NHS
West Kent
Clinical Commissioning Group

Patient Transport Services – update on procurement

Background

- The contract for patient transport services (PTS) is hosted by NHS West Kent CCG on behalf of all Kent and Medway CCGs.

- Historically PTS services were provided by a range of providers in Kent and Medway.

- The previous PCT cluster re-procured the service in 2011/2012 and NSL Care Services were appointed as a new provider for the whole of Kent and Medway.

- NSL took over the contract in July 2013. The contract is for three years with the option to extend by up to two years.

- Contract performance since July 2013 has been poor.

- The contract ends in June 2016 and Kent and Medway CCGs have agreed to re-procure a new provider from that date and not extend the current contract.

Objectives of procurement

The aim procurement is to ensure provision of a service to provide routine (not emergency or urgent) transport for eligible Kent and Medway patients with a medical need for transport, between their places of residence and providers of NHS funded healthcare (services traditionally provided in hospital), in reasonable time and comfort without detriment to their medical condition.

- Patients will be transported in safe and timely manner in a vehicle appropriate to their needs
- Patients will not spend an unreasonable amount of time on vehicles
- Patients will be collected promptly, in reasonable timescales following their appointment
- Patients will be treated with courtesy, dignity and respect at all times
- There will be no detriment to patients' health and wellbeing during their journey
- The specified requirements of how these outcomes will be met are set out in the Service specification.

Service for patients – eligibility criteria

The DH published national eligibility criteria in August 2007 (Attachment 1). The current contract uses the South East Coast Eligibility criteria for NHS funded Patient transport (Attachment 2) that have been in use for many years. The South East Coast Eligibility criteria set out in more detail how the national criteria are to be interpreted locally; they do not restrict the national criteria.

The revised specification does not change either of these.

The revised service specification strengthens the requirement for a provider to meet these criteria.

Service specification

An updated service specification is being produced for the procurement. The specification is being jointly developed with CCGs and Trusts

Although the service for patients has not been changed the requirements for providers have been significantly improved from the one used to procure the current service. Specific changes are:

- ### Darent Valley Hospital

  Darent Valley hospital has been excluded from the procurement as they are intending to take the service in-house. This is to better enable them to manage transports into and out of London.

- ### Reintegration of call centre function

  The original service specification separated the contract into two lots, the call centre and provision of journeys. This could have resulted in two providers! In the new specification these are not separated and the same provider will be sought for both functions. This will allow greater integration between the call centre and planning and day control.

- ### Renal transport

  The new contract will be tendered in two lots. One for Renal services one for the rest. Renal transports are a stable and predictable set of journeys and providing a ring-fenced service will enable improved service standards for these patients.

- ### Improved liaison with trusts

  The new specification requires a much greater level and seniority of liaison and day to day planning control with individual provider trusts.

- ### Improved performance standards

  Performance standards for patient discharges are being tightened up so that all patients are collected within 2 hours of the hospital advising the PTS provider that the patient is ready to be collected. The current contract allows between 2 and four hours.

  Automatic penalties or reductions to payment are being introduced for failure to meet Key Performance indicators.

- ### Accurate activity data

  The specification includes activity data from the current provider and from trusts for journeys they have had to arrange themselves. This data is considerably more accurate than the information used in the previous tender.

- ### Improved clarity

  Lessons learnt over the last 18 months have been built into the specification to significantly improve clarity and reduce ambiguity.

The service specification includes much clearer operational descriptions of the interface with other transport providers (SECAMB, the Cardiac transport provider, the intensive care transport provider)

Patient Engagement

There have been a number of local events to discuss PTS provision with local people:

- 12 January Canterbury and Coastal CCG CPRG(12 attendees)
- 13 January South Kent Coast HRG (12) plus two locality chairs meetings: Deal (10) – and Shepway (16)
- 13 January West Kent Chairs meeting – (24 public)
- Ashford locality chairs PPG received information virtually
- 27 January Thanet PPG – (40 patients, carers and VCS)
- 28 January Swale Patient liaison Group – (10 public)
- 29 January DGS chairs – (11 public)
- TBC - Medway

The outcome from the work has been pulled together into the attached report setting out the views of local people about the services (attachment 3).

The key themes were:

- Delayed journeys and waiting time for transport (punctuality), long journey times
- Eligibility criteria
- Low awareness of PTS (as well as other transport options, including voluntary and community schemes)
- Confusing, lengthy and difficult to access booking procedures
- The need to strengthen the links between PTS and other NHS services especially mental health and hospital trusts
- Staff attitudes: showing a lack of understanding and consistency in dealing with the transport of carers/escorts, failure to inform families/care homes of progress, particularly in case of delays
- Lack of capacity and suitable range of vehicles
- Instances of poor level of care provided

Patients from each clinical commissioning group area have volunteered to join the Patient Transport Service working group and will meet together to test the patient experience standard and turn it into a charter, they will also comment on any subsequent iterations of theService Specification and Key performance Indicators. They will also receive training and support in the spring to take part in the formal assessment and evaluation of any bids and the prospective contractors.

Next steps timeline

The current timeline is as follows, this is not finalised:

Issue PQQ	April/May 2015
Shortlist and issue ITT	May/June 2015
Bids received and evaluation	June/July 2015
Contract award recommended	Aug/Sept 2015
Contract Award	Sept/Oct 2015
Contract Commences	1st July 2016

Appendix1

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			

First published date

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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

- *Ambulance and Other Patient Transport Services: Operation, Use and Performance Standards*, HSG (91)29, NHS Executive, December 1991.

- 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

Attachment 2 - South East Coast Eligibility Criteria

1. Introduction

A non emergency patient is defined as a patient who, whilst requiring treatment, does not need the skills of an ambulance paramedic or technician, but may require trained personnel to undertake a journey to or from a health facility.

The NHS expects patients to make their own way to and from outpatient and inpatient appointments unless there is a clearly defined medical reason why they can not use conventional transport options including:

- walking
- cycling
- public transport including bus, train, community transport schemes, voluntary transport schemes, taxi
- private transport including lifts by friends, carers, neighbours, relatives, or the patient's normal network of support
- Or a combination of the above.

The revised process and protocols for the eligibility criteria will be rolled out from April 2010 on all new and existing contracts across the South East Coast Strategic Health Authority to provide non emergency transport only to those patients who have a medical need.

Patient Transport Services (PTS) will continue to offer ambulances and care vehicles for eligible patients and will continue to provide appropriate transport where the medical need and entitlement criteria are applicable.

2. Principles

Not all patients attending a health facility will be entitled to non emergency PTS.

The Principle for the entitlement to non emergency PTS is defined as:

- The patient having a medical condition such that they require the skills of ambulance staff or appropriately skilled personnel on, or for the journey

And/or

- Following a documented clinical decision, it has been determined that the medical condition of the patient is such that it would be detrimental to the patient's condition or recovery if they were to travel by any other means

- Where the entitlement to PTS is clear the patient will be offered PTS regardless of distance and circumstances.

- An agreed assessment tool will be used to determine the patient's entitlement to PTS services and the type of PTS services that are available for patients to travel in, to and from their place of treatment

3. <u>Patients who are entitled to Patient Transport Services (PTS)</u>

- For mental health and learning disability patients -

    1. All community patients and some in-patients (*identified below) should exercise all means available to them to reduce reliance upon health provided transport. This will include, walking, cycling, driving, utilising public transport, lifts from care home staff/partner/carer/family/friends or using a public taxi where affordable to access

healthcare services and appointments.

2. If none of the above means of transport are available/accessible/appropriate on health grounds, people will be eligible to access health provided transport for the duration of their treatment if it is assessed as being required by an individual's care co-coordinator/care manager and it forms part of a care plan subject to regular review. This may be a car or ambulance type vehicle dependent upon assessed need.

3. For people receiving treatment for mental ill health/learning disability as an in-patient, health funded transport (this may be in the form of a vehicle retained at the hospital for patient transport) will be available for people detained under the mental health act 1983 (revised 2008) who will be escorted by at least one staff member for the duration of the journey.

4. *People receiving in-patient treatment on a voluntary basis and needing to access alternative healthcare services or appointments where transport is necessary if for whatever reason 2 above is not appropriate then 3 above shall apply.

    - Patients with an intravenous infusion that requires medical supervision
    - Patients requiring oxygen.
    - Patients with a chest drain or morphine pump.
    - Patients attending renal dialysis sessions two or more times per week (for the duration of treatment).
    - Patients attending radiotherapy/chemotherapy sessions two or more times per week (for the duration of treatment).
    - Patients where independent travel presents a clinical risk such as low immunity patients or patients with a reasonable possibility of an event occurring during transport that requires skilled assistance i.e. Epilepsy
    - Patients who have a clear need to travel in a wheelchair (providing they do not have a specially adapted vehicle, a mobility allowance or are unable to use public transport)
    - Patients who cannot walk without continual physical support (not including the use of aids such as walking sticks or Zimmer frames)
    - Patients who cannot use public transport (bus, train, community transport schemes, voluntary transport schemes, taxi) because they:
        - Have a medical condition that would compromise their dignity or cause public concern.
        - Have severe communication difficulties which routinely prevent them using public transport.
    - Patients who are Blind, profoundly deaf or have speech (not language) difficulties which mean they are unable to travel alone.

5. <u>Assessment criteria</u>

The following assessment criterion has been developed to ensure PTS is provided to patients who are entitled to it and to determine the type of vehicle they need. A series of questions is proposed to enable those assessing a patient's entitlement to make a clear decision and to be able to give those asking for patients transport an understanding why they are not entitled to receive PTS and what alternatives exist.

Stage 1 Assessing entitlement

FULFILLING ANY OF THE ETITLEMENT CRITERIA IN SECTION 3 WILL MAKE THE PATIENT ELIGIBLE TO PATIENT TRANSPORT SERVICES

If the MEDICAL reason is not detailed in the entitlement criteria the assessment team will use the next series of questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least monthly) get into a

If patients do not have a medical reason listed or are assessed as not eligible for booking Patient transport Service the following advice should be offered.

- **Patients should be reminded that Hospital transport is only provided for those people with a medical need.**
- **Advise Patients of alternatives i.e. Volunteer Car Bureau (48 hours notice required, charges apply, approximately half price of Taxi cost)**
- **Train and bus time tables along with maps and routes to hospitals can be found at (input local information websites)**
- **Patient may be able to get Travel Expenses (HTCS) reimbursed if eligible.**
- **HCI forms for future help or HC5 form for refunds**

Stage 2: Assessing the type of patient transport

Does the Patient need to travel lying down on a stretcher?	For Patients up to 18 stone in weight, book as a Normal Stretcher (NS) Mobility Note: - HCT address assessment required
	For Patients over 18 stone in weight, book as a Bariatric Stretcher (BS) Mobility (State number of Assistants required to transfer, 2, 3, 4, 5 or 6) Note: - HCT address assessment required
	For Patients able to transfer to a seat for transit? Book as Wheelchair Assist (WA) Mobility (State number of Assistants required to transfer 1, 2, 3 or 4 and if oxygen required)
Does the Patient need to use a wheelchair or more than one assistant to walk?	For Patients unable to transfer to a seat for transit, book as a Wheelchair In-situ (WI) Mobility (State number of Assistants required to transfer 1, 2,

Patients and Carers

ESCORTS AND CARER'S WILL BE PROVIDED OR ALLOWED

- **When transferring a patient to/from a secure area (i.e. under Mental Health Section).**
- **For all persons under 16 years of age.**

If a patient requests an escort or carer to assist them, and they do not fit into the categories above the following information will be sought to ensure a carer/escort is only considered in the appropriate cases:

- **The patient's condition is such that they require constant attention or support, as confirmed by clinical assessment.**
- **The patient has severe communication difficulties for example, Blind, profound deafness or speech (not language) difficulties, and therefore is routinely unable to travel alone.**

Proposed assessment weighting linked to questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least once a week) get into a normal car by themselves and travel as a passenger?
- Does the patient use public transport (at least once a week)?

Assessment score for entitlement +5

Part 1

- Medical Condition/Disability is such that further assessment is not needed + 5
- Medical Condition/Disability is such that further assessment is needed + 3

Part 2

- Patient uses public transport, taxi, own car or walks to see GP - 3
- Patient only receives home visits from GP + 2
- Patient routinely travels in a car as a passenger - 3
- Patient routinely uses public transport - 3

Attachment 3 – Patient Insight report

1 Introduction

In preparation for the re-procurement of the non-emergency Patient Transport Service, South East Commissioning Support Unit engagement and insight staff have worked with each clinical commissioning group and their regular patient reference/PPG chairs groups, as well as previously collating and analysing four years of evidence from across Kent and Medway about patients' experience of the current service. This was drawn from the 2010 Kent Link report, 2013 and 2014 Kent Healthwatch meetings, NSL complaints, media reports, information reported through the seven health networks over the last two years, and performance and quality reports.

During January 2015, the engagement and insight teams met with the five regular patient forums which work with the clinical commissioning groups for: Canterbury and Coastal, Dartford Gravesham and Swanley, South Kent Coast, Swale, and West Kent; whilst Ashford PPG received the information electronically. Some of the groups cascaded the information to their GP practices and the patient participation groups, their wider virtual health network members, or specific service user groups with an interest in patient transport; who in turn fed back their views which were then collated together in this report The engagement team also held a workshop with Thanet health network members and there is another booked for Medway in February. So far, 125 patients, carers and service users have been involved in direct discussions on this topic, with many more feeding in their views through their extended networks.

All of the CCG patient groups were able to discuss the procurement process, the lessons learned from the first Kent and Medway procurement and the South East CSU report which collated and analysed the key themes from a variety of sources of Kent and Medway patients' experience of the current and previous Patient Transport Services. The key themes were:

- Delayed journeys and waiting time for transport (punctuality), long journey times
- Eligibility criteria
- Low awareness of PTS (as well as other transport options, including voluntary and community schemes)
- Confusing, lengthy and difficult to access booking procedures
- The need to strengthen the links between PTS and other NHS services especially mental health and hospital trusts

- Staff attitudes: showing a lack of understanding and consistency in dealing with the transport of carers/escorts, failure to inform families/care homes of progress, particularly in case of delays
- Lack of capacity and suitable range of vehicles
- Instances of poor level of care provided

Many of those present at the recent discussions confirmed the key themes from this research concerning difficulties understanding the eligibility criteria and assessment process, difficulties over long waits or long journeys to incorrect destinations. There were many questions to establish the scope of the PTS contract: whether it was 24/7, whether a range of suitable vehicles were specified, and if the new contractor would have sufficient capacity to deliver contract effectively, if it covered GP practices and so on.

- *"From my experience the service is very difficult to use, nobody explains the service or how it works unless requested"*
- *"People wait all day to be taken home, so once discharged they have to sit for several hours, often late into the night time"*
- *"No updates are given to keep the patient informed"*
- *"Nobody explains that the service is "round the houses" and has multiple drop-offs, and is not direct for the individual patient, and therefore may take several hours - obvious to some, but not to others"*
- *"Many patients were very stressed by it, especially elderly patients who were often very distressed indeed." DGS patient*
- *"I think their main problem is communication as the booking service is in Shrewsbury who would know nothing about the local areas and hospitals, the drivers are all very good and helpful it is not their fault when they turn up late if they are given wrong addresses and details. I am sorry for going on but I have experienced a lot of problems with them."*

2 Measures of success to inform the service specification

The patients groups were then asked to discuss how they would frame measures of success which could be included in the service specification, either through the key performance indicators in the draft service specification, or by inserting a patient experience quality standard (a sample version was shared with them from some London boroughs, together with some statements suggesting what patients want from a high quality service). The patients also looked at the current eligibility criteria and how to make them clearer, or

suggested questions which the contractor could use to make the assessment process easier by using simple questions which elicit the patients' needs and capabilities in plain English. These questions could be used to frame staff training, improving the assessment process and the description of the eligibility criteria themselves.

2.1 Issues which were brought up during the discussions and virtual feedback were:

2.1.2 Location or disposition of vehicles

In our experience some South East Coast Ambulance vehicles were in the wrong places and then had to travel further to pick up patients. How will management of vehicles be written into the service specification to ensure fit with area and high patient need?

The current provider spent money on their fleet of vehicles but were blind to the requirements (for instance too many ambulances and not enough cars). When the contract goes to tender, would the new company change the makeup of vehicles to suit the needs of the population? Are they willing to spend the money?

The commissioners seem to be making the service cover an increasingly large geographical area. Why can we not have a local service with local knowledge?

2.1.3 Poor performance over time keeping, better contracts or penalties

Patients were well aware of the poor performance and bad time keeping issues with the current provider, and so were anxious to know how this can be avoided within the next service specification and contract. Patients discussed the key performance indicators and some of the thresholds and asked whether there would be penalties for missed discharge times. (See Appendix1 and the specific notes on KPIs)

- The current time slots for collection are generally considered too generous, and still feature most frequently in complaints to NSL. Patients suggested promotion of better time keeping, possibly by using the national benchmarking confidence levels to ensure the contractor is in the top quintile of performers. Incentivise the performance levels which would make the most difference to patients, possibly between an acceptable performance and a good performance: 80 per cent of costs paid for acceptable performance, 90 per cent if meet target, 100 per cent if in top quintile over three consecutive quarters; rather than the alternative which is to penalise poor performance on similar sliding scale set out?

- Could commissioners retain a portion of the overall contract payment for snagging issues when new contractors take over to incentivise smooth transition between incoming and outgoing providers?

- Patients felt there should be more onus on the service provider to arrange alternative vehicles if it could not make the pick up within the agreed time. There should be contingency plans which are put into place rather than just letting time lapse and patients wait unduly.
- Most importantly the service should be proactive about contacting or communicating with patients and/or staff caring for the patients, so that they know the service has been delayed and how much longer it will be.
- Patients felt there should be better planning by hospital trusts of when inpatients being discharged will be ready to leave hospital, taking into account potential causes of delay such as provision of medication.
- The contractor should recognise the patients with time imperatives such as very specific appointment times, and act accordingly to ensure swift journeys to meet specific appointments, differentiating from patients with more approximate time slot.
- It is important that when the hospital cancels appointments at short notice this is passed on to the PTS provider. When appointments are rescheduled, PTS should also be informed by the NHS service provider.
- Patients should not be returned home late at night or only if due consideration and care is taken to ensure they are able to return home safely, with friends/family or care givers contacted to assist.
- Patients in Swale have complained of too many patients being carried in one vehicle and being asked to “budge up to squeeze in another one” when mobility needs suggest careful carriage and assistance rather than rough and tumble of public bus service.
- When vehicles carry several patients, the delay with one patient can subsequently affect the journeys and appointments of several patients. So capacity needs to be considered and there needs to be communication about the knock-on impact and mitigating actions taken, if possible, to divert colleagues/other types of vehicle to collect some of the passengers.

2.1.4 Eligibility criteria

Patients agreed the eligibility criteria need greater clarity, and have worked on questions to assist in making the assessment process friendlier and easier for both parties.

There were calls for clarity, especially around whether carers can travel with patients. An example given by a member of the patient reference group is that of a patient who requires help with toileting needs. They were told they could not take a carer and that the driver could not help with this.

The eligibility criteria looks as if it will take quite a bit of time to go through. Questions were asked about the flexibility within the criteria, and how sensitively they are applied.

The criteria around senses, do they recognise only registered blind people or varying visual problems? A suggestion was made that neurological conditions should also be recognised, particularly if people are likely to have seizures or fits during journeys.

A question was raised about whether assistance dogs can travel in PTS vehicles with their master/mistress. If a patient is ineligible, would the provider be able to suggest a suitable alternative, such as volunteer transport schemes?

Patients recognise the hardship some people have in affording suitable transport, so think it is very important to provide information to those on low income who do not meet the hospital transport criteria about how they can reclaim hospital transport costs. "*We have experience of those who have appointments out of area, who do not meet the eligibility criteria and do not have the funds to pay for public transport. They are not accessing the follow up medical care they need."*

The criteria state those undergoing radiotherapy/chemotherapy are eligible – "*in my experience with our Volunteer Transport Scheme patients have not been eligible for hospital transport solely for this reason – we have many of our clients asking to use our scheme for this reason who have been turned down by the current system".*

2.1.5 Staff

It is important that call handlers are educated to converse clearly, especially if they have any accents. People with hearing disabilities will have difficulty understanding any dialects they are not used to.

All the staff should be friendly, polite and courteous as this behaviour can make people feel welcome and capable under difficult circumstances. Several people commented favourably on the ambulance drivers and support staff.

Patients would like to have seen more about quality requirements within the service specification to ensure better service delivery and client satisfaction. They would like the requirements of and training of the transport and control room staff to be stipulated within the final specification.

2.1.6 Differentiating between certain patients

Patients requiring chemotherapy were suggested as a potential group of patients which could be separated out, like renal patients, as requiring a contract of their own.

One CCG manager suggested those being taken home following a trip to A&E or ambulatory care should be prioritised to ensure smooth working of the urgent care system.

Renal patients and staff fed back their views on the current service to inform a service specification which would address their particular needs as patients who are regular users of the Patient Transport Service. These are noted in Appendix 1 at the end of this report, many of the suggestions are consistent with the needs of all patients using Patient Transport Services..

2.1.7 Difficulties with public transport

Patients reminded commissioners and providers that difficulties with public transport, particularly in rural areas, and at bank holidays, or in the evening, make attending hospital or returning home difficult. This should be seriously considered and taken into account when planning service contracts. They also highlighted the importance of alternatives such as volunteer car driver schemes – which have a cost attached, which can sometimes put patients off.

Publicising and supporting volunteer driver schemes: "*In my experience some patients choose alternatives before approaching hospital transport, it usually means a more direct route A to B and they are waiting around less before and after appointments. I think it is important that this information is available to the public so patients have choice."*

2.1.8 Integrating services and contracts

The services should work effectively together so that when patients receive information about their appointment they also get information about booking non-emergency transport and about alternative transport services. (For trust/service providers to action)

3 Detailed examination of the measures for success

Forty members of the Thanet health network attended a workshop to discuss three topics in detail: the key performance indicators (KPIs) from the current draft service specification, improving the eligibility criteria, and drafting a standard for high quality patient experience of a Patient Transport Service which could be embedded in the service specification and influence any additional work on the KPIs.

3.1 Key Performance Indicators

The participants were asked to rank whether they agreed with the indicators and suggest alterations if they felt could be improved and if so, how.

For instance:

Patients arrival time: Patients should arrive within an hour of their appointment time.

The performance indicator suggested: 95% no more than 60 minutes prior to appointment

Patients suggestions:

☺ can we reduce payment/increase penalty to only pay 50 per cent of cost?

☹ **the** consequences not clear enough, how it is worked out.

😐 an hour is too long, 30 minutes would be better.

😐and ☹ as were split 60 minutes being realistic pending number of patients included in one vehicle and distance/times etc. and split about breach rate being too low. Plus, does not feel provider will be truthful.

The patients had a chance to comment on every key performance indicator and threshold in the draft specification and many of their views and the language describing what they expect from the service has been carried through into the most recent version of the service specification.

3.2 The Eligibility Criteria

The patients discussed this in small groups and suggested that:

- Patients who regularly use the Patient Transport Services should be registered with Patient Transport Services.
- GP surgery or practice staff should undertake the eligibility assessment process: asking questions to assess patients' eligibility, and make sure this assessment process could be recorded on patients practice records. It could also record if the booking is to be made by patient.
- If GP makes decision, it would take out interpretation by provider.
- Make sure eligibility is written in easy-read format for people who can't read or have limited English.
- Also when treatment/care starts in hospital then medical practitioner could make the decision and likewise mark the records, and who assessed the patient.
- Eligibility questions are too detailed.
- Too many statements – no more than six are needed.

- At the booking staff need to get a clear idea of what kind of appointment, as well as the practicalities of the distance and location within the facility, as these requirements have a bearing on the amount of support needed for patients to arrive at point of treatment.

3.3 Questions which have been suggested as a means to assess someone's need and eligibility for the Patient Transport Service:

3.3.1 General assessment

- Have you attended before and how did you get there?
- How would you usually travel to hospital given your needs?
- Have you got someone that can take you?
- Have you got transport?
- Who is your GP? Where is your appointment?
- Are you receiving hospital treatment currently?
- Have you been advised by a health worker to use Patient Transport?
- Do you need support to go to hospital?
- Do you have anyone that could take you?
- Can you travel on public transport?
- Return journeys: Do you live alone? Do you have any dependants who should be told of your return?

3.3.2 General health

- Are you disabled or do you have a long term condition?
- Are you on any medication that restricts you from driving? Or will you receive treatment at your appointment that restricts you afterwards?

3.3.3 Mobility:

- How far can you walk? Between two lamp posts (75 metres)?
- Can you use public transport? If so – how far is it from home?

- Do you require or use a walking aid? Wheelchair? Mobility scooter? Stretcher?
- Do you receive attendance/mobility allowance?
- Do you use aids to support you?
- Do you use public transport on your own?
- Do you walk well on your own?
- Do you find walking hard?
- Do you have any walking aids like a stick, or zimmer/walking frame?
- Can you walk unaided or do you need help?
- Are you able to step up into a bath/public bus?
- Do you have difficulty stepping up into some cars such as people carriers/black cabs or minibuses?
- Do you need to travel with a wheelchair?
- Can you walk 83 steps or more unaided? (This measurement is based on an average step being 0.76 m/2.6ft – defined on pedometers, so someone with reduced mobility might have a step length reduced to 0.6m or 2 feet, therefore 83 steps equates to fifty meters.)
- Can you walk the length of two coach buses without assistance?

3.3.4 Carer accompanying patient

- Do you have a carer who accompanies you to your appointments?
- Do you need a carer to accompany you?
- Do you need someone to come with you? If so why?
- When you go out do you usually get someone to pick you up?

3.3.5 Senses

- Do you find communicating difficulties?
- Do you have any problems hearing or seeing

- Should be a way to check whether patient has regular seizures or fits such as neurological condition: Do you regularly have fits or seizures?

The exercise reveals to the patients taking part exactly how interrogatory an assessment process could easily become through volume of personal questions, and so recommend a minimum number is used to ascertain someone's needs.

4 Patient Experience Standard

Patients recognise that service standards must be realistic and achievable and that, in any contract, risks must be fairly shared and true partnerships developed. 'Working in partnership with the NHS' should not be a slogan on the side of an ambulance or other transport but a commitment on both sides. Otherwise disputes are inevitable and patients are then let down. The Patient Transport Service needs to work as an effective component of a patient's care and connect well with the NHS service it is taking the patient to and from as well as the patient and any family or carers involved in their care.

The engagement staff shared a sample of a patient experience quality standard based on previous discussions with patients in Kent and an example created by patients and the voluntary and community sector organisations from several London boroughs. This was shared with the patients involved in the workshop and they agreed that this was a useful way to set out clearly the standard quality of service which they felt should govern how the service worked, inform the training of staff, and influence the monitoring and measurement of any contractors' performance.

The majority of the draft standard was agreed with reservations about the wording specifically those with time-related standards, which the patients felt needed more detailed work to be realistic and ensure consistency with any of the key performance measures.

See draft standard below.

4.1 Service Standards describe how a service provider does what they agree to do. One measure of the quality of services, or *how well* a service provider does what they agree to do, is shown and measured by patients' experience of those services.

Patient experience includes their whole experience of services (healthcare, social care and the third sector) from beginning to end. It spans the whole patient journey, from knowing what services are needed and how to access them, continuing with the first contact such as telephone call, or appointment letter; it includes interactions with both clinical and support staff as well as smooth transfers between services and/or care providers; and it includes experiences of care in all settings such as home, community, hospital and all phases of care including preparation for care, acute care, continuing care and after care.

Patient experience is broader than satisfaction. You could be satisfied with the outcome of your care if for instance your hip was replaced, but you may have had a bad experience during your stay in the hospital because you experienced a lot of pain. Similarly, you may not be satisfied with the outcome of your journey to hospital if your journey is delayed so you miss an episode of care if for instance you were three hours late for your chemotherapy. This experience of poor care could be made easier through good communication: receiving the bad news about the delay to the journey could become a 'good experience' if you were kept informed by friendly staff, and your appointment was rearranged for you by the booking service, so that you felt cared for despite the difficult circumstances.

From a patient's perspective when I have a **'good experience'** of care, I feel:

- Confident of receiving an accurate timely care
- Positive about receiving high quality service
- Respected, safe, comfortable, and cared for
- Listened to and understood
- Informed and involved in decision making
- Able to take responsibility for and contribute to my own health as a partner in my care
- Assured of having full access to all available resources

A ***'good experience'*** of care is enabled when:

- My care is planned with me and centred on my needs and is inclusive of my family and carers
- My care is co-ordinated across health, social and any voluntary services
- Equipment and resources are available to meet my needs and requirements
- Staff are effective at communicating and sharing information with me and also with other staff within and across health, social and third sector services
- The vehicle/environments where I receive care are appropriate, accessible, clean, welcoming and enable my privacy and dignity to be maintained

Staff:

- Are professional, honest and accountable

- Are approachable, kind, compassionate and cheerful
- Maintain my confidentiality, privacy and dignity and treat everyone with respect
- Are prepared and informed about me, my care needs and other services
- Have the right knowledge, attitude and skills and adhere to policies
- Work in partnership with me, my family and carers and other professionals

4.2.1 Booking

Joined up services mean that when I get the information about my appointment I also get information about booking non-emergency patient transport and any alternative transport services. (For trust/service provider)

When I call to make a booking I will be able to get through in a minute or less, to a person, not an automated system and I will be given a clear explanation of the eligibility criteria.

When I call to make a booking, the person responding will ask if I have any specific communication needs (for example, I may want them to speak more loudly or slowly or repeat things)

I will be able to choose to make a booking on-line

On the day before my booking, I will get a reminder

I will be able to choose to get a reminder by text message, confirming estimated time of arrival

4.2.2 **Eligibility criteria** will be used to assess my need for non-emergency patient transport and make sure I get the right type of vehicle and support on my journey

Before asking me any detailed questions, the person I speak to will ask if I have received information on the eligibility criteria

Please use simple examples to help me to explain my mobility and care needs, in terms of distance I can easily walk, or the type of aid I require.

If I don’t meet the eligibility criteria, please provide me or my carer with contact details of suitable alternatives types of transport, such as volunteer transport schemes

When my booking is confirmed, please tell me who to contact if something changes or if I have a problem and how to cancel a booking. Then, if I need to cancel my booking, I will be able to make a new one in the same way that I made my original booking

4.3 My Outward Journey

I will be given a clear time, or time slot in which to expect my transport to collect me. I can expect that my transport will **almost always** arrive within 30 minutes of the time slot that I have been given

If there is a problem with my transport, I will be contacted and told about it. If my transport is delayed by more than 30 minutes I will be given a new time or time slot, and everything I would usually expect from a booking will happen for the new (revised) time or time slot

I will be given a **realistic** estimation of my journey time, taking into account the type of vehicle, any other passengers, the time of day, any road works and diversions, weather conditions and usual traffic flow on that route

The service will get me to my appointment **on time**, taking into account what kind of appointment I have and any procedure-related instructions that came with my appointment letter

My journey time and arrival for my appointment will be **reasonably** similar to that of someone using their own personal vehicle

Collection

When my patient transport arrives at my address, the driver or any escort will make every effort to let me and/or my family or carer(s) know that they have arrived to collect me. This should include following any directions made at my booking (for example, I may need someone to knock very loudly or contact a warden by interphone)

The driver and/or escort will have a suitable photo ID, or wear uniform or branded clothing so the patients can easily recognise them. They will check with me that the journey they are collecting me for is the journey I have booked, and they will ask me if I have any belongings and/or equipment that I need to take with me

I will be asked respectfully and positively about my needs in a manner that encourages me to say what sort of assistance is best for me (for example, the driver and/or escort might use an open ended question, “Is there anything else I can do to make you more comfortable?”)

The driver and/or escort will give me enough time to **safely** and **comfortably** settle into the vehicle, as independently as I am able to

At all times during collection, the journey, drop-off and return the driver and/or escort will be considerate of my **comfort** and **wellbeing** and be mindful of my **dignity**

4.5 Drop-Off

The driver and/or escort will give me enough time to **safely** and **comfortably** leave the vehicle as independently as I am able to

When we arrive at the healthcare facility, the driver and/or any escort will make every effort to let staff know that they have arrived to drop me off. This will include following any instructions added to my booking (for example, I may need to borrow equipment or wait for a porter)

If I need assistance from carers, staff or family, the driver will check that someone knows this and can assist me.

4.6 My return/homeward journey

"Please remember I have had treatment and so will be feeling frailer than usual, please plan a swift journey by the most direct route and keep me informed of any delays"

Please give me a clear time or time slot in which to expect my transport to collect me.

I expect that my transport will **almost always** arrive within 60 minutes of the time slot that I have been given, and if there is a problem with my transport I will be contacted and told about it.

If my transport will be delayed for more than one hour, I will be given a new time or time slot, and everything I would usually expect from a booking will happen for the new (revised) time or time slot.

I will be given a **realistic** estimation of my journey time, taking into account the type of vehicle, any other passengers, the time of day, any road works and diversions, weather conditions and usual traffic flow on the most direct route.

My estimated journey time will be **reasonably** similar to the same journey if a person used their personal vehicle.

If my transport is unable to make the journey for whatever reason I, and/or my family or the staff caring for me will be informed, and contingency arrangements made.

When my transport arrives at my home/resident address the driver and/or any escort will make **every effort** to let my family, staff or carer(s) know that they have arrived to drop me off; following any instructions added to my booking (for example I may need someone to knock very loudly or contact a warden by interphone)

4.8 Quality of care (For frail/vulnerable patients)

If I am to be transported home between 8pm and 8am, please inform my family or those who provide care for me and check that measures will be put in place to ensure any care needs I have are met in full.

All my needs will be considered, not just my journey, so that if I have specific medical or social care needs they are known and noted, and extra care is taken to contact and work with the family, staff or care support I receive at either end of my journey to ensure all my care is joined up.

> "I expect the staff to treat me as they would their own family: with kindness, care, and consideration. As a person deserving dignity and respect at all times"

Next steps

A summary of this work and the progress with the procurement will be shared with all of the patient forums which have contributed.

Patients from each clinical commissioning group area have volunteered to join the Patient Transport Service working group and will meet together to test the patient experience standard and turn it into a charter, they will also comment on any subsequent iterations of theService Specification and Key performance Indicators. They will also receive training and support in the spring to take part in the formal assessment and evaluation of any bids and the prospective contractors.

Appendix 1

Renal patients have to regularly receive treatment which means they are regular users of the Patient Transport Service. As patients with a chronic condition, they are often frail and concerned about the hygiene of their environments, due to an increased risk of infection. Those patients receiving dialysis have very specific bookings to use the equipment and cannot afford to miss their appointment/treatment times; which is why the key performance indicators have shorter time differentials in the draft service specification.

In gathering the views of renal patients and the staff who treat them, we have worked with East Kent NHS Hospitals University Foundation Trust and reviewed the findings of the national renal transport audits 2008, 2010 and 2012, along with the National Institute of Health and Care Excellence guidance on management of chronic kidney disease.

Patients and staff said that the main problems were:

1. Patients left waiting unacceptably long time for return transport post-dialysis
2. Patients booked to travel with others who may be finishing much later/earlier.
3. Afternoon patients brought in long before their booked appointment time and having to wait for a machine to be ready.
4. Difficulty in contacting NSL staff to discuss issues – especially after 5pm and at weekends
5. Being informed transport is 'nearly with you' and then finding, once it eventually arrives, that it was still a long way off when the call was made.
6. There is an inadequate service on a Saturday – just one car for all the patients here, and sometimes patients are completely forgotten.
7. It is often our most vulnerable patients, in wheelchairs requiring more help and specific transportation, that are left waiting. They become very anxious about getting home for their carers as they may miss their evening meal.

Suggested improvements:

1. Give the crews the "ready times" on the day in good time
2. Answer the phone sooner (the control line)
3. Tell the truth about where vehicles are and what time to expect them
4. Sort your regular bookings first (as being left waiting three times a week is not fair).
5. Speak to the renal unit if you know in advance there is going to be a problem, as we may be able to work around it
6. Learn the local areas and distances (suggest control team/planners go out riding shot gun, for a few hours each, with the crews, to see what the job involves)
7. Turn down the volume (or get rid of the horrible and irritating and painfully loud 'music' that is played when one is on hold. It doesn't help).
8. Control/planners should have a rough understanding of the way the renal units work, with timed slots, no spare machines, knock on effect when patients are late, no food available, closing times, staffing levels, cutting treatment times etc.

9. Try and get patients here at the right time and collect them on time, or is that too obvious?
10. Individual renal units should set their own time standards, taking into account local conditions but these should not result in more than 75% of patients waiting more than 30 minutes before or after dialysis
    Note – despite the first (Thanet) patient group rejecting the idea, there is a suggestion that journey times in a private vehicle be taken into account when setting these standards, that is when identifying acknowledged exceptions that would trigger single occupancy protocol
11. Where it is acknowledged that waiting times may be close to, and sometimes in excess of 30 minutes (especially with transport from rural areas or in zones of known traffic congestion), multiple pick up and drop off points should be avoided
12. Multiple vehicle occupancy should be rationalised and planned to give the closest approximation to a single occupancy direct route and should take into account timing of dialysis slots and length of session
    Note – this has an impact on technical vehicle specs as it presumes satellite navigation' equipped vehicles and efficient, real-time, dispatch to vehicle communications
13. Monitoring against time standards should be ongoing and separate from 'overall experience / satisfaction' surveys
14. Patient collection times should be closer to fixed times rather than longer 'windows' or time slots
15. Dispatch and vehicles should be able to communicate directly with renal unit staff to allow for more effective management of start times for dialysis and minimise waiting once patients arrive, or when planning their return journey