidance 'Ambulance and other patient transport service – Operation, use and performance standards' (1991)		
Action Required	To take account of the revisions in PTS eligibility		
Timing	Immediate		
Contact Details	Ambulance Policy 11th Floor New Kings Beam House 22 Upper Ground SE1 9BW emergencycare@dh.gsi.gov.uk www.dh.gov.uk/consultations/fs/en		
For Recipient's Use			

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http://www.dh.gov.uk/publications

Contents

Document Purpose

1. ‘Ambulance and other Patient Transport Services: Operation, Use and Performance Standards’ [HSG 1991(29)] was published in 1991. This set out guidance for the NHS on the operation, use and performance standards for emergency and urgent ambulances. It also set out criteria for establishing which patients were eligible for non-emergency patient transport services (PTS).

2. The White Paper (‘Our health, our care, our say: a new direction for community services’, January 2006) made a commitment to extend eligibility for the Hospital Travel Costs Scheme (HTCS) and PTS to procedures that were traditionally provided in hospital, but are now available in a community setting. This will mean that people referred by a health care professional for treatment in a primary care setting, and who have a medical need for transport, will also receive access to PTS and HTCS.

3. This extension to PTS, as outlined in this document, is expected to come into force in 2007/08, although Primary Care Trusts (PCTs) can of course amend local eligibility criteria for PTS in line with the White Paper before that date, should they wish to do so.

4. This document therefore updates and replaces the 1991 guidance and applies to both NHS and independent service providers contracted to the NHS.

What is PTS?

5. Non-emergency patient transport services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients’ medical needs.

Who is eligible for PTS?

6. PTS should be seen as part of an integrated programme of care**.** A non-emergency patient is one who, whilst requiring treatment, which may or may not be of a specialist nature, does not require an immediate or urgent response.

7. Eligible patients should reach healthcare (treatment, outpatient appointment or diagnostic services i.e. procedures that were traditionally provided in hospital, but are now available in a hospital or community setting) in secondary and primary care settings in a reasonable time and in reasonable comfort, without detriment to their medical condition. Similarly, patients should be able to travel home in reasonable comfort without detriment to their medical condition. The distance to be travelled and frequency of travel should also be taken into account, as the medical need for PTS may be

affected by these factors. Similarly, what is a "reasonable" journey time will need to be defined locally, as circumstances may vary.

8. Eligible patients are those:
   - Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
   - Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
   - Recognised as a parent or guardian where children are being conveyed.

9. PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator. Discretionary provision such as this would need to be agreed in advance, when transport is booked.

10. A patient's eligibility for PTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:
   - clinically supervised and/or working within locally agreed protocols or guidelines, and
   - employed by the NHS or working under contract for the NHS

Who provides PTS?

11. For simplicity, the text of this guidance will refer to PCTs when discussing the role of the commissioner. There is an expectation that over time, where it is not already the case, PCTs should take on responsibility for PTS contracts and commissioning.

12. PCTs are responsible for commissioning ambulance services (which could include patient transport services) to such extent as the PCT considers necessary to meet all reasonable requirements of the area for which they are legally charged with providing services. It is for the PCT to decide who receives patient transport services in their area. PCTs should therefore apply the principles outlined in this document either to consider each case on its merits or to develop more detailed local criteria for PTS use. PCTs may lawfully ask other bodies to assist in the exercise of their commissioning functions. Yet where they make such arrangements, it is still the responsibility of the PCT to ensure that appropriate services are being provided at an appropriate cost and standard.

13. A range of different providers may provide PTS - for example the local NHS ambulance trust, independent sector providers, or a combination of providers.

14. PTS eligibility has not been extended to include patients who do not fit the criteria outlined above e.g. those who have a social need for transport. Local transport plans should address issues of access to health services to enable integrated transport provision and PCTs have been encouraged to engage in this process through accessibility planning guidance and the NHS Modernisation Agency's 'Driving Change – Good Practice Guidelines for PCTs on Commissioning Arrangements for Emergency

Ambulance Services and Non-Emergency Patient Transport Services' best practice material.

15. The White Paper ('Our health, our care, our say: a new direction for community services') made clear that PCTs and local authorities should be working together to ensure that new services are accessible by public transport. Existing facilities should also work closely with their PCTs and with accessibility planning partnerships (in those areas that produce local transport plans) to ensure that people are able to access healthcare facilities at a reasonable cost, in reasonable time, and with reasonable ease.

Who pays for PTS?

16. Eligible patients are not charged for patient transport services provided by the NHS. PCTs are ultimately responsible for the costs of PTS.

17. The cost of providing PTS is for PCTs to negotiate for their registered population, dependent on local needs and priorities. It will vary depending on the nature of services provided, distance to be travelled and is a matter for local agreement.

18. The cost of PTS remains within the scope of Payment by Results as an integral part of the relevant tariffs and will remain within tariff during 2006/07 and 2007/08. If it is agreed locally that the acute trust should not be responsible for providing PTS then locally agreed adjustments should be made to the tariff to facilitate the PCT contracting for PTS directly with providers.

Duty of care to patient

19. The provider of the transport service owes a duty of care to the patient (and any accompanying escort or carer) being transported, from the time they collect the patient to the time they hand them over. However, during patient transfer, the NHS will still owe a duty of care to a patient, regardless of whether there is an escort in attendance. The PCT will still be responsible to the patient being transported in so far as the PCT must exercise reasonable care to ensure that the arrangements it makes for provision of PTS ensure that PTS will be provided to a safe and adequate standard. See Chapter 20 of the finance guidance for more detail on quality standards.

Out of area

20. Patients are now being offered a choice, through the extended care network, over where they receive treatment when they are referred for elective care. Therefore, it is likely that the number of out of area PTS journeys will increase. The principle that

should apply is that each patient should be able to reach hospital in a reasonable time and in reasonable comfort, without detriment to their medical condition. Distance to be travelled should actively be considered when assessing whether the patient has a medical need for transport.

21. In terms of funding arrangements, the general principle should be that a patient's home PCT would be expected to bear the cost of their PTS journeys.

22. See Chapter 20 of the finance manual for more detail on charging for out of area journeys.

Private patients

23. If a private patient is treated as such by a NHS Trust, any requirement for PTS will generally be provided under the PCT service agreement. However, the NHS Trust will recover the cost from the patient rather than the patient's home PCT by reflecting the cost of the transport provided in the private patient rates it charges and, if necessary, by supplementing those charges to allow for the cost of any additional PTS activity. It will then reimburse the PCT.

24. If a private patient is treated in a private hospital, any PTS supplied by an NHS PTS provider will be charged to the private hospital, which will make its own arrangements for recovering the cost from the patient.

25. A private patient transferred as an NHS emergency case is liable for the cost of transport only if the patient, or a person acting on the patient's behalf, opts for private treatment and signs an undertaking to pay charges.

Escorts

26. PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with physical or mental incapacity, children or to act as a translator. Only one escort should travel with a patient under such circumstances. Such discretionary provision would need to be agreed in advance, when transport is booked.

27. The eligibility criteria for PTS have not been extended to include visitors.

28. Where, exceptionally, a friend or relative accompanies a patient to hospital or for treatment, return transport provision is at the discretion of the provider.

Carriage of wheelchairs

29. There is currently no regulation covering the carriage of wheelchairs: the Department for Transport (DfT), Local Government and the Regions (DTLR) document VSE 87/1 Code of Practice: "The Safety of Passengers in Wheelchairs on Buses" remains the main guidance available.

30. Some patients have wheelchairs with special seating or controls. Such patients have the right, wherever possible, to be transported in or with their wheelchair for reasons of comfort and mobility. In deciding how best to meet requests for wheelchair transport, purchasers/providers will, however, need to adhere to the requirements produced by the DfT and guidance provided by the Medical Devices Agency, which is referenced at the end of this document.

Setting standards

31. *Our Health, Our Care, Our Say* sets out the Department's intention to provide national standards for what people can expect from patient transport services, as well as exploration of options for accrediting independent sector providers of PTS, to ensure common minimum standards.

32. In the meantime, PCTs should ensure that whatever arrangements are adopted for the provision of PTS are underpinned by an effective transport management quality assurance, and health and safety system.

Social needs for transport

33. The NHS can use income generation powers to charge patients for the provision of transport for 'social', rather than 'medical' needs.

34. PCTs do not have to provide transport for social reasons however Section 7 of the Health & Medicines Act 1988 allows a charge to be levied for the provision of transport to patients with a social need. The main provisos for income generating schemes are:

    a) The scheme must be profitable as it is unacceptable for it to be subsidised from NHS funds;
    b) The profit must be used for improving the health services; and
    c) Income Generation schemes must not in any way interfere with the provision of NHS services to patients.

35. Guidance is contained in National Health Service income generation – 'Best practice: Revised guidance on income generation in the NHS', February 2006.

Help with travelling expenses and travelling arrangements for patients on low incomes – Hospital Travel Cost Scheme (HTSC)

36. The Hospital Travel Costs Scheme provides financial assistance to those patients who do not have a medical need for ambulance transport, but who require assistance in meeting the cost of travel to and from their care. Reimbursement of travel fares are provided for services that must be:

    - Currently under the care of a consultant (such as a surgeon or rheumatologist, but not a GP)

    - for a traditional hospital diagnostic or treatment, (i.e. non-primary medical services or non-primary dental services), regardless of where the treatment is carried out

    - paid for by the NHS, regardless of whether it is carried out by an NHS care professional or an independent one

37. Benefits and allowances that entitle patients (and their dependents) to full or partial reimbursement of travel expenses under HTCS are means-tested and include Income Support, Income-based Jobseeker's Allowance, Pension Credit Guarantee Credit, Child's Tax Credit, Working tax credit with Child's Tax Credit, Working Tax Credit with a disability element, or the NHS Low Income Scheme.

38. PCTs are ultimately responsible for payment of the scheme. However, in practice and for convenience, patients claim their expenses from the NHS trust where they receive their treatment, and that trust reclaims the expenses from the responsible PCT. Guidance on the operation of the scheme is available from the Department of Health's website

39. http://www.dh.gov.uk/assetRoot/04/12/77/39/04127739.pdf

Complaints

40. From 1 September 2006, changes to the NHS complaints regulation came into force. The changes were designed to make the complaints procedure clearer and easier to access for those who need it. Purchasers of emergency ambulance services and PTS should ensure that local arrangements and procedures for investigating complaints conform to the requirements of that guidance. Guidance is available through the DH website:

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/NHSComplaintsProcedure/fs/en

41. Independent Complaints Advocacy Service (ICAS) provides support to people in England wishing to complain about the treatment or care they received under the NHS. ICAS delivers a free and professional support service to clients wishing to pursue a complaint about the NHS.

42. Patient Advice and Liaison Services (PALS) provide confidential advice, support and information on health-related issues to patients, their families and carers.

43. A more general complaints leaflet is available for the public, available on the DH website: www.dh.gov.uk/assetRoot/04/02/00/39/04020039.pdf

References

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- Establishing the Responsible Commissioner www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634

- *Our health, our care, our say: a new direction for community services*, The White Paper, Department of Health, January 2006. www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

- *NHS Trusts - Detailed Guidance - 20. Finance arrangements for patient transport services (PTS)*, Department of Health www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/c13b0f39ccbfd3fa802568a9005a0c1f?OpenDocument

- Code of Practice: *The Safety of Passengers in Wheelchairs on Buses* Department for Transport (DfT), Local Government and the Regions (DTLR) document VSE 87/1

- *Guidance on the Safe Transportation of Wheelchairs (MDA DB2001(03) June 2001)*, the Medical Devices Agency. www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON007343&RevisionSelectionMethod=LatestReleased.

- *Guidance of the Safe Use of Wheelchairs and Vehicle-mounted Passenger Lifts (MDA DB2003(03) March 2003)*, the Medical Devices Agency. www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON007320&RevisionSelectionMethod=LatestReleased

- *Medical Devices Regulations 1994 (SI 1994 No 3017)* www.opsi.gov.uk/SI/si1994/Uksi_19943017_en_1.htm

- *Manual Handling Operations Regulations 1992 (SI 1992 No 2793)* www.opsi.gov.uk/SI/si1992/Uksi_19922793_en_1.htm

- *The Health & Medicines Act 1988*, Section 7, ISBN 0105449881 www.opsi.gov.uk/ACTS/acts1988/Ukpga_19880049_en_1.htm

- *National Health Service income generation - best practice : revised guidance on income generation in the NHS,* Department of Health, February 2006 www.dh.gov.uk/assetRoot/04/13/06/68/04130668.pdf

- *The Hospital Travel Costs Scheme Guidance*, Department of Health, May 2005 www.dh.gov.uk/assetRoot/04/12/77/39/04127739.pdf

APPENDIX 3

SUMMARY OF TRUST'S ELIGIBILITY CRITERIA

	Dartford & Gravesham NHS Trust	**East Kent Hospitals University Trust**	**Medway NHS Trust**
Decision maker	Can only be booked by a medical practitioner or their designated representative or a ward nurse.	Authorised by lead therapist.	Determined either by a healthcare professional or by non-clinically qualified staff who are clinically supervised and/or working within locally agreed protocols or guidelines.
How decided	Scored against fitness, mobility, visual or hearing impairment, mental health, general health and social factors.	A registered Nurse is accountable for undertaking assessment against the criteria for in-patient discharge. Scoring system isn't publicly available.	Scored against fitness, mobility, visual or hearing impairment, mental health, general health and social factors.
Escorts	Escorts allowed depending on the severity of the patient's medical condition. Assessment to be signed off by the Consultant of Care or General Practitioner.	Carer only conveyed if their presence is essential for the journey.	Provided where the escorts particular skills and/or support are needed.
Notes		Exceptional non-medical need (lack of availability of other forms of transport and the distance to be travelled) at the discretion of the patient's GP or lead therapist	

	Medway NHS Trust	Dartford & Gravesham
Criteria	**Weighting**	**Weighting**
Fully mobile	0	0
Limited mobility 50-100 metres	1	1
Limited mobility to less than 50 metres	2	2
Walks unaided	0	0
Needs walking aid(s)/chair at hospital	1	1
Needs carry chair to/from hospital	2	-
Needs to travel in own wheelchair	2	2
Needs to travel on stretcher	4	4
Requires escort	1	1
Child under 16	1	-
Is likely to be receiving bad news	1	-
All senses	-	0
Blind	-	2
Registered blind	2	-
Partially sighted	1	-
Deaf	-	1
Totally deaf	2	-
Hard of hearing	1	-
Mute/speech impaired	2	-
Mental health problems	2	-
Dementia	2	2
Learning disabilities	2	2
Chronic ill health	1	1
Acute ill health	2	2
Leg in full POP cast	2	2
Major surgery within last 6 weeks	2	2
Condition or procedure precludes driving or alternative transport	1	1
Has to be@ DCU BY 0700hrs		2

Hospital Travel Costs Scheme (HTCS)

Taken from: www.direct.gov.uk

You may be able to get financial help from the Hospital Travel Costs Scheme if you're on a low income, need NHS treatment at a hospital, other NHS centre or private clinic and have been referred by an NHS hospital consultant.

Who can claim?

You're automatically entitled to claim Hospital Travel Costs Scheme if you (or those you depend on) get at least one of the following:

- Income Support
- income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance
- Guarantee Pension Credit

You also qualify if your income is £15,050 or less and you also get one of the following:

- Child Tax Credit (with or without Working Tax Credit)
- Working Tax Credit with the disability element or severe disability element

If an adult or your dependent child has to travel to your treatment with you for medical reasons, you can claim their travel costs too.

If you're on a low income but don't get any of these benefits or allowances, you may still claim travel costs through the NHS low income support scheme.

How much do you get?

If you're on entitled benefits or allowances you get back the full travel costs by using the cheapest form of public transport available, including any concessions or promotions. This applies to however you travel. If for example, you use a private car you can claim for petrol instead (and car parking charges where unavoidable) up to the cost of the same journey by public transport.
The hospital should tell you the mileage rate for petrol costs for private transport.
If public transport is unavailable or impractical (perhaps you can't get to your appointment on time or your mobility is restricted), you'll need to contact the hospital well before your appointment. They will need to check your new travel arrangements are allowed.
If you're on the NHS low income scheme you may get back all or some of your travel costs depending on which certificate you've been given.

How to claim

You can claim at the NHS hospital or clinic at the time of your appointment. You'll be paid back immediately in cash, when you show any of the following:

- proof of a qualifying benefit (like an award notice)
- a tax credit exemption certificate (you'll get this automatically if you qualify)
- a certificate showing you qualify for the NHS low income support scheme

The NHS low income support scheme

To apply for the NHS low income support scheme, you'll need to fill in form HC1.
You can order form HC1 online, by phone; call the NHS Patient Services helpline 0845 850 1166 (8.00 am to 6.00 pm Monday to Friday - calls are charged at the local rate) or get it from:

- NHS hospitals
- Jobcentre Plus offices
- some GP surgeries, dentists and opticians

Your form will be assessed and if you're entitled you'll get a certificate that confirms whether you receive full or partial help with your hospital travel costs.

What else you need to know

Backdated claims

You can claim help with travel costs up to three months after your appointment, as long as you can prove you were eligible to claim at the time. To do this, you'll need to fill in a refund claim form (HC5), which you can get from:

- NHS hospitals
- Jobcentre Plus offices
- the NHS Patient Services helpline, on 0845 850 1166 (8.00 am to 6.00 pm Monday to Friday - calls are charged at the local rate)

Appendix 5a

NHS Car Parking – consultation on improving access to patients: Kent and Medway LINk responses

Consultation reach

The Department of Health (DH) online consultation was replicated using 'Survey Monkey', a free website designed for producing online surveys, and publicised to LINk participants across Kent and Medway through the following the following channels:

- The LINks newsletter which reaches 1,141 participants and participant organisations in total across Kent and Medway
- The LINk's Bulletin which is sent out to those individual participants and participant organisations who do not have access to the internet or emails
- Direct emails to individual participants and participant organisations who can be contacted by email.

Paper versions made available who were unable to access the online version. The online survey only generated 18 online and paper responses. A number of our participants are actively engaged with the NHS through the LINk and their participation in steering groups, consultations and direct NHS community engagement, so had already completed the DH online version (see Appendix A for a record of the responses).

The consultation paper was presented at the Kent LINk's quarterly Community Engagement Event in Tonbridge on 25 February 2010. The 85 people that attended then participated in round table work shops around the following proposals from the consultation paper:

- Providing free car parking for visitors to inpatients
- Providing free car parking for visitors to inpatients who have hospital stays of greater than for example three or more nights
- Providing free car parking for outpatients with, for example, more than three appointments in a single course of treatment
- Capping daily parking charges for outpatients in priority groups
- Having no mandatory concessions but improving adherence to current guidance.

Outcomes

Comments that came out of the round table workshops and the survey indicated that there was an understanding of the issues around finances, capacity and potential abuse, typified by the following comments:

- "It would be lovely to see free parking for all, but this is likely to be exploited by some"
- "To scrap all car park charges within the NHS would leave an incredible financial deficit!"
- "The cost of providing car parking spaces should not be taken from funds for patient treatment, which would be the case if there were no parking charges".

Comments for alternatives included references to:

- Improving public transport options, particularly through the implementation of 'Park & Ride' schemes
- Tailoring charges; "we pay quite a high price for two hours parking even when we have a 15 minute appointment" or allowing some limited concessions, for example, free emergency parking for going in to A&E.

It should be noted that there was an element of suspicion about the consultation, including concerns that the use of the £180m figure were "DH scare tactics" and that the cost of free parking would be "a drop in the ocean for NHS budget".

Provide free car parking for visitors to inpatients

30% of respondents to the survey felt that this option should be implemented. There was recognition that providing free or reduced car parking for visitors would be complicated, but should be implemented in certain circumstances or that there should be some targeted concessions. Examples of this were:

- "One free parking permit could be issued for each inpatient" to be shared across visitors
- Free parking should be available to frequent visitors, "Say, on average five times a week or more. Occasional visitors shouldn't have the same rights"
- Visitors to patients "with serious life threatening illnesses where both the patient and the relative need to have the presence".

Provide free car parking for visitors to inpatients who have hospital stays of greater than for example three or more nights

45% of survey respondents felt this was a good idea. The main concern of the positive responses from the survey and the round table discussions was the positive impact that visitors have on inpatients. There were no dissenting voices. Comments from the round tables included:

- "Wellbeing is part of any patient's treatment. Visits from friends and family are an essential part of treatment"
- "For the morale of the patient and to alleviate worry for visitors".

Provide free car parking for outpatients with, for example, more than 3 appointments in a single course of treatment
75% of survey respondents felt that this was a good idea. The responses from the round table discussions were equally emphatic with comments which included:

- Free parking should be provided for outpatients regardless of how many appointments might be needed
- Free parking should be available for essential appointments and to ensure equality of access
- Patients with long term conditions that need more appointments, particularly those with cancer and other serious conditions need to have the anxiety of finding the money for these visits lessened.

Suggestions included:

- 20 day Radiotherapy for cancer to be given season-ticket at £1.50 for the week, (each stay no more than 30 minutes)
- Introduction of a ticket system (sent with appointment)
- Providing a colour coded ticket to a patient that is going to be at the hospital for three plus hours.

Cap daily parking charges for outpatients in priority groups
Nearly 80% of survey respondent agreed with this proposal with one respondent saying:

- "There should be a cap on daily charges for all outpatients, not just priority groups. What would be the criteria for selecting priority groups? How would unfairness (real or perceived) be avoided?"

Again, this was echoed at the round table discussions with comments including:

- Fixed price parking, say £1 (all day parking!), should be available
- There should be a standard outpatient rate managed through a voucher system
- Discount cards for regular users
- Free parking for over 65s
- Parking shouldn't be free for any group, but there should be a significantly reduced rate for particular groups like outpatients in priority groups.

No mandatory concessions but improved adherence to current guidance
This option received just one positive response via the survey, with no comment or justification made. However at the debate there were comments that:

- "If concessions aren't mandatory they won't be applied"
- "Concessions should be enforced"
- And one person who agreed with the proposal, but qualified it by saying that it was "subject to more information on details of guidance".

General comments
The round table discussions enabled people to express their concerns about issues that, while they may sit outside the direct scope of the survey, are none the less worth noting. There were comments about the need to improve facilities for disabled, including:

- "More disabled parking including some less narrow places for those who don't need wheelchair access"
- "Disabled bays to be nearer to facilities (entrances)".

Issues around how public transport impacts on peoples access to healthcare was a common theme. A number of people suggested including local transport systems into hospital travel planning, for example through the use of 'Park & Ride' schemes, as this would help to reduce issues around parking and improve the experience of patients and visitors. There was also several comments abut the need to address overall lack of car parking spaces:

- "The scope of the Consultation should be expanded to consider the adequacy of the number of parking spaces provided at all NHS centres (including GP surgeries) as this is the greater 'access' concern of the patient's group."
- "Is there a parking space at all rather than what is the charge!"

Finally, there were suggestions made about better management of the existing spaces, including:

- "Opening staff parking to hospital visitors in the evenings"
- Matching spaces to bed numbers, for example "A&E and maternity are key wards – there should be maximum car parking spaces available for the amount of beds".

Neville Dack
LINk Project Worker
March 2010

		What are your most important considerations/ needs in relation to your attending hospital either as a patient or visitor?						
	Do you have any other comments?	cost of parking	safety/security	availability of convenient parking	good access by other means of transport	affordable access by other means of transport	Are there any others? If so, please specify below:	Please comment on your responses if you wish.
1		Yes		Yes				
2			Yes	Yes	Yes	Yes		
3		Yes	Yes	Yes	Yes	Yes	As stated previously To be able to use bus pass at all time if attending for treatment. Or the appointment for older folk made at a time when they can use a bus pass to get to the treatment.	
4	I do not believe that parking charges will ever be removed, but I think that if charges have to be made then they should be based on the amount of time spent in the car park, like all other car parks. Charges should be severely limited or not made for outpatients and inpatients' close family as described above. Any patient with such illnesses as cancer or those needing kidney dialysis etc should never be charged.	Yes	Yes	Yes	Yes	Yes	Good public transport, but it doesn't exist in the East Kent area.	Good affordable access by public transport is the obvious ideal, but in a huge area like the East Kent Hospitals Trust and the Eastern and Coastal PCT it is impossible to get to hospital centres from outside the actual town where the building is situated. Green transport policies are useless to us who live 15 to 20 miles away from hospital. The East Kent University Hospitals Trust have hired consultants to review their parking. Suggest you contact Nicholas Doe the Parking Manager.
5	If we don't manage to provide some free parking then perhaps we could look at reducing the charges.	No	Yes	Yes	Yes	Yes		
6				Yes		Yes		
7		Yes		Yes				
8		Yes	Yes	Yes	Yes	Yes		
9		Yes	Yes	Yes			How close I am to the patient I'm visiting is the most important factor.	
10		Yes	Yes	Yes	Yes	Yes		If the Government insists on building "out of town" hospitals, they must put in place regular, Easy access public transport.
11	No.	Yes	Yes	Yes	No	No		Build bigger car parks provide stickers with clinic appointment cards.
12	Our members have commented that the lack of Disabled Spaces is particularly acute at the William Harvey and Canterbury Hospitals. Also, that use of the Blue Badge does not gain exemption from charges at these Hospitals	Yes	Yes	Yes	Yes	Yes	All the above are important to our Members.	
13		Yes	Yes	Yes	Yes	Yes	Distant from car park to place in hospital needing to attend.	
14		Yes		No	Yes	Yes		
15		Yes	Yes	Yes			A place where people attending A&E/intensive care can park close to the entrance	I strongly believe that the NHS should not have to bear the cost of care parking and that these costs should be placed on those able to pay, with appropriate concessions. All hospitals should adhere to the same policies for charging and for concessions, with extra charges being able to be made for inner city hospitals.
16	None	Yes	Yes	Yes		Yes		
17			Yes	Yes	Yes	Yes		
18	Car parking charges should generally do no more than cover the cost of providing and maintaining the car park, and certainly not exceed the charges by Local Authorities in the area.			Yes	Yes	Yes	The predominant concern of car park users is whether there will be a parking space available, rather than the cost. This concern forces patients to come unduly early and this increases the pressure on parking spaces. Also two carers are often needed, one to accompany the patient and the other to stay and park the car when possible. Stress and congestion multiple. Any reduction in parking Charges must avoid abuse by non-hospital users and must not reduce the parking income so as to reduce the funds available to provide adequate parking spaces.	

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Canterbury City Council Health Scrutiny Panel
Patient Transport to Hospitals

1. Introduction

The Health Scrutiny Panel agreed the scope for a review into patient transport in August 2009. The Health Scrutiny Panel Members that took part in the review were Councillors Seath (Chairman), Bissett, MacCaul, Calvert-Mindell, Jackie Perkins and Sonnex.

As patient transport is potentially a vast and complicated topic, the scope of the review was limited to looking at the qualitative patient experience of non-emergency transport to the local hospitals. This had been the subject of Member and public comment over the past year. The Panel's concern was that the quality of the patient transport experience to the local hospitals could be improved in terms of: timing: punctuality and journey length, cost, comfort and information on transport choices.

During the early stages of the review, the Panel became aware of a wider review of patient transport that was to be conducted by the Kent Local Involvement Network (LINk). The Kent LINk is an independent network of local people and community groups that work to influence and improve Kent's health and social care services. LINks have statutory powers to investigate the NHS.

The Development Worker for the East Kent area of the LINk attended a meeting of the Panel's investigation to explain about the review and how patient transport had come to be a priority in the LINks programme. It was explained that the LINks review was wider in scope and the geographical area it would cover. As part of the LINks evidence gathering the Health Scrutiny Panel could participate by providing local information to this wider review. The Panel therefore agreed to submit its findings to the Kent LINk's review of patient transport to provide local evidence and avoid any potential duplication.

2. Summary of key findings

The Panel's key findings are set out in section 5 of this report. They are summarised as follows:

- *Opportunities for improving communication between the different agencies must be incorporated into the next review of contracts between the Eastern and Coastal Kent PCT and transport providers.*

- *Patient transport needs must to be monitored and re-evaluated during treatment.*

- *The PCT must ensure that a consistent approach to monitoring patient satisfaction is taken by the various transport providers through the next review of contracts.*

3. Conduct of the review

The Panel held a series of meetings to gain an understanding of the non-emergency patient transport services operating within the district. The Panel met with representatives from the following organisations:

- Canterbury and Herne Bay Volunteer Centre
- Eastern and Coastal Kent Primary Care Trust
- Kent County Council
- Kent LINk
- Kent Karrier
- Pensioners Forum
- South East Coast Ambulance Service
- Whitstable Volunteer Centre

The Panel would like to thank those who gave their time and insight to the review.

4. Background to patient transport services

Non-emergency patient transport services to hospitals are provided through a number of contracts agreed with multiple commissioners.

In the Canterbury district, patient transport is primarily commissioned by the Eastern and Coastal Kent Primary Care Trust and delivered by the East Kent Hospitals University NHS Trust. Other providers include South East Coast Ambulance Service, Volunteer drivers, Kent Karrier, public transport and taxi drivers.

A summary of these organisations and their role with regard to non-emergency patient transport is provided below:

4.1 Eastern and Coastal Kent Primary Care Trust

The Eastern and Coastal Kent PCT commission patient transport services based on the needs of the population. The PCT covers over 700 square miles and encompasses the Canterbury, Ashford, Dover, Shepway, Swale and Thanet areas.[1] The PCT was created in October 2006 and replaced the five former PCTs of Ashford, Canterbury and Coastal, East Kent Coastal Teaching, Shepway and Swale PCTs.

The contracts between the PCT and transport providers are currently being reviewed in terms of service specifications and funding. The PCT holds monthly performance meetings with transport providers to ensure that the specifications in the contracts are being fulfilled. However, currently information on patient satisfaction is not a requirement of the contracts

[1] http://www.easternandcoastalkent.nhs.uk/about-us/nhs-eastern-and-coastal-kent/

between the PCT and transport providers. Therefore, no information on patient satisfaction is currently received by the PCT.

It was explained to the Panel that the number of transport providers commissioned by the PCT was largely historic and had arisen out of bringing together the five former PCTs. It was intended that in the long term, the PCT would tender for one contract to encompass the entire PCT area. However, there was currently a mixture of different transport providers that require co-ordination.

4.2 East Kent Hospitals University NHS Trust (EKHU NHS Trust)

East Kent Hospitals University NHS Trust is the largest provider of non-emergency patient transport across the PCT area. The Trust provides free non-emergency transport to people too ill or immobile to get to hospital by car or public transport. The service operates 24 hours a day, seven days a week.

The Trust has 46 ambulances and also uses Medicar, volunteer drivers and private taxis to support its service. Two types of ambulance are used; large ambulances capable of carrying people on stretchers and smaller vehicles that take up to five people. The Trust undertakes 200,000 patient journeys each year including taxi and volunteer driver journeys. Journey lengths are calculated using an IT system called CLERIC. Patients should not be in the vehicle for longer than one hour and should not have to wait longer than two hours before being picked up from their homes to be taken to the hospital. It was explained to the Panel that 94% of patients were picked up within two hours (the national target is 96%), 75% within one hour and 34% within half an hour.

4.3 South East Coast Ambulance Service (SECAMB)

The Eastern and Coastal Kent PCT commission South East Coast Ambulance Service to provide non-emergency transport. Overall they provide 436 000 journeys per year, although a significant proportion of these are outside of the district. Within the district SECAMB focus on transport to and from the cottage hospitals including Gregory Day Unit in Canterbury and the Queen Victoria Memorial Hospital in Herne Bay.

In addition to their own vehicles and drivers, SECAMB use volunteer drivers to support the service they provide. Approximately 20% of journeys are undertaken by volunteer drivers. The current quality standard is that no patient journey should be longer than one hour and should arrive within 30 minutes of the appointment time.

Patients are requested to be ready 1.5 hours in advance of their appointment. If the transport is running late, SECAMB contact the hospital to ensure they are still able to see the patient before they are transported.

SECAMB operate between the hours of 8am and 6pm. Outside of these hours it is possible for patients to travel on emergency vehicles. However, generally transport is not provided outside of these travel times.

4.4 Volunteer Drivers

Both the Canterbury and Herne Bay Volunteer Bureau and Whitstable Volunteer Bureau offer a driver service that can be booked directly by the patient or by the patient's G.P or hospital. Volunteer drivers are primarily used by patients who are not eligible for free transport provision and passengers are charged approximately 40 pence per mile.

Patient transport providers rely on volunteer drivers to supplement their service. The EKHU NHS Trust and SECAMB both employ volunteer drivers. The EKHU NHS Trust use 37 volunteer drivers and provide them with basic training on hygiene and customer care. SECAMB use 136 volunteer drivers. They are CRB checked and have their driving ability assessed. Volunteer drivers are not expected to lift patients and are therefore not provided with manual handling training.

Because the service is run by volunteers, transport has to be pre-booked and the drivers are normally not able to respond to immediate transport needs in the same way as the PCT commissioned transport. The difficulty in recruiting enough drivers to fully support the service was also highlighted.

It was explained to the Panel that patients mobility and need were monitored by the volunteer centres to ensure that the appropriate driver and vehicle were booked. It was reported that patients often establish a rapport with particular drivers. Also that the service was preferred by patients as they could be picked up at a more specific and convenient times and travel individually. The drivers stay with the patient whilst they wait for their appointment or arrange with them a time to be picked up. Therefore the patient is able to travel straight home after their treatment. The volunteer drivers also help patients by carrying out additional tasks such as picking up prescriptions from local pharmacies, although this is at the discretion of the individual driver.

4.5 Kent County Council

Kent County Council (KCC) both arrange and procure transport primarily between home and schools. However, access to healthcare is a key criteria when commissioning public transport services. The government target NI 175 sets a percentage target for the number of households that are within 30 minutes of a hospital by public transport. KCC's five-year plan for this target is that 55% will fall within the 30 minute radius.

KCC's spends £40 million each year on transport provision. Of the bus services across the county, approximately 80% are commercial services and 20% are supported by KCC. Access to health is one of the four criteria KCC use to assess whether bus services should be subsidised along with employment, education and essential food shopping.

This necessary bus service budget is £7.5 million. Of this approximately £2 million is allocated from the rural bus subsidy grant awarded by the government.

People who do not live on a bus route can claim for the cost of alternative transportation through the hospital travel cost scheme. All public buses are required by legislation to be accessible for people in wheelchairs by 2017. It was reported that Kent is on target to achieve this.

The East Kent Integration Transport Group which consists of County representatives and bus operators produce three leaflets on transport options to the Kent and Canterbury, William Harvey and Queen Elizabeth Queen Mother hospitals. The leaflets include information on public transport, volunteer schemes and Kent Karrier (see 4.6 below) as well as the hospital travel cost scheme. Each leaflet is distributed widely at GP surgeries, railway stations, public libraries, and Gateways. The Panel considered it particularly important that these leaflets were displayed clearly in all GP surgeries across the district to ensure transport options are communicated clearly to patients.

4.6 Kent Karrier

Kent Karrier is a membership transport scheme funded by KCC and the city council. Canterbury district has the most extensive service across the county and the highest Membership with approximately 420 Members. Like the volunteer service, the Kent Karrier provides an alternative to those people who do not qualify for non-emergency patient transport. The Kent Karrier operates one return journey per day Monday to Friday from different areas of the district to Kent and Canterbury Hospital. It also operates a return journey to Herne Bay and Tankerton Hospitals on Monday, Tuesday and Friday.

5 Key findings

A summary of the key findings which the Panel would like the Kent LINk to consider as part of its review of patient transport is set out below:

5.1 Journey length and comfort

The evidence received by the Panel was that generally patients were picked up from their homes and transported to hospital within the time period targets set in the contracts between the PCT and transport provider. However, this still means it can take up to three hours between the time the patient has to be ready for and arrival at the hospital. This wide time window also means that patients often arrive either early or late for their appointments extending the amount of time they spend in hospital waiting for treatment. However, the Panel did note that in cases where the transport is late, the transport provider liaises with the hospital to check whether it is still possible for the patient to be seen for treatment.

It was reported that it was more challenging for transport providers to meet the demand of patients waiting for transport once they have been discharged as

there was less scope to plan journeys in advance. For example, a member of the public stated that following discharge they had waited approximately eight hours for transport to arrive before having to cancel it due to the late time. They finally arrived home at 8.40pm the following day.

In addition, the target wait time between the patient being discharged and their transport arriving does not include the time they may have already waited to collect prescriptions at the hospital. For example, in accordance with the East Kent Hospitals University NHS Trust's target, patients should not have to wait more than two hours from the time they are discharged to when their transport arrives. However, the reality is that they may have waited longer than this once the time waiting for medication is included. The wait time monitored between discharge and transportation does not therefore give a full picture of how long a patient may have waited in total.

5.2 Communication

The Panel learnt that due to the large number of different agencies and people involved in booking and providing patient transport, communication between them is extremely critical. Several people and agencies are normally involved in booking an appointment, for example, G.P, hospital and transport provider. In addition, each of these has individual computer systems with patient and journey information. Finally, there are multi transport providers.

The Panel considered that whilst patients do not mind which agency is supplying the transport, there was a lack of awareness and sometimes confusion caused by the number of different providers involved. The Panel felt that patients should where possible, be made aware which transport provider will be collecting them and given a telephone number they can ring.

In addition, examples of where communication had broken down were reported to the Panel by both transport providers and members of the public. For example, more than one vehicle being booked for the same patient, inappropriate vehicles being booked or no transport arriving at all. This was attributed to the number of different agencies involved in booking patient transport and an indication of poor co-ordination. Commissioning one patient transport provider for the PCT area could help overcome this potential confusion. Therefore the Panel welcomed the PCT's long-term plan to commission one provider.

The Panel welcomed the fact that a Transport for Health Working Group has been established to overcome these communication issues. The Group is jointly chaired by the PCT and KCC and its intention is to co-ordinate the various work streams and communications. *The Panel considered that opportunities for improving communications between the different agencies must be incorporated into the next review of contracts between the PCT and transport providers.*

5.3 Booking patient transport

The importance of matching the right type of vehicle to the patient was highlighted to the Panel. Also that patients needs should be continuously monitored throughout their treatment as the type of vehicle required may change. The Panel found that there were examples of inappropriate transport being booked due to communication issues. Patient transport needs are initially assessed by a doctor, midwife or approved social worker. *However, the patients' transport needs are not re-evaluated during treatment and the patients' mobility needs do not always match the transport booked.*

Patient transport is booked through a Patient Transport Service located at Ross House in Folkestone. If a patient needs to discuss their transport provision they also contact Ross House. However, it was reported to the Panel that patients can experience difficulty getting through. The Panel also noted it was difficult to find information about this service. There are plans to upgrade the telephone system, as it was acknowledged the service is not as effective as it could be.

5.4 Patient satisfaction

The Panel considered a more consistent approach to monitoring patient satisfaction must be introduced via the contracts between the PCT and transport providers. Currently the transport providers monitor satisfaction to varying degrees. SECAMB monitor patient satisfaction once a month for non-emergency transport and twice a month for the service provided by volunteer drivers. However, the East Kent Hospitals University NHS Trust do not have a mechanism for monitoring patient satisfaction with their service and it is not a requirement of their contract with the PCT. Nor does Kent Karrier. In addition, the contracts should ensure action plans are introduced and regularly monitored to address any issues arising out of patient satisfaction results and comments.

The Panel considered that any review or future contracts between the PCT and transport providers must clearly specify that information on patient satisfaction should be regularly monitored and reported to the PCT.

6. Conclusion

The Panel welcomes the review of patient transport being conducted by the Kent LINk and expects that this short review will highlight some of the issues regarding patient transport experienced in the Canterbury district. In particular, the Panel would like the Kent LINk through its review, to seek improvements to the way patient satisfaction is monitored and communication between the various agencies involved in booking patient transport and the patient. Currently the various providers and types of provision can be complicated and confusing to patients. *The Panel recommends improvements to the patient transport booking system to include all service elements: patient need, method of booking, communications to relevant parties, monitoring of performance and capability of booking systems.*

Contact officer: Charlotte Hammersley Tel: 01227 862 332

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NHS
Eastern and Coastal Kent

Health Overview and Scrutiny Committee Briefing on the Pharmaceutical needs Assessment

Summary

The PCT has a statutory duty to publish its first pharmaceutical needs assessment (PNA) by 1 February 2011. Failure to meet this duty could lead to a judicial review. This paper provides information on PNAs and the action the PCT will need to take.

Background

In July 2007, the then Minister of State for Public Health, the Rt Hon Dawn Primarolo, MP announced that the Department of Health would publish a pharmacy White Paper.

Pharmacy in England: Building on strengths - delivering the future was accordingly published on 3 April 2008. It builds on *A Vision for Pharmacy in the new NHS* launched in July 2003 and *Our health, our care, our say: a new direction for community services* published in January 2006 and aligns closely with *High Quality Care for All* published in June 2008 and *Our vision for primary and community care* published in July 2008.

The White Paper set out the Government's programme for a 21st century pharmaceutical service and identified practical, achievable ways in which pharmacists and their teams can contribute to improving patient care through delivering personalised pharmaceutical services in the coming years.

Following consultation in autumn 2008, two clauses were included in the Health Bill 2009 (now Health Act 2009):

- to require Primary Care Trusts to develop and publish pharmaceutical needs assessments (PNAs); and

- then to use PNAs as the basis for determining market entry to NHS pharmaceutical services provision.

The Health Act 2009 contains the powers needed to require Primary Care Trusts to develop and publish PNAs and then to use PNAs as the basis for determining market entry to NHS pharmaceutical services provision. This second provision will be subject to further draft regulations and consultation later in 2010.

In July 2009, a regulatory Advisory Group drawn from interested parties was set up, to translate these proposals into reality. The Group's terms of reference are to: '*subject to Parliamentary approval of proposals in the Health Bill 2009, to consider and advise on, and to help the Department devise, regulations to implement a duty on NHS primary care trusts to develop and to publish pharmaceutical needs assessments and on subsequent regulations*

required to use such assessments as the basis for determining the provision of NHS pharmaceutical services'

The new regulations - The National Health Service (Pharmaceutical Services) (Amendment) Regulations 2010 and guidance are a result of their work

The duty on the PCT

The regulations place a statutory duty on each PCT to develop and publish their first PNA by 1 February 2011. The regulations set out the minimum requirements for the first PNA produced under this duty, and these include such things as data on the health needs of the PCT's population, current provision of pharmaceutical services, gaps in current provision and how the PCT proposes to close these gaps. The PNA will also consider the future needs for services

PCTs will be required to undertake a consultation on their first PNA for a minimum of sixty days, and the regulations list those persons and organisations that must be consulted e.g. the Local Pharmaceutical Committee, Local Medical Committee, LINKs and other patient and public groups.

Market Entry

In addition to being a tool to commission pharmaceutical services, PNAs will in future be used to determine applications form pharmacy and appliance contractors to open new premises in the PCT's area, or to move to new premises. This will replace the current system whereby the PCT decides if it is necessary or expedient to approve an application in order to secure access to pharmaceutical services in a particular area (also known as the control of entry system) and will help the PCT to commission pharmaceutical services to meet the health needs of its population. It is therefore important that the PNA is a robust document that it links to the PCT's Joint Strategic Needs Assessment.

Definition of Pharmaceutical Services

For the purposes of the Pharmaceutical Needs Assessment pharmaceutical services are:

- Essential Services
    - Dispensing of medicines
    - Repeat dispensing
    - Waste management (pharmaceutical)
    - Public Health
    - Signposting
    - Support for self-care
    - Clinical Governance
- Advanced Services
    - Medicines Use review and prescription intervention services

    - Appliance Use reviews
    - Stoma Appliance customisation
- Enhanced services
    - Locally (PCT) commissioned additional services for example smoking quit adviser, provision of emergency hormonal contraception (EHC)

They are provided by pharmacy and appliance contractors. The PNA also includes dispensing services provided by GPs but not enhanced services provided by GPs.

NHS White Paper; Equity and Excellence: Liberating the NHS

On 12th July the Secretary of State for Health launched the new NHS White Paper; Equity and Excellence: Liberating the NHS. It structurally changes the NHS with the creation of an independent and accountable NHS Commissioning Board. Amongst the roles this board will have will include the commissioning of certain services that cannot solely be commissioned by GP consortia. This includes GP (as provider) dentistry, community pharmacy and primary ophthalmic services.

The impact of this change from the direction of travel where pharmaceutical services were to be commissioned by PCTs based on need is currently not known. The relevant section of the Department of Health has been contacted to provide clarification. A meeting is also scheduled locally with the Department of Health team in early August where more clarity may be available.

Actions to date

- A County wide steering group has been set up to oversee the development of the PNA and agreement reached that all Kent PCTs will check for border consistency as part of the consultation process.
- The nomination of a Director responsible for the development of the PNA.
- Identification of the resources needed to develop and consult on the PNA
- The involvement of the key stakeholders.
- The development of a communication and patient engagement plan.
- The setting up of a local operating group.
- The development of the data collection process and criteria.
- Mapping of the current provision of pharmaceutical services.

Timetable

Action	Date	Status
Governance of production agreed	April to May 2010	Completed
Data collection and mapping of services, controlled localities and need	April to August 2010	Ongoing: controlled locality work to transfer from paper base into geographical information system taking some time
Writing of first draft	April to August 2010	Ongoing
Sharing through internal PCT Commissioning groups	August 2010	
Finalise first draft	August 2010	
Consult for 60 days widely	September to October 2010	
Amend PNA in the light of comments	November 2010	
Finalise PNA for agreement through PCT Commissioning Groups and Commissioning Subcommittee	November to December 2010	
PNA Board sign off	January 2011	
PNA Published	February 2011	

Andrew Scott-Clark
Deputy Director Public Health
July 2010

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 23 July 2010

Subject: Item 8. Dover Healthcare.

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1. Background

(1) At the meeting of the Committee held on 14 May 2010 the Members discussed the Forward Work programme. It was observed that much Committee time had been devoted to the issue of a new hospital in Dover and that as the scheme should be progressing there would be little need to include the issue on the work programme again. However, the Overview, Scrutiny and Localism Manager was asked to request a written update from East Kent Hospitals Trust for Members' information.

(2) This information has now been received and is attached.

2. Recommendations

(a) The Committee is asked to note the report.

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East Kent Hospitals University NHS
NHS Foundation Trust

Our Ref: SB/sbs

Chief Executive
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG
Tel: 01227 866405
Fax: 01227 864120

25 June 2010

Paul Wickenden
Overview, Scrutiny and Localism
Manager
Democratic Services
Sessions House, County Hall
Maidstone, Kent
ME14 1XQ

Dear Paul

Dover Hospital

Thank you for your letter dated 4 June 2010, in which you request an update on the Trust's progress with the Dover Hospital project for the Health Overview and Scrutiny Committee.

The Outline Business Case for the Dover Project was presented to Trust Board earlier this year, in January, and following lengthy discussion The Board asked that a number of further options be considered around possible phasing of the Dover development (i.e. to build the new hospital over three separately timed phases) and to explore whether it may be possible to provide part of the estates solution in modular buildings.

A full analysis of these various options was written into the Outline Business Case, which was then re-submitted and approved by the Trust Board in April.

The further option work confirmed the Board's previous decision to build the new hospital on the Buckland site and asked the Executive Director leading the project to continue to work with the PCT and the PbC around service models and provision.

The Trust has fully committed its capital programme for the current financial year on capital development schemes that were approved in 2009/10. However, the Dover Project remains very high on the Trust's agenda and the Trust is planning to commence writing the Full Business Case for the Dover Project with a forecasted start-on-site date in 2011/12.

Yours sincerely,

Stuart Bain
Chief Executive

Putting patients first

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 23 July 2010

Subject: Item 9. Forward Work Programme.

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1. Background

(1) At the meeting on 14 May, colleagues from Primary Care Trusts had been invited to attend to answer questions on The Future of PCT Provider Services and the Use of Community Hospitals. However, they had received advice from the Department of Health stating that until there was clarity over the direction of Government policy on this topic, the attendance of NHS officers at the Committee should be postponed. The Overview, Scrutiny and Localism Manager was requested to liaise with the Chairman, Vice-Chairman, Political Group spokesmen and colleagues in the NHS with a view to scheduling an alternative time for them to meet with Members and answer questions on this topic.

(2) The meeting of 3 September 2010 has been agreed as the most appropriate time for The Future of PCT Provider Services and the Use of Community Hospitals to be considered.

(3) In order to allow this subject to be explored in depth, the Chairman has decided to postpone the subject of Accessing Mental Health Services, scheduled for the 3 September, until a later date.

2. Recommendations

(a) The Committee is asked to note this change to the Forward Work Programme.

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 23 July 2010

Subject: Item 10. Update on Referral to Secretary of State for Health.

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1. Recommendations

(a) The Committee is asked to note the attached letter from the Secretary of State for Health and the report from the Independent Reconfiguration Panel.

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From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
mb-sofs@dh.gsi.gov.uk

POC1_514447

Councillor Godfrey Horne MBE
Chairman Health Overview and Scrutiny Committee
Legal & Democratic Services
Session House
County Hall
Maidstone
Kent ME14 1XQ

01 JUL 2010

Dear Councillor Horne,

REFERRAL FROM KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (WOMEN'S AND CHILDREN'S SERVICES AT MAIDSTONE AND TUNBRDIGE WELLS NHS TRUST)

Thank you for your letters of 24 February 2010 and 18 March 2010 to Andy Burnham respectively in which you formally refer proposals for the reconfiguration of women's and children's services at Maidstone and Tunbridge Wells NHS Trust.

As set out in his letter of 24 March 2010, the previous Secretary of State for Health asked the Independent Reconfiguration Panel (IRP) to provide him with initial advice on your Committee's referral.

The Panel has now completed its initial assessment and shared its advice with me.

A copy of the Panel's advice is appended to this letter. Their advice will be published on their website on **1 July 2010** (www.irpanel.org.uk).

In order to make a decision on this matter, I have considered the concerns raised by your Committee and have taken into account the IRP's advice.

Grounds for referral by Kent HOSC

Essentially, your referral covers ten main grounds all of which are dealt with individually below.

Transport

You believe that when the response to the 2004 consultation was produced, you assumed that improvements to the A228 connecting Maidstone and Pembury would be made by the time the new hospital was due to be completed. The plans are women's and children's services to move into the new hospital by January 2011, but you believe the new road scheme is unlikely to progress until 2014 at the earliest. Your Committee understands that the majority of transfers for women in labour from the planned midwife led birthing unit at Maidstone hospital will not be made under emergency blue light conditions, and that these small number of cases may not be directed to Pembury. However, your Committee still feels that the transport connection between the two sites is currently unsatisfactory and transfers that are too long will be distressing and not in the best interest of women.

The IRP considers transport is a matter for local assessment and advancements in dialogue and any subsequent planning should be realised through further engagement with both the local NHS and the local community.

Original consultation

In your referral letter, you state that although the HOSC formed part of the Joint Select Committee that produced a response to the 2004 consultation, you believe there remain questions held by many local people about just how effectively the NHS presented a range of alternatives and engaged the public, particularly in the Maidstone area.

In their initial advice the IRP describe the fact that this consultation took place in 2004 and it is noted in the first point of the IRP view that the proposals were supported by the HOSC as part of a joint select committee.

I understand the decision about the future of local obstetrics was taken by the Primary Care Trusts (PCTs) that preceded West Kent PCT.

I note the PCTs consulted the public on the future shape of maternity services in West Kent and the consultation indicated there was a strong desire for a service, that included both midwife led and consultant led elements. Although the 2005 decision (following consultation in 2004) to proceed with the changes to services was

endorsed by the then Joint HOSC, the current HOSC established a task and finish group back in November 2009 to re-examine the changes.

This group indicated that while it believes the original decision made by the then Joint HOSC to support the proposals was right; it wanted plans to be referred to the Secretary of State for Health in light of what it considered growing public concern over recent months.

Lack of ongoing communication/engagement with the public

Your referral goes on to say that since the local NHS agreed these plans back in 2005, you believe there has been a lack of information coming out of Maidstone and Tunbridge Wells NHS Trust to explain what progress had been made and what the practical impact of the changes will be. You believe this has led to a lot of confusion in the public mind and has led to a degree of loss of public confidence in the trust. You go on to state further that the PCT and the trust have failed to convince the local community of the validity of their plans.

This is an issue which I have now asked the local NHS to remedy in consultation with the local authorities and others

Lack of communication/engagement with staff

Similarly your referral goes on to say that the task and finish group heard from a number of members of staff at the trust that they too had not been kept up to date with developments and have felt excluded from the unfolding decision making process. Evidence has ben provided by several consultants, along with others, of their reasons for dissatisfaction. You suggest that all this may potentially be having an impact on staff morale.

The IRP considers that the communication and engagement with staff is essentially a matter for local assessment, and to be realised through further engagement with the appropriate staff.

State of trust's readiness

You say your Committee is not confident that the trust will be able to provide all the relevant services in facilities that are fit for purpose by the intended deadlines. The task and finish group understands that planning permission has yet to be requested for the midwife led birthing unit at Maidstone and furthermore that the Committee has

yet to receive a finalised list of where all services will be provided in the new two site configuration (this points to services being provided in the community as well).

In their advice, the IRP states that the state of the trust's readiness is an issue concerning implementation of the proposals and is therefore the responsibility of the local NHS to manage.

Lack of integration across the trust

MTW was formed in 2000. However, your Committee believes over the course of the subsequent decade appears to have done little to integrate the staff and cultures at the two geographical ends of the trust (i.e. Maidstone and Tunbridge Wells). You believe this may have a negative impact on patient care when services are centralised on one site and staff are asked to relocate.

This is an issue concerning implementation of the proposals and is the responsibility of the local NHS to address.

Patient choice

You say one of the main concerns raised by the task and finish group was what is believes was the lack of promotion of patient choice as it relates to women's and children's services. There is a public perception that going to Pembury will be the only option for some services and this will de facto be the case if women are not informed about the range of choices available to them. You say yourself this is not directly the responsibility of the trust, but you feel it is something that needs addressing before any changes are fully implemented.

The IRP states that the inclusion of birthing centres at both Pembury and Maidstone is acknowledged as being part of the consultation process and as such as part of the proposals supported by the HOSC as part of a joint select committee. I have asked the local NHS, in its further work, specifically to address how prospective maternal choice can be met, consistent with clinical safety.

Demographics

Since the original consultation was carried out back in 2004, Maidstone has been awarded government growth point status, which will significantly increase the local housing stock and population, with your consequent belief that full hospital services should continue to be provided at Maidstone hospital.

Department of Health

Again, the IRP believes this is a matter for local assessment and for further engagement with the local community as implementation moves forward and I support this assessment.

Health inequalities

Connected with the point above, the Maidstone area has some of the most deprived areas in the county with high rates of teenage pregnancy. You believe these women are excluded from exercising choice through lack of money and their own transport and as such will require a full service locally more than any other.

The IRP believes this is a matter for local assessment and for further engagement with the local community and I support this.

Other IRP decisions

You point out in your referral that a number of recent decisions by the IRP against analogous plans to centralise obstetric services, such as those in East Sussex.

Essentially and perhaps most importantly, each referral from any Health Overview and Scrutiny Committee is considered on its own merits. This is something, which I strongly believe in. Each case for change is vitally important to the people who are reliant on its services.

IRP advice

Essentially, the IRP believes this referral is not suitable for full review. The Panel believes it is in the best interests of the local health service for any outstanding issues raised by your task and finish group should be tackled locally. I have asked the local NHS to engage with you and with clinicians, local GPs and patient groups, to consider the proposals and their implementation and specifically examine the reservations you have raised.

Conclusion

Based on the IRP's initial assessment of all the documentation provided by your Committee and the local NHS, I support in full the IRP's advice. Both the trust and NHS South East Coast have confirmed there have been no changes to the original 2004 proposals.

However, since the advice was submitted to my predecessor on 5 May, I have set further criteria against which changes should be judged. As I have asked to be done in other circumstances across England, I want now to ensure that service changes reflect these new criteria.

I believe it is vital for patients and service users of the NHS that through these criteria changes must focus on improving patient outcomes and they must be based on sound clinical evidence, reflect current and prospective choice for the patient and have support and backing from GP commissioners.

On this basis, I am asking the local NHS to engage again with clinicians, the local authorities, local GPs and patient groups, to consider the proposals and their implementation. This should encompass the further assessments recommended by the IRP and should examine specifically the reservations you have raised.

I have asked the SHA to report to me within two months. This further assessment and report should not prejudice the work to open the Pembury Hospital as planned, nor the current work in establishing services there.

I hope, based on that report, it will be possible for me to be assured concerning the proposals for services concerning Maidstone & Tunbridge Wells Trust and their compatibility with future needs for the area.

I am copying this letter to:

Candy Morris, Chief Executive, NHS South East Coast
Steve Phoenix, Chief Executive, NHS West Kent
Glenn Douglas, Chief Executive, Maidstone and Tunbridge Wells NHS Trust
Dr Peter Barrett, Chair, IRP

ANDREW LANSLEY CBE

AG 01.07

IRP

Kierran Cross
First Floor
11 Strand
London
WC2N 5HR

The Rt Hon Andrew Burnham MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

5 May 2010

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE FOR HEALTH
Referral from Kent County Council Health Overview and Scrutiny Committee
(Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust)

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Godfrey Horne, Chair of Kent County Council Health Overview and Scrutiny Committee (HOSC). NHS South East Coast provided initial assessment information. We requested and received supplementary information from NHS South East Coast. A submission from Maidstone Action for Services in Hospital (MASH) was also received. A list of all the documents considered in the initial assessment is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. The IRP considers each referral on its merits and its advice in this case is set out below. **It concludes that this referral is not suitable for full review.**

Background
The Maidstone and Tunbridge Wells NHS Trust (MTW) is currently based on three acute sites – Maidstone Hospital, the Kent and Sussex Hospital in Tunbridge Wells and Pembury Hospital. A new PFI-financed hospital is under construction at the Pembury site. Once completed, the Trust will consolidate its services on two acute sites, Maidstone and Pembury, with the first occupation of the new building scheduled to take place in January 2011.

The Trust currently provides complex and routine care for women and children at both Maidstone and Pembury. However, the plans being implemented centralise consultant–led obstetric services and inpatient care for babies and children in the new Pembury Hospital.

Concerns about the Trust's ability to sustain its services for women and children at Maidstone and Pembury date back to 2000. The proposal to create a single centre for complex women's and children's care was first considered in 2003 following consultation

with the Trust's clinicians. Formal public consultation took place in autumn 2004. The consultation document, *Excellence in care, closer to home: the future of services for women and children – a consultation document,* outlined proposals to centralise consultant-led obstetrics and non-cancer gynaecology, inpatient children's care and the special care baby unit on the new Pembury site. Midwife-led birthing centres would be provided at both Pembury and Maidstone.

A joint select committee, comprising representatives of Kent County Council, East Sussex County Council, Kent District/Borough Councils, East Sussex District/Borough Councils and the Patient and Public Involvement Forum, was formed to consider the proposals. It responded to the consultation in December 2004 commenting that *"The Committee supports the proposals for the redesign of Women and Children's services"* and making a number of further recommendations.

A joint committee of NHS boards from West Kent and East Sussex agreed the proposals for women's and children's services - including the centralisation of consultant-led obstetrics and non-cancer gynaecology, inpatient children's care and the special care baby unit at Pembury - in February 2005. Detailed plans and the business case for the new hospital, including the Women's and Children's Centre, were subsequently agreed by the Treasury and the Secretary of State for Health and building work began in 2008. The Women's and Children's Centre is scheduled to open in two phases (January and July 2011).

In November 2009, following a Councillor Call for Action at Maidstone Borough Council, the Kent County Council HOSC agreed to establish a Task and Finish Group to examine the plans for women's and children's services at MTW. The report was presented to the HOSC at its meeting of 19 February 2010 when, in view of ongoing concerns about the plans, the committee voted to refer the matter to the Secretary of State for Health.

Basis for referral
At its meeting on 29 March 2010, the HOSC resolved that:

> *"In noting the conclusions of the Task and Finish Group which the Health Overview and Scrutiny Committee support the weight of public concern is sufficient to refer the issue of the provision of Women's and Children's Services across the Maidstone and Tunbridge Wells NHS Trust to the Secretary of State for Health to review the decision taken by the West Kent Health Economy in 2005 – with particular emphasis on the services to be provided at the Maidstone Hospital…"*

A letter of referral was sent to the Secretary of State for Health on 24 February 2010. A further letter of 18 March 2010 to the Department of Health clarified that:

> *"…the primary grounds of referral are under section 4(7) of The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (No.3048). As my original letter made clear, there remain questions about the*

original consultation, but the other nine main grounds which were outlined all provide support for the case that 'the proposal would not be in the interests of the health service in the area of the committee's local authority.'..."

Ten grounds for referral are cited – Transport; Original consultation; Lack of ongoing communication/engagement with public; Lack of ongoing communication/engagement with staff; State of Trust's readiness; Lack of integration across the Trust; Patient choice; Demographics; Health inequalities; Other IRP decisions.

IRP view

With regard to the referral by the HOSC, the Panel notes that:

- The NHS proposals were supported by the HOSC, as part of a Joint Select Committee response to the consultation.
- Consequently, the proposals have been incorporated into the NHS's planning for the new hospital at Pembury
- Building work for the new hospital, based on a business case, planning and design that includes a Women's and Children's Centre to replace services at the two existing sites, commenced in 2008 and is scheduled to be operational in two phases (January and July 2011)
- The NHS has made a substantial long-term financial commitment to the PFI development at Pembury based on the agreement to the redesign of services for women and children. At this late stage, the adverse financial consequences on local health services of a change in direction are a legitimate consideration.
- The HOSC supports the conclusions of its own Task and Finish Group, including:
  "*a) With the exception of the additional provisos mentioned in this report, we support the conclusion of the 2004 Joint Select Committee*
  b) None of these provisos would by themselves warrant a referral to the Secretary of State for Health
  c) However, there has been so much local public concern expressed about the implementation of the decision to reconfigure the Women's and Children's Services, that in order to reach a definitive conclusion, there remains only the option of referral to the Secretary of State for Health to obtain closure".
- In its report, the HOSC's Task and Finish Group note that *"an alternative solution that is deliverable, workable and acceptable ...has not been forthcoming from any of the witnesses and stakeholders interviewed".*
- Many of the issues raised in the HOSC referral, whilst of legitimate concern and interest, are about perceived weaknesses in the NHS's implementation of the agreed proposals for women's and children's services rather than the nature of the proposals themselves.
- Changes in key assumptions such as accessibility, population need and staff requirements have been cited as causes for concern. However, their impact on the proposals, or any viable alternative course of action, has not been assessed by the HOSC despite the fact that, as the IRP found in the case of population for example, data exist to inform such an assessment.

Conclusion

The proposals are in the latter stages of a long and complex implementation that involves a major PFI investment. There are legitimate anxieties and concerns about process and progress as the date for changing services gets closer. As the HOSC's Task and Finish Group advises, these issues can and should be tackled locally as implementation proceeds. The local NHS should engage fully with this process.

There remain some sections of the local community that do not accept that the proposals that have been agreed and are being implemented are in their best interests. The opportunity exists to engage these sections of the community in a realistic and informed assessment of the current position.

The IRP considers that this process would be better led by the HOSC in the first instance rather than through a full Panel review - though the latter remains a course of action in the last resort.

Further action

The IRP advises that:

- The implementation of the current proposals should proceed.
- The issues identified by the Task and Finish Group should be addressed by the local NHS, overseen by the SHA.
- A local assessment, led by the HOSC and involving all stakeholders, of the impact of any changes in assumptions such as population, accessibility and staffing, on the safety, sustainability and accessibility of the proposals should be undertaken within two months.
- The assessment should take into account the lack of identified viable alternatives.

Yours sincerely

Dr Peter Barrett
Chair, IRP

Independent Reconfiguration Panel
Tel: 020 7389 8045/6/7/8 *Fax: 020 7389 8001*
E Mail: info@irpanel.org.uk *Website:* www.irpanel.org.uk

APPENDIX ONE

LIST OF DOCUMENTS CONSIDERED

Kent County Council Health Overview and Scrutiny Committee

1 Letter of referral and attachments from Cllr Godfrey Horne, Chair, Kent County Council HOSC, to Secretary of State for Health, 24 February 2010
Attachments:
2 HOSC minutes of meeting 27 November 2009
3 Report of the Task and Finish Group considering the provision of Women's and Children's Services within Maidstone and Tunbridge Wells NHS Trust
4 Letter from Cllr Godfrey Horne, Chair, Kent County Council HOSC, to Department of Health, 18 March 2010
5 Letter from Cllr Godfrey Horne, Chair, Kent County Council HOSC, to Secretary of State for Health, 29 March 2010, attaching:
6 HOSC minutes of meeting 19 February 2010

NHS South East Coast

1 IRP template for providing initial assessment information
Attachments:
2 Birth data for area 2006 - 2009
3 Clinical services by site 2008/09 and 2012/13
4 *Excellence in care, closer to home: The future of services for women and children – a consultation document*, October 2004
5 Appendix 1 – birth maps and graphs
6 Papers for Joint Board Meeting in Public to Consider the Outcome of the Public Consultation into Services for Women and Children, South West Kent PCT, 17 February 2005
7 Map of key sites

Supplementary information requested

1 Clarification from NHS South East Coast regarding schedule for transfer of services to new Pembury Hospital and assessment of the demographic impact on services of the projected growth in population

Other information

1 Letter and attachments from Dennis Fowle, Chair, Maidstone Action for Services in Hospital (MASH), 3 April 2010
Attachments:
2 Submission
3 Letter to Cllr Michael Lyons, Chair, Kent County Council HOSC, 3 April 2010
4 Copy of Kent County Council HOSC letter of referral, 24 February 2010

5 Copy of letter from Dennis Fowle, Chair, MASH to Secretary of State for Health, 24 February 2010

6 Kent County Council HOSC minutes of meetings, 2007-2010

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 23 July 2010

Subject: Item 11. Committee Topic Discussion.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve.

(2) At the meeting on 26 March, Members of the Committee requested an opportunity at each meeting to discuss what they had heard and decide whether the outcomes for each main agenda item had been achieved, or whether there was a need for further information to be requested, and from whom.

2. Recommendations

(a) The Committee is asked to assess whether the outcomes for this meeting have been achieved or if further information on any topic is required by the Committee.

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